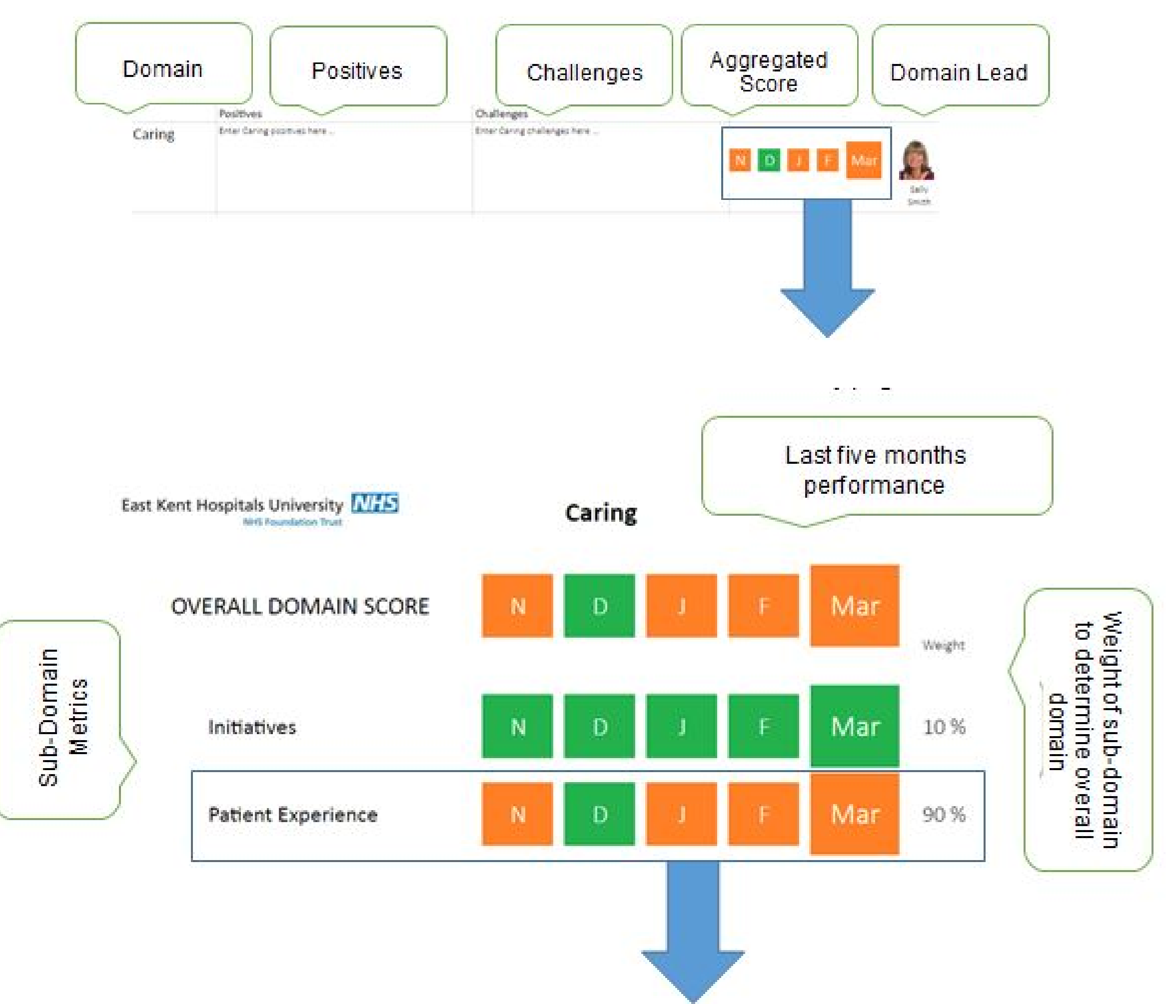
SEPTEMBER 2019

INTEGRATED PERFORMANCE REPORT

Understanding the IPR

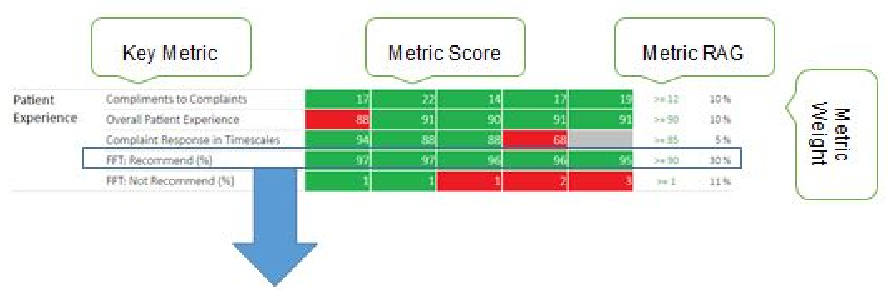
1 Headlines: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that the CQC organises its inspection into specific areas.

2 Domain Metrics: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall domain score. The second page illustrates key (but not all) metrics measured within that sub-domain.
This is important as it explains why the sum of each metric doesn't total 100%. A list of all metrics used in the calculation is summarised in the Glossary pages.

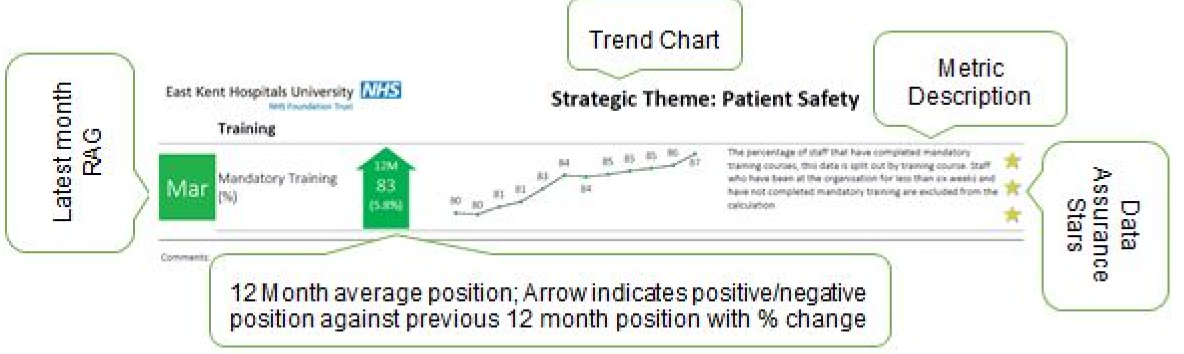


Understanding the IPR

3 **Key Metrics:** This section provides the actual data that builds up into the domain, the actual performance in percentage or volume terms for any given metric. These metrics are explored in more detail in the next section, Strategic Themes.



4 **Strategic Themes**: The Strategic Theme pages house key metrics with additional analysis, showing trend over the last 12 months. They show the latest month RAG together with the last 12 months position status (ie improved or worsened % from the previous 12 months plus average metric score). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.



All RAGs are banded as Green, Amber and Red. A grey cell indicates that data is not yet available. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

Strategic Priorities

Headlines

	Positives	Challenges	
Caring	Friends and Family Test (FFT) a) "recommended" and b) "not recommended" remains green, registering 97% and 1.3% respectively in September.	Mixed sex accommodation (MSA) breaches is reporting red in September. Recovery action continues to be led by the Trust MSA Collaborative action plan. Complaints response within timeframe is registering red in September. This deterioration reflects (in part) reduction in the number of complaint timeframe extensions being agreed. Following an independent review of the complaints function work is underway to increase the local ownership of complaints, to improve patient experience and timeliness.	M J J A Sep Amanda Hallums

Effective

Beds
The weekly review of all patients with a length of stay over 21 days (super stranded) has become embedded and supported the safe discharge of complex patients. Senior MDT review rounds have been implemented at QEQMH, WHH and K&CH.

Bed occupancy is green on the RAG rating, however, has deteriorated from 90% from 92%.

Clinical Outcomes
The percentage of non-elective 30 day readmissions has improved to 12.6% as has the percentage for elective readmissions to 3%, which is the highest performance in the past 5 months.

Demand and Capacity
The number of DNA for New out patients has improved to 6.3%. and with Follow up out patients improving to 7.6. The New : FU ratio is static at 2.

Productivity
Length of stay across elective pathways is static at 3.4% and non elective at 6.5 bed days. Theatre utilisation has remained static at 80%.

The number of non-clinical cancellations is 1.2%. The number of non-clinical cancellation breaches has improved this month from 29 to 12.

Beds
The number of DTOC (Delayed Transfers of Care) in September have increased from 76 to an average of 78 per day. The high number of DTOC continues to have a detrimental impact on patient flow.
Patients admitted as an emergency may be delayed in ED awaiting transfer to a ward, which results in a poor patient experience and compromises the achievement of the Emergency Access Standard. Escalation is in place at CEO level across the health economy, together with an increased daily focus on reducing internal and external delays from Site Director and senior management teams.

The number of patients discharged before noon has decreased slightly to 16%. There is a daily focus through the site clinical teams to increase the number of patients who are discharged in the mornings; last minute diagnostics and waiting for discharge summaries continue to be the key issues for delay.

Demand and Capacity
To manage an increasing demand in referrals across a range of specialities, eg endoscopy and colorectal surgery.

To provide sufficient emergency capacity to mange an increase in emergency attendances to ED, together with also the increase in emergency admissions which have put pressure on emergency patient pathways.

Productivity
To maximise theatre capacity and to increase productivity by improving on Theatre on start times.
To improve length of stay by reducing internal and external delays.

M J J A Sep

Lee Martin

Responsive

4 hour Emergency Access Standard.
September performance was 78.42 which is a slight deterioration in performance from 80.23%. This has been delivered with a 8% increase in attendances in month and a continued 7% increase in attendances to ED year to date.

RTT
Performance of 81.55% has been achieved against a trajectory of 80.00%.
The number of patients waiting over 52 weeks for first treatment is 3. This is a significant achievement since April 2018 when there were 222 patients waiting.

Cancer
2ww performance has been achieved at 97.83% against a performance standard of 93%. The demand for 2ww referrals has increased to 3413, although this may be due to seasonal variation.

DM01
Although the Trust has failed the DM01 by achieving 98.70 against a 99% standard, there have been improvements in all specialities with the exception of endoscopy, which had 164 of the 178 breaches this month.

4 hour Emergency Access Standard
To reduce the number of ED breaches due to bed availability and improve performance against the 60 minute standard which was 43.7% this month.

To resolve and reduce the number of internal delays and reduce the number of patients delayed in hospital over 7days (stranded) and 21 days (super stranded) who require a supportive discharge.

RTT
The Waiting list has increased from 46,121 to 46,544 and the backlog has also increased from 8389 to 8554. It is a priority to maximise out patient capacity, whilst also identifying substantive capacity to meet increased demand in specific specialities.

CANCER
September performance for 62 day treatments is 79.70% against an increased trajectory of 85.97%, validation continues until the beginning of November in line with the national timetable.

To manage the continued increase in referrals and identify sufficient capacity to enable the first appointment to be within 7 days.

To reduce any delays in a patients pathway once they have been referred on to a tertiary centre for on going assessment or treatment.

To minimise delays relating to diagnostic pathways, such as endoscopy.

DM01
Maintaining performance consistently across all diagnostic modalities.

To ensure that there is sufficient endoscopy capacity to meet the increasing cancer demand and also the diagnostic 6ww patient demand.

Lee Martin

Safe

Year to date we continue to have no hospital onset MRSA bacteraemias.

Harm Free Care experienced in our care (New Harms only) continues to be positive.

HSMR and RAMI for the latest reporting period remain below the previous 12 month average and both are below 100.

The Cancer care group and the two surgical care groups have sustained their VTE assessment recording performance >95%.

Overall Harm Free Care (HFC) relates to the Harms patients are admitted to the trust with, as well as those they acquire in our care. The Safety Thermometer for September (91.5%) shows a slight improvement to last month but remains below national average (94.0%).

Although there is a low rate of falls with harms the number of falls incidents Trust wide remains higher than the acute trust figure (prevalence of 2.1% versus 1.5%). Similarly although the prevalence of category 3/4 pressure ulcers remains low the overall prevalence of all pressure ulcers (6.8%) remains above the acute Trust average (4.2%)

Despite good performance in VTE assessment recording in some care groups this is not achieved in all care groups and the overall Trust performance in this remains plateaued at 94%, just beneath the 95% threshold.

Paul Stevens

Well Led

The Trust generated a consolidated deficit in month of £4.0m which £0.5m better than the planned position. This brought the year-to-date (YTD) position to a £19.2m deficit which was £1m better than plan. The year-end forecast remains in line with the plan of a consolidated £37.5m deficit excluding technical adjustments.

The Trust has secured an aligned incentive contract with the East Kent Commissioning group which reduces income risk for the 2019/20 financial year.

The Trust’s annual CIP target of £30m represents a significant challenge to deliver as it is the maximum the Trust considered achievable and requires concerted efforts on driving efficiency and cost consciousness throughout the Trust.

The CIP plan increases throughout the year therefore it is crucial that the Trust continues working up savings schemes for 2019/20 focusing on delivery of planned target and moving Red and Amber schemes to Green.

Total cash borrowed increased to £108m which will require paying back when the Trust is delivering a surplus.

Susan Acott

Workforce	There has been a positive push within each of the care groups to improve the delivery of meaningful appraisals with more accurate reporting and recording as well as more timely completion. These continue to be monitored via the EPR and supported within the care group by the HR business partners in conjunction with the Clinical Directors, Directors of Operations and Heads of Nursing. Furthermore, there has been a concerted push to drive statutory and mandatory training across the board resulting in an increase in performance overall. Again we have seen an improvement in the delivery of new staff and inroads into the retention of others. We have seen a further reduction in the level of nursing turnover, monthly time to hire and necessity for use of agency resources.	Sickness absence continue to present a challenge. In particular absence reported due to work related stress. There have been a number of difficult employee relations cases which have also seen reporting absent for extended periods during the investigation processes. The trust is working on a strategy to reduce the time taken for investigations as well as supporting new initiatives to support improved health and wellbeing for all staff. We have seen a general reduction in overtime over recent months but a slight rise de to the impact of the annual leave period, availability of flexible resources and incentives to facilitate safe care. The increase in turnover is subject to close scrutiny and is monitored under a corporate retention group which seeks to address the impact of turnover across the trust with particular focus on the ED. The recruitment of HCAs has been very successful but has also seen some early turnover in this particular group. A revised recruitment and selection process has been introduced which will address this.		Andrea Ashman

Caring

		May	Jun	Jul	Aug	Sep	Green	Weight
Patient Experience	Mixed Sex Breaches	0	0	4	4	57	>= 0 & <1	10 %
	Number of Complaints	68	79	77	70	70		
	AE Mental Health Referrals	75	44	61	61	94		
	IP FFT: Recommend (%)	96	97	96	98	97	>= 95	30 %
	IP FFT: Not Recommend (%)	1.8	0.9	1.8	0.8	1.3	>= 0 & <2	30 %
	Complaint Response in Timescales %	84.9	75.0	83.3	69.2	65.0	>= 85	15 %
	Compliments	2553	3758	3515	3272	2980	>= 1	

Effective

		May	Jun	Jul	Aug	Sep	Green	Weight
Beds	DToCs (Average per Day)	94	85	70	76	78	>= 0 & <35	30 %
	Bed Occupancy (%)	96	94	94	90	92	>= 0 & <92	60 %
	IP - Discharges Before Midday (%)	19	18	19	18	16	>= 35	10 %
	IP Spells with 3+ Ward Moves	510	482	553	495	471	Lower is Better	
Clinical Outcomes	FNoF (36h) (%)	60	60	64	61		>= 85	5 %
	Readmissions: EL dis. 30d (12M%)	4.1	4.0	4.0	4.4	4.0	>= 0 & <2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	17.8	17.1	17.0	17.8	16.4	>= 0 & <15	15 %
	Audit of WHO Checklist %	96	100	100	100	100	>= 99	10 %
	4hr % Compliance from Presentation to Stroke Ward	33	37	40	40	41	Higher is Better	
Demand vs Capacity	DNA Rate: New %	6.8	7.2	7.3	6.6	6.4	>= 0 & <7	
	DNA Rate: Fup %	8.8	11.0	9.2	7.7	7.6	>= 0 & <7	
	New:FUp Ratio (1:#)	2.1	2.1	2.1	2.1	2.1	>= 0 & <2.13	
Productivity	LoS: Elective (Days)	3.2	3.2	3.3	3.3	3.4	Lower is Better	
	LoS: Non-Elective (Days)	6.5	6.6	6.3	6.5	6.5	Lower is Better	
	Theatres: Session Utilisation (%)	80	82	80	80	80	>= 85	25 %
	Theatres: On Time Start (% 15min)	43	41	43	50	46	>= 90	10 %
	Non-Clinical Cancellations (%)	1.2	0.9	1.2	1.2	1.2	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	10	11	7	29	12	>= 0 & <5	10 %

Responsive

		May	Jun	Jul	Aug	Sep	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	84.26	84.65	84.61	83.81	82.13	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	81.22	81.40	81.35	80.23	78.42	>= 95	1 %
Cancer	Cancer: 2ww (All) %	96.53	96.16	98.02	98.31	97.83	>= 93	10 %
	Cancer: 2ww (Breast) %	93.81	86.32	96.27	96.00	97.26	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	95.72	92.83	97.66	94.28	97.67	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	94.12	91.07	100.00	74.58	94.23	>= 94	5 %
	Cancer: 31d (Drug) %	99.18	99.07	100.00	98.32	100.00	>= 98	5 %
	Cancer: 62d (GP Ref) %	80.18	72.94	82.80	80.22	79.70	>= 85	50 %
	Cancer: 62d (Screening Ref) %	91.89	73.33	97.14	88.89	92.31	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	85.71	72.00	73.91	63.64	87.72	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.45	99.60	99.42	99.08	98.69	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	
RTT	RTT: Incompletes (%)	80.66	82.06	82.46	81.81	81.62	>= 92	100 %
	RTT: 52 Week Waits (Number)	4	3	2	1	3	>= 0	

Safe

		May	Jun	Jul	Aug	Sep	Green	Weight
Incidents	Clinical Incidents: Total (#)	1,591	1,395	1,597	1,459	1,384		
	Serious Incidents (STEIS)	14	13	13	13	22		
	Harm Free Care: New Harms (%)	99.3	99.0	98.3	99.5	99.4	>= 98	20 %
	Falls (per 1,000 bed days)	5.29	5.45	4.85	5.14	5.23	>= 0 & <5	20 %
Infection	Cases of C.Diff (Cumulative)	16	24	30	39	48		40 %
	Cases of MRSA (per month)	0	0	0	0	0	>= 0 & <1	40 %
Mortality	HSMR (Index)	95.0	94.6	93.6			>= 0 & <90	35 %
	Crude Mortality NEL (per 1,000)	28.5	23.5	24.3	23.6	25.7	>= 0 & <27.1	10 %
Observations	VTE: Risk Assessment %	93.8	94.5	94.2	94.1	94.3	>= 95	20 %

Well Led

		May	Jun	Jul	Aug	Sep	Green	Weight
Data Quality & Assurance	Uncoded Spells %	0.5	0.5	0.4	0.3	0.8	>= 0 & <0.25	25 %
Finance	Forecast £m	-36.6	-36.6	-36.6	-36.6	-36.6	>= Plan	10 %
	Cash Balance £m (Trust Only)	18.8	7.4	7.5	8.8	15.5	>= 5	20 %
	I&E £m (Trust Only)	-3.2	-2.4	-1.7	-3.0	-3.2	>= Plan	30 %
Health & Safety	RIDDOR Reports (Number)	4	0	0	6	2	>= 0 & <3	20 %
Staffing	Agency %	7.3	7.4	7.3	7.1	7.1	>= 0 & <10	
	Bank Filled Hours vs Total Agency Hours	68	71	71	75	74		1 %
	Shifts Filled - Day (%)	99	101	101	97	96	>= 80	15 %
	Shifts Filled - Night (%)	98	98	97	96	95	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	11.2	10.7	10.6	11.4	10.7		
	Staff Turnover (%)	14.2	14.3	12.5	14.9	14.7	>= 0 & <10	15 %
	Vacancy (Monthly) %	9.3	9.5	9.5	10.2	9.3	>= 0 & <10	15 %
	Sickness (Monthly) %	3.6	3.5	3.7	4.0	4.9	>= 3.3 & <3.7	10 %
Training	Appraisal Rate (%)	77.2	71.8	74.5	78.4	80.5	>= 85	50 %
	Statutory Training (%)	94	94	94	94	94	>= 85	50 %

Strategic Theme: Annual Objectives 2019/20

	Achievement/Trajectory				Commentary	
Theme	Quarter 1 - 19/20	Quarter 2 - 19/20	Quarter 3 - 19/20	Quarter 4 - 19/20	BAF Risk	Assurance
Getting to good					There is one overarching risk to achieving this objective which is within the Board's risk appetite. None of the actions to mitigate this risk are overdue and updates are provided on those due within the next couple of months. There has been no movement in the risk score and this is due to the implementation timescale of the outstanding actions.	There is an adequate level of assurance for this risk. A gap has been identified in delivery of the pressure ulcer improvements and this is managed at Care Group meetings and Executive Performance Reviews. Quality Committee received an update on this at its September 2019 meeting.
Higher standards for patients					There are 6 risks to achieving this objective 1 of which is outside the Boards risk appetite. This risk relates to the establishment of Urgent Treatment Centres and engagement with the CCG, GPs and the Trust, this risk is being actively managed and updates are provided. Two of these risks have reduced in severity over the period which shows good management. A further two of these risks have 1 action each that is overdue but updates are provided.	There is an adequate level of assurance across the risk profile for this objective. The Finance and Performance Committee receives monthly reports on the progress with these objectives and the metrics are also reported in the Integrated Performance Report. One gap in assurance has been identified in relation to delivery of the 62 day cancer standard but performance is being sustained.
Delivering our future					There are 5 risks to the achievement of this objective all of which are within the Boards risk appetite. The highest risk, in relation to the clinical strategy and pre-consultation business case, has been reduced in the period due to progress being made against the agreed timeline. There are clear updates to the outstanding actions.	There is an adequate level of assurance over the risks, oversight is through the Finance and Performance Committee and directly at Board in relation to the clinical strategy. There are no limited assurances and no gaps in assurance.
Healthy finances					There is one overarching risk to the achievement of this objective which remains outside the Boards risk appetite for a second quarter. There has been no movement in this risk and given the actions to mitigate the risk are due over the next 6 months this is understandable. There are a number of actions that were due to deliver in September and updates are provided.	Overall there is adequate assurance over this risk which is overseen by the Finance and Performance Committee. There are a couple of external assurances but of note there are 3 limited assurances. One relates to assessment of the clinically led planning processed and this will be reviewed once the Well-Led report is received. The other 2 relate to activity and control of agency. The oversight Committee receives regular updates on both these areas.
A great place to work					There are 3 risks to the achievement of this objective, all of which are within the Boards risk appetite. 2 out of the 3 risks have been downgraded in th period but both the inherent and residual risk scores are the same, indicating that the outstanding actions are those that will provide the mitigation. There is only one outstanding action that is overdue and this has an update against it. The other actions span to September 2020 suggesting movement in the residual score will be limited.	Overall there is adequate assurance in place and the Strategic Workforce Committee receives update on all aspects of the objectives. Limited assurance is identified in relation to appraisal compliance which is an on-going topic for the Committee.
Right skills right time right place					There is one overarching risk to the achievement of this objective which is within the Boards risk appetite. The risk score has been reduced during the period but remains the same as the Inherent Risk Score which indicates the current controls are not adding value. The plans to mitigate this risk span 18 months so rapid improvement should not be expected.	Overall there is adequate assurance over this risk and the Strategic Workforce Committee receive regular updates on the programmes of work focussed on improving the culture. There is one "limited" assurance level in relation to Staff Networks as this requires further embedding. In addition whilst the Staff Survey provides external assurance it also identifies the areas for improvement that then drives the improvement plans.

Strategic Theme: Annual Objectives 2019/20

Objective	Measure	Related plan or strategy	What will this mean for patients/staff?	Achievement	Commentary
Quality and safety standards embedded at all levels in the organisation; e.g. pressure ulcers, falls rates, MUST scores	Pressure ulcers >= 0 & <0.15 % Falls >= 0 & <5 % MUST – TBC MUST assessment within 24 hours – 95% VTE >= 95 % MRSA / MSSA / C. Dificile	Trust Organisational Strategy 2019/ 22 Quality Strategy Mealtime Matters Plan Exemplar Ward Project Electronic Daily Audits	Improved quality, safety and experience resulting in good and outstanding care; Improved quality and experience of care offered , timely treatment and appropriate interventions; Access to best care consistently; Improved staff job satisfaction through access to information , education and tools to carry out their role		Performance has rallied achieving average of 0.7 per 1000 bed days in Q2 for category 2 PU, on track for end of year reduction. Improvement also focuses on improving the reporting of unstageable Pressure ulcers to provide an accurate basis for broader PU improvement and to achieve reduction in deep ulcers. Recovery action focuses on delivering training (to develop capability and staff confidence) and to align PU practice within EKHUFT to support increasingly effective system working. Refresh of the Trust Improvement plan supports this. Baseline audit in all clinical areas against National standard (mealtime matters standard) Achieved (7 focus areas 'red' for improvement) Baseline Audit of MUST compliance Trustwide Achieved (Compliance 40%) with monthly reporting from all relevant care groups on MUST compliance. Achieved 95%of all ward/Departmental managers and link nurses to have received a MUST training update
Improved identification, treatment and support of patients at high risk of deterioration	Achieve 98%% of patients having their vital signs recorded accurately to ensure early detection of deterioration and 100% were Early Warning Score (NEWS)	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Improved quality, safety and experience resulting in good and outstanding care; Improved quality and experience of care offered , timely treatment and appropriate interventions; Access to best care consistently; Improved staff job satisfaction through access to information , education and tools to carry out their role		Data tool for collection of baseline data of the deteriorating patient agreed. Achieved. Use of RESPeCT tool across the East Kent System agreed Achieved Clinical leads identified to include an intensivist (Nurse lead identifed and recruited to, medical lead out to advert being covered by Michelle Webb)
Deliver the Falls Stop programme and reduction in falls	Programme delivered Falls >= 0 & <5 %	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Improved quality, safety and experience resulting in good and outstanding care; Improved quality and experience of care offered , timely treatment and appropriate interventions; Access to best care consistently; Improved staff job satisfaction through access to information , education and tools to carry out their role		The average falls rate per 1000 bed days is 4.91 for Q2. Registering Green. Three impact actions are being measured as part of the falls CQUIN. 1. Lying & Standing BP to be recorded 2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale documented 3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided. Work is underway to refresh the Trust wide Improvement plan to ensure that improvement continues and furthermore that action is threaded from ward to strategic level. To deliver actions and progress that is credible, visible and meaningful to front line staff as well as delivering measurable improvement in patient experience and outcome.
Improved medicines safety	Completion of essential checks and audits; Achieve the required national standards for medicines reconciliation; Report on Staffs view of medication safety via the Trust Medication Safety Self-assessment tool; Medication Safety thermometer; Reduction in omitted doses of medicines to below national benchmarks; Medication incidents; Reduction in harm (by 50%) caused by medication incidents	Trust Organisational Strategy 2019/ 22 Quality Strategy Trust Medication Safety Plan Exemplar Ward Project Electronic Daily Audits Drugs and Therapeutics Committee Hospital Pharmacy Transformation Plan	Improved Medicines Value – i.e. positive health outcomes from effective use of medicines; Improved quality, safety and experience resulting in good and outstanding care; Improved quality and experience of care offered , timely treatment and appropriate interventions; Access to best care consistently; Improved staff job satisfaction through access to information , education and tools to carry out their role		Reduction in omitted doses of medicines to 9.8% Sept (Average for Q2 13.9%). The percentage of missed doses due to 'not documented' is < 25% of all missed doses Not achieved 29.8% (Aug 52%) Average for Q2 47.3%. The percentage of patients of a missed dose of critical medicine is < 6.5% (including patient refusal) Achieved 5% .Average for Q2 6.4%. The percentage of missed critical medicines is 25% (excluding patient refusal) Not achieved 57.1% (Aug 52.9%). Average for Q2 54.9%. All wards should have a ward storage audit compliance in each of the six metrics > 95% Not achieved 90.8% (Aug 87.6%). Average for Q2 90.6%. All wards should have CD audit compliance > 95% Not achieved 83% (Aug 87.4%) Average for Q2 84.3% Medicines reconciliation rate within 24 hours to be at 25% Not Achieved 20.1% (July 25.3%) 45% of EDN's to be screened by pharmacist Not Achieved 44% (July 45%)
All ward-based audits complete	All wards peer reviewed and consistently exceeding minimum % rating for good / compliance Monthly audits – "green " , zero tolerance of nil returns Mock CQC surveys in all care groups – rating Good	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Improved quality, safety and experience resulting in good and outstanding care; Improved quality and experience of care offered , timely treatment and appropriate interventions; Access to best care consistently; Improved staff job satisfaction through access to information , education and tools to carry out their role		Education for clinical staff complete with expectations of undertaking audit to agreed standard in own areas. 63% of wards have completed the electronic audits but 57% have completed the audits according to the standard

Strategic Theme: Annual Objectives 2019/20

Objective	Measure	Related plan or strategy	What will this mean for patients/staff?	Achievement	Commentary
Patients pathways improved to reduce the number of attendances at A&E for respiratory conditions	Improvement trajectory of 87.6% by 31 March 2020	Operational Performance and Delivery Plan ED Improvement Plan	Improved patient experience. Timely patient care. Improved patient flow , reduced pressures on ED.		September performance 78.42%, against a trajectory of 85.3%. Attendances 7% above plan and challenges around patient flow. ED Improvement Plan has been refreshed. Working internally and with external partners to improve patient flow, LoS and DToC. Respiratory Steering Group in place - Chaired by CCG. Work programme in place with a number of joint initiatives. Lightfoot data being used to develop respiratory dashboard.
The number of patients waiting longer than 52 weeks for planned care is eliminated	Zero 52 week waiters.	Operational Performance and Delivery Plan	Patients will have their planned care within an appropriate timescale; to reduce the risk of their condition worsening whilst waiting for treatment		As at Q2 3 52ww patients were reported in September 2019. All patients have treatment plans. The waiting list has grown and work is being done to reduce the booking agreements. All patients over 40 weeks are routinely reviewed to ensure each patient has an appointment/admission plan in place. Challenged specialties have improvement plans in place.
National Cancer standards for access to cancer care, achieved	Compliant 62 day pathway from January 19 Zero 104 day breaches	Operational Performance and Delivery Plan	Cancer patients will receive their care in a timely way, which will ensure the best possible outcome.		September 62 day performance is currently 79.70% against the improvement trajectory of 85.97%. This is an improving position and a recovery plan is in place to achieve compliance by the end of March 2020.
Working with CCGs, co-located Urgent Treatment Centres are established	UTCs to be established by December 2019	Operational Performance and Delivery Plan ED Improvement Plan	Improved patient experience. Timely patient care. Improved patient flow , reduced pressures on ED.		Project plan and Project Team Meetings in place. Deadline for delivery has been extended to March 2020. Works have commenced at QEQM.
Frailty and older people's pathways are integrated	Frailty & older peoples pathways integrated.	Local Care – Integrated Case Management (Dorothy Model)	Ability for acute and community physicians to work in an integrated way to ensure the best possible care for patients. Improved patient experience. Admission avoidance.		FAU mobilisation on 16th September 2019. Initial phase 1 will be ongoing quality improvement cycle. The team will use a process of daily and weekly review of pathway to develop stage 2.

Strategic Theme: Annual Objectives 2019/20

Objective	Measure	Related plan or strategy	What will this mean for patients/staff?	Achievement	Commentary
Work with partners to establish an Integrated Care System / Integrated Care Provider and new contract arrangement	Successfully working with partners to establish clear contractual arrangements and have a number of services which become integrated within the ICS / P by March 2020	10 Year Plan Organisational Strategy	Improved patient access Reduced length of stay Improved efficiency Fewer barriers for patients Flexible ways of working		The East Kent ICP Develoment Board have agreed the Vision, Purpose and Collaborative Behaviours for the ICP going forward. A governance structure is currently being developed that will support the ICP to operate in shadow format from April 2019 and in mature state by April 2020.
Establish other routine elective surgical procedures that could be undertaken on a planned site/s	Agree through the STP, which surgical specialties will be delivered from the planned site/s. by August 2019	Clinical Strategy	Improved patient access Reduced length of stay Improved efficiency Improved career pathway choice Flexible ways of working		Further work has been undertaken with the CCGs to help the commissioners reach a decision on the future models of care for routine elective surgery. The CCGs are currently considering their position.
Undertake a pilot elective orthopaedic centre for in-patient surgery established	Agree the BC for the pilot EOP including identification of the funding scheme	Clinical Strategy GIRFT	Improved patient access Reduced length of stay Improved efficiency Improved career pathway choice Flexible ways of working		Following the introduction of phase one of the pilot orthopaedic centre at K&C a number of bids for capital have been submitted to NHSE/I. In parallel, agreement has been reached to progress with a rental option and a project group is in place. Early indications are that the latest bid for NHSE/I capital may have been successful, at least in part.
To produce the first full draft of PCBC completed for review	Finalise evaluation criteria by June. To sign off the PCBC (current CCG timeline) November 2019 for submission to NHSI / E December 2019	Clinical Strategy	Improved clinical sustainability i.e. workforce, estate, clinical adjacencies Improved financial sustainability Improved patient outcomes		The PCBC is currently in draft format and is due to be submitted to NHSE/I in November 2019. The Clinical senate review is scheduled for November. The PCBC is on track to be submitted in line with the agreed timeline.
Undertake a public consultation on short listed options.	DoH approval to commence consultation (currently there is no CCG timeline for this)	Clinical Strategy	Improved clinical sustainability i.e. workforce, estate, clinical adjacencies Improved financial sustainability Improved patient outcomes		The PCBC is on track to be submitted to NHSE/I in line with the agreed timeline.
'Go live' with phase one of T3 (EHR).	Successful deployment of Sunrise CM™	Digital Strategy	Improved reputation Cost reduction / savings Improved patient experience Releasing clinical time to care;		Build of Sunrise nearing completion. User acceptance testing copmmenced. Phased roll out agreed with first stage being Order Communications & Single Clinical Portal due to commence end March 2020.

Strategic Theme: Annual Objectives 2019/20

Objective	Measure	Related plan or strategy	What will this mean for patients/staff?	Achievement	Commentary
1-3 year strategic financial programme developed	Meet planned control total for 2019/20 (measured against the financial plan) Developed plan for 2020/21 & 2021/22	Financial Plan	Improved morale for key vision/ divert financial resource to front line services		Q2 I&E plan is on track to be delivered, unless significant unanticipated worsening in September. Draft year plan is developed including financial recovery trajectory – approved by FPC/Board.
A clear workforce document outlining vacancies, future needs and a recruitment plan by care group	Reduction in the use of agency – measured against the agency reduction trajectory	Workforce Strategy	Reduced agency staffing should lead to improved outcomes for patients and staff		Workforce document has been developed and internally approved for adoption.
Patient Level Costing, Service Level Reporting, Model Hospital, GIRFT and RightCare in annual business planning and monthly monitoring	Undertake work through Q1/Q2 to identify areas of focus and present to FPC the end of year plan to improve in specific areas – at that point a metric will be agreed	Financial Plan	Will move staffing levels to national best in class		Opportunities are being identified & developed by PMO and Finance team, but a trajectory for monthly monitoring is not yet completed.
100% agency/bank and overtime shifts signed off against a robust temp staffing policy	Agency and back reduction trajectory	Workforce Strategy	Staffing levels will be clearly planned for in advance reducing risk to patients		Temporary staffing policy developed and approved by staff committee.
Nursing and medical rostering effective, 100% sign off and even leave distribution	Trajectories to come from Care Groups by end of Q1 and measuring against them thereafter	Workforce Strategy	Staffing levels will be clearly planned for in advance reducing risk to patients		Erostering tool adopted & used – usage reported at Eexecutive Performance Review meetings.
Finance training rolled out to all care groups	All budget holders to have reviewed and been tested on the SFI's Q3/4 Specific / group training delivered to all budget holders by end of March 2020	Financial Plan	Improved staff understanding of budgeting		The SFI's have been formally approved by Trust Board, but the training package for budget holders in being developed and is not yet complete.

Strategic Theme: Annual Objectives 2019/20

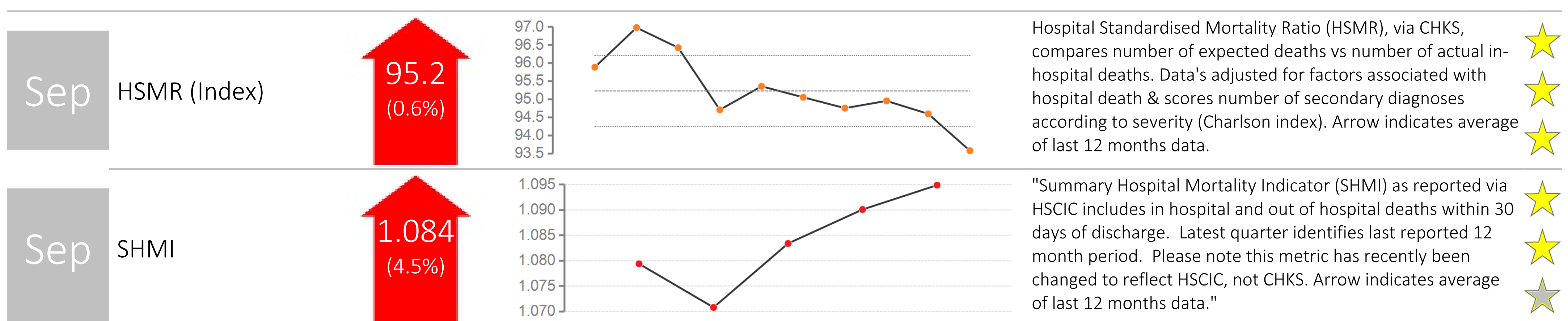
Objective	Measure	Related plan or strategy	What will this mean for patients/staff?	Achievement	Commentary
Respect for each other and our contributions to delivering service excellence in place	Staff survey reduction in number of grievances	People Strategy	Improved communications between staff will facilitate better care		This will be measured in part by the staff survey and numbers of issues raised via employee relationsl The respect campaign has been relaunched and cascaded throughout the care groups during Q1. ongoing sessions and resliilence training have also been undertaken which shoudl provide staff a vehicle to access support when needed and also restate and reframe our values.Progress against the Q1 &Q2 milestones has been acieved with work on track to meet Q3
Behaviours that are inconsistent with our values, are challenged	Increase in use of freedom to speak up guardians, workplace buddies and use of Vandebilt programme	People Strategy	Improved behaviours will result improve retention and support the retention of experienced staff to provide high quality care for patients		Staff need to feeel able to challenge and to be taken seriously This needs to be at the earliest moment to prevent poor behaviour escalating. The Vandebilt training is being deliverd December to support early intervention and prevention of further issues arising. Milestones for Q1 have been reached with Q2 due for completion this month
Organisational Development (OD) framework for consistent leadership standards in place	The OD framework used as the basis for assessment and measurement of performance underpinning personal development plans	Integrated Education Board (IEB) strategy People Strategy including OD and leadership strategy	Well led staff will provide higher standards of care for patients arising from with objectives, expectations and standards of provision		The OD framework and leadership stategy have been developed in conjunctino with senior leaders. This was a key element of the Q1&2 milestones which ave been achived. The main focus now is to embed this within the care groups and see the result in the delivery of better patient care.
Meaningful appraisals support staff, their careers and skills acquisition	Personal development plans aligned to skills development opportunities at all levels	People strategy IEB strategy OD / leadership strategy	Patients will benefit from staff who are engaged in a process of continuous professional development with enhanced skills to enable better provision of care.		The fiurst hurdle has been to I crease the rate of appraissals. This has steadily improved and Q1 tand 2 targets have been achieved.but has yet to reach the Trust targewhich is set for deivery in Q4t. The content should be used to support career management and personal development includng succession planning.
Staff supported in first year of employment is embedded	Staff retention within first year improved	People strategy IEB strategy OD / leadership strategy	Increased retention leads to higher experienced staff to patient ratios therefore better care.		Retention overall in key staff groups has imprvoedwith voluntary turnover at or around 12%. However early turmover in HCAs has increased . There is a direct correlation with high volume recruitment and early turnover therefore interventions have been put in place to address this a a matter of urgency. This includes a different approach to on boarding for this specific staff group.
Staff recognition/ reward programme	New elements added to the reward and recognition programme. Increase in staff use of benefits platform	People Strategy	Better staff engagement and motivation, improved attitudes and behaviours evident to patients.		There have been significant additions to the staff benefit programme in the last 6 months with improved offers that appeal directy to staff. The use of the platform has increased accordingly . Ilestones for Q1 &2 achieved.
Infrastructure/capacity to deliver 'quick wins'	Improvement in staff survey results	People Strategy	Some quick wins relate to people, other to physical estate and provision of equipment. Improvements in all areas will enhance the patient experience.		The trust has responded positively to requirements for improement in the physical aspects of the estate wherever possible This has included some significant changes to patient and staff areas across all site. The number of substantive staff has increased during the last 12 months whilst our reliance on agency workers has reduced. The number of staff benefits has incresed together with a drive to provide better leadership and management to support our staff and patients.

Strategic Theme: Annual Objectives 2019/20

Objective	Measure	Related plan or strategy	What will this mean for patients/staff?	Achievement	Commentary
A robust recruitment pipeline is in place	Reduction in vacancy numbers, reduction in time to hire	Recruitment & Retention strategy	Reduced number of vacancies, reduction in agency / bank workers, more consistent patient care		Q1 &2 milestone have been achieved. There is a strong recruitment pipeline in general terms but some roles remain more challenging than others. Retention of nurses is att he best level for five years but early turnover of HCAs is an area for further ttentino and has a specific set of actions to address this.The metrics are green in terms of measurement but we need to keep under constant review
We attract staff who haven't traditionally considered a role in the NHS	Increased apprenticeships, wide range of sources of recruitment	Recruitment & Retention strategy People Strategy	Staff employed in non traditional roles and diverse training support providing specialist care		The number of apprecnticehsips being offerred has increased with a wider variety of roles available . Recruitment events are targeting more school, colleges and universities to encourage a broader range of applications for roles that havenot been available traditionally other than to medical / nursing applicants.
Local Terms and Conditions enable individuals to have flexible working, with financial efficiencies and reduced reliance on temporary staff	Increase in variety of flexible working contracts / informal arrangements reduction in temporary workforce	Recruitment & Retention strategy People Strategy	Reduced number of vacancies, reduction in agency / bank workers, more consistent patient care		Q1 & 2 milestones achieved The Trust has set of good policies which encourage flexible working and provide a suitable platform for more felxible, non traditional ways to provide services. . On this basis the measure is green but the challenge lies in supporting supervisiors and managers to respond to the changes in ways of working with more flexible approaches to roster management. The Trust is exploring a pilot for team based rostering to support and pormote greater flexbilities.
A positive approach to mental health, including mindfulness, promotes personal resilience for staff	Increased take up of resilience workshops / mindfulness training or similar, reduction in absence due to mental ill health, staff survey , Friends and family	Occupational Health (OH) strategy People Strategy	Staff have more positive and resilient approach towards patients and co workers		1 & 2 milestones achieved. There is an increased level of awareness of mental health and wellbeing . Take up of resilience training is increasing however it has highlighted that there is a greater demand than than we are currently able to service which is being reviewed..
Kent & Medway Medical School research strategy	Trust R&I Director consulted on drafting KMMS research strategy	Research & Innovation Strategy	Increased opportunities for staff to be employed on joint clinical-academic departments between EKHUFT, KMMS and local Universities		Q1milestone achived. Q2 in progress with greater emphasis now placed upon rsearch opportintotes with KMMS as part of more general recruitment to the Trust.
Staff have ready access to support to create a healthy, supportive and caring environment	Reduced absence due to mental ill health, staff survey, friends and Family Test	OH Strategy People Strategy			Staff have access to support but ther demand on the service is high. Managers are being developed to understand their role in supporting their team members . The level of absence due to stress related issues is high but appropriate intevrentions are made available. Not all presentations are due to work related stress but reflect the multiple issues that staff have to juggle.

Strategic Theme: Patient Safety

Mortality



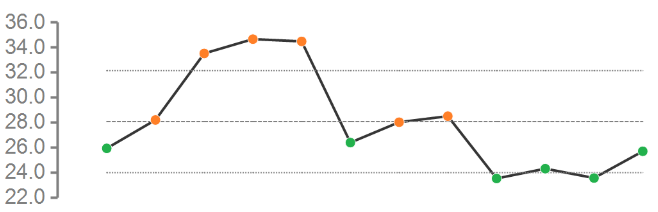
Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.

"Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data."

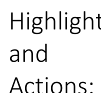
Strategic Theme: Patient Safety

Sep

Crude Mortality NEL (per 1,000)



"The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."



Highlights and Actions:

Crude mortality and HSMR continue to exhibit their seasonal variation, the difference between our crude mortality and our peers has not changed over the last 5 years, driven by the difference in demographics and comorbidity between the East Kent population and the England average. The Trust rate of 1.38% is 0.14% higher than the peer rate of 1.24% for the 5 year period. Of note the winter peak this year has been lower than previously despite the increase in emergency attendances.

Although our HSMR is in the 50th to 75th quartile in comparison to peers for the latest 12 month period the Trust HSMR was 95.4 and in the latest month for HSMR reporting (July 2019) Trust HSMR was 89.4 compared to an average peer value of 81.8.

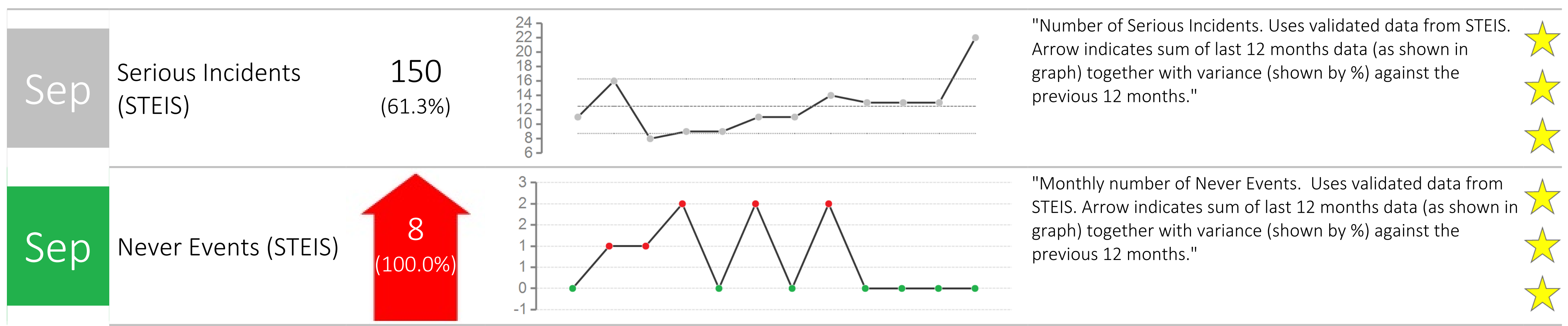
Risk adjusted mortality index (RAMI, not shown in this report) shows a similar pattern. For the 5 year period RAMI is in the 50th-75th centile of Acute Trust Peers. For the latest 12 month period the Trust RAMI was 93.7, in the latest month (July 2019) Trust RAMI was 86.4 compared to an average peer value of 81.4.

Summary hospital mortality index (SHMI) in the latest reported data on NHS digital is from the April 2018 - March 2019 period and was 1.09 (0.89-1.12, 95% over dispersion control limits) and is still reported 'as expected'. SHMI is now reported by site and the figures for the 3 sites (all reported 'as expected') were K&CH 0.81, QEQMH 1.08 and WHH 1.14. The monthly variation from CHKS data for the Trust level SHMI suggests a rising trend since 2015 and until the January 2019 data point 9 data points had been above the mean for the latest 5 year time period that data is available. SHMI is also affected by depth of coding. From our population demography and comorbidity depth of coding would be anticipated to be higher than the England average. However the Trust depth of coding for both elective and non-elective admissions is below the England average (3.5 versus 4.6 and 3.9 versus 4.8 respectively). Latest data from CHKS suggests that the Trust depth of coding is now approaching the England average and may partially explain why the Trust HSMR and RAMI have both been lower in the last 2 months data (June & July 2019 data). SHMI data is reported 6 months in arrears and the impact of increased depth of coding will take longer to appear.

The work that has seen an improvement in depth of coding needs to be sustained and additional work is still required to ensure that the palliative care code "Z515" is captured as failure to capture this has a negative impact on HSMR. This appears to be the key difference between us and our peers, for us Z515 is applied to around 18% of our finished consultant episodes (FCEs) as opposed to 34% in our peers.

Strategic Theme: Patient Safety

Serious Incidents



Highlights and Actions:

During September 2019, 22 new Serious Incidents (SIs) were reported and 15 SIs closed (including 2 downgrades).

At the end of September 2019 there were 95 SIs open, of which 17 were breaching, six non-closure responses were required and 21 were awaiting a closure decision by the CCGs. The remaining SIs were within timeframes or extensions had been granted by the CCGs.

The weekly Executive led SI panel continue to support rigorous analysis of SIs and the development of improvement plans focused on systems and mitigation of Human Factors. The panel ensures the Care Groups are managing delays in investigations and responses to the CCGs.

Practical support is provided by the Corporate Patient Safety team to investigation teams to improve the quality of investigations and reduce delays where possible. The Patient Safety team will be fully established by the end of October 2019, therefore the Patient Safety Facilitators will enable additional support and challenge to be provided during the investigation process.

Learning from SIs is shared through Lead investigator presentation to the Executive SI panel enabling constructive critique, cross Care Group learning and senior leadership oversight of emerging risks. Newsletters sharing the stories and learning from SIs are shared with staff via Care Group Governance mechanisms and the RiskWise newsletter which is circulated Trustwide. The Corporate Patient Safety team and specialists with a Trustwide remit also share learning when out in practice, during training delivery and at QII hub learning events.

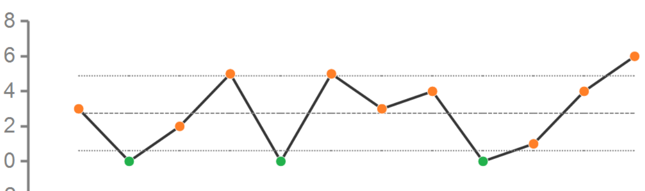
Strategic Theme: Patient Safety

Infection Control

Month	Indicator	Value (variance)	Description
Sep	Cases of MRSA (per month)	3 (-57.1%)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Sep	Cases of C.Diff (Cumulative)	48 (23.1%)	"Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01)."
Sep	E. Coli	91 (16.7%)	"The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Strategic Theme: Patient Safety

MSSA



"The total number of MSSA bacteraemia recorded, post 48hrs.

Highlights and Actions:

C.difficile
This financial year to date the number of hospital associated cases of CDI is identical to the arbitrarily set trajectory for this year. The trajectory is usually set based on previous years data but because the definitions for reporting have been changed this financial year there is no yardstick on which to base an 'expected' number of hospital associated CDIs.

MRSA
Year to date there have been no hospital onset MRSA bacteraemias.

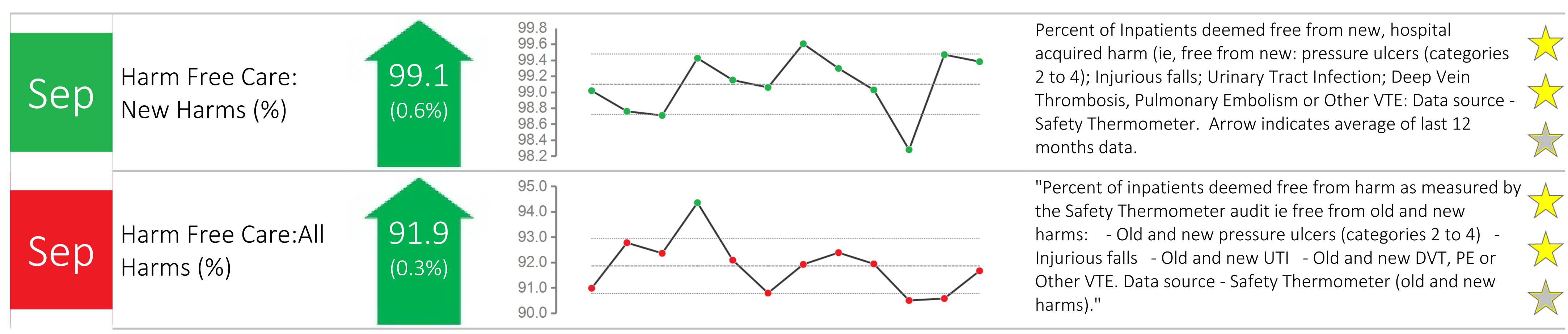
MSSA
The upper control limit for numbers of hospital onset MSSA bacteraemias has breached the upper control limit this month. Our overall local hospital onset MSSA bacteraemia rate year to date is 5.32/100,000 bed days compared to the the Southern region average of 5.15/100,000 bed days (range 1.93-13.05). MSSA has a strong age and gender association and these data are not adjusted for age and gender.

E.coli
E.coli bacteraemia also has a strong association with age and gender. This month our local number of hospital associated E.coli bacteraemias has gone up. The overall rate for both EKHUFT (16.5/100,000 bed days) and Kent & Medway (15.9/100,000 bed days) is above the Southern region average of 12.8, range 5.2-23.3.

Actions are targeted at reducing urinary tract infection through hydration and urethral catheter campaigns and also through the ‘Improving the management of lower Urinary Tract Infection in older people’ CQUIN. Actions aimed at reducing biliary tract infection and infections associated with colonic pathology include promotion of ‘hot gall bladder’ operations and the ‘Improving appropriate antibiotic surgical prophylaxis in elective colorectal surgery’ CQUIN.

Strategic Theme: Patient Safety

Harm Free Care



Highlights and Actions:

Overall Harm Free Care (HFC) relates to the Harms patients are admitted to the trust with, as well as those they acquire in our care. The Safety Thermometer for Sep-19 (91.68%) shows an improvement to last month (90.58%) but remains below national average (93.90%).

A marked improvement 89.19% is shown in general and specialist medicine (86.25% Aug-19).Work will continue to ensure robust validation of prevalence data to ensure harms are kept to a minimum and that patient safety remains a priority.
Actions include:

- Pressure Ulcer - Collaborative working through GTG

- VTE - Getting It Right First Time (GIRFT) National Thrombosis Survey to commence for 3 months - World Thrombosis Day on 13th October information within the QII hubs.

- Falls - Focused work on patients having more than one fall to improve preventative measures

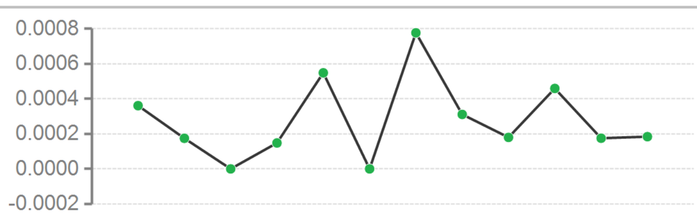
- UTI's - Six wards will have implemented the updated National catheter pathway paperwork/passport by the end of October.

Harm Free Care experienced in our care (New Harms only) at 99.38% remains similar to last month (99.47% Aug-19). All new harms remain significantly below the national average for acute hospitals.

Strategic Theme: Patient Safety

Pressure Damage

Pressure Ulcers Cat 3/4 (per 1,000)



"Number of category ¾ hospital acquired pressure ulcers per 1,000 bed days. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

There was a total of 38 category 2 and above reported, an increase of 6 from August 2019.

- Twenty-seven of these were category 2 ulcers, an increase of 7. Although the rate has increased from August 2019 (0.583/1000 bed days in August and 0.797/1000 bed days in Sept) the trust met the 10% reduction trajectory for this month. Common themes for category 2 ulcers were lack of repositioning evidence.
- There was 1 confirmed category 3 pressure ulcer, 1 equal to last month. This was a low harm incident. No confirmed category 4 ulcers were reported. Compared to August 2019 the rate was almost identical (0.029 in August 2019 and 0.030/1000 bed days in Sept). The trust met the 10% reduction trajectory for the second consecutive month.
- Ten potential deep ulcers were reported (7 more than last month). 1 was suspected deep tissue injury (SDTI) and 7 were unstageable ulcers. The trust did not meet the set 10% trajectory for Unstageables and the rate increased from August (0.027/1000 bed days in August 0.098/1000 bed days in Set). 2 of these are moderate harm both at WHH. For SDTIs we were under the 10% reduction trajectory.
- 29 reported incidents were due to Moisture Associated Skin Damage an increase of 2 from August 2019.
- There were 7 category 2 medical device related pressure ulcers. All currently low risk incidents.

Actions:

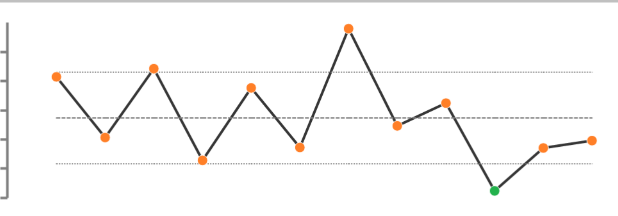
- Site based study day held on all acute sites
- Work with representative of getting to good group to maximise pressure ulcer prevention actions.
- Trust wide action plan reconfigured to reflect trust wide priorities
- Teaching commenced to all ED staff at QEQM
- Lead TVN attended community link nurse meeting to share good practice and improve lines of communication
- Monthly pressure ulcer review meeting held on Cambridge J staff to share learning and identify actions.

Recommendations:

- Reintroduce pressure ulcer panels to ensure that ALL RCA action plans are robust and effective.
- Safeguarding training to include elements of pressure ulcer prevention
- TVNs to attend trust induction programme
- Chair cushion trials to commence to improve availability of vital equipment
- Further funding sought for Hybrid and active mattresses

Strategic Theme: Patient Safety

Falls



"Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

Falls incidents Trust wide have remained stable in September. There were a total of 184 patient falls compared with 182 in August 2019, but 6 falls occurred outside of ward areas. There were 42 at K&CH (35 in August), with the highest numbers on Kingston (10) and Harbledown (9). 1 patient fell twice and 1 fell 3 times on Kingston, with 1 fall resulting in an unavoidable hip fracture. There were 56 at QEQMH (50 in August), with the highest number on St Augustine's (8) and Fordwich (8)- 1 patient fell twice and there was 1 avoidable hip fracture. There were 84 at WHH (96 in August) with the highest numbers on Cambridge M1 (11)- 1 patient fell twice and and 1 fell 3 times.

Within this overall figure there has been a increase on the KCH and QEQMH sites and a significant decrease at WHH.

Clinical Support Services remain the Care Group with the highest rate at 88.28, Urgent and Emergency Care at 23.19, General and Specialist Medicine at 4.98, Surgery and Anaesthetics at 4.19, Cancer Services at 4.58, Upper Surgery, Head, Neck and Dermatology at 3.52 and Women and Children at 0.65. There have been minimal rises in the Women and Children and Surgery and Anaesthetics care groups and a more significant rise in Urgent and Emergency Care (22.46 in August).

High impact actions:

• All patients who had more than one fall were assessed by the Falls Team and measures put in place to prevent falls.

• Monitoring by the Falls Prevention Team of the compliance with weekly ward based audits to identify areas requiring challenge and support (with triangulation with falls incident data). Data is now being shared with nominated wards (3 per site per month) with the Falls Team supporting and carrying out Post Fall audits. Wards will be expected to present their own data and actions in future. The Falls Team are also using ward manager meetings and 'cluster' to discuss audit results, falls incidences and ongoing investigations. Where possible this is being supported by the Clinical Governance teams.

• Continued focus on FallStop programme.

• CQUIN- 3 high impact actions for falls prevention. Year to date achievement is at 72% for lying and standing blood pressures, 97% for non prescribing of sedating drugs and 93% for mobility assessments, with overall compliance with all measures at 68%.
Risks:

The Falls Team continue to highlight risks relating to the achievement of the CQUIN and Trust target to reduce the rate of falls, due to the lack of staff resources to deliver further quality improvement via the FallStop programme. A business case for 2 band 4 practitioners for FallStop has been prepared but is delayed whilst a service review is being undertaken.

Strategic Theme: Patient Safety

Incidents

Month	Measure	Value	Description
Sep	Clinical Incidents: Total (#)	18,164 (9.2%)	"Number of Total Clinical Incidents reported, recorded on Datix.
Sep	Blood Transfusion Incidents	112 (-5.9%)	"The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."
Sep	Medicines Mgmt. Incidents	1,885 (6.1%)	"The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."

Strategic Theme: Patient Safety

Highlights and Actions:

A total of 1373 clinical incidents have been logged as occurring in Sep-19 compared with 1455 recorded for Aug-19 and 1285 in Sep-18.

In Sep-19, 22 incidents have been reported on StEIS. Nine serious near miss incidents have been reported. Comparison of moderate harm incidents reported: 11 in Sep-19 and 11 in Aug-19, and 12 in Sep-18.

Over the last 12 months incident reporting remains constant at K&CH, but is declining at both WHH and QEQM.

IPR report for Medicine management – September 2019
As of 15/10/2019 the total number of medication related incidents reported in September 2019 was 155. These included 114 no harm, 38 low, 1 moderate harm and 2 death incidents. One of these death incidents was highlighted by the legal department from a case in 2017 relating to fluconazole toxicity. The other death incident relates to a patient that wasn't given antibiotics that had been prescribed on discharge from the Emergency Department. The moderate harm incident was a further obstetric incident relating to inaccurate VTE risk assessment and prescribing of enoxaparin that led to a pulmonary embolism.
The severity of medication related incidents reported in September 2019 shows that 71.8% of incidents reported were no harm incidents. There were three medication related incidents that were sTEIS reported. The themes from incidents reported include the administration of the wrong release opiate preparations, particularly oxycodone and tramadol.
The data produced by the Medication Safety Thermometer in September 2019 was taken from 29 wards across the sites, and has shown that the percentage of patients with an omitted dose of medication was 9.8% (National 9.6%) and the percentage of patients with a missed critical medicine was 5% (National 6.4%) in September.
Jackie Shaba
Medication Safety Officer

Blood transfusion (submitted by the Blood Transfusion Coordinator)

There were 11 blood transfusion related incidents in September 2019 (7 in August 2019 and 8 in September 2018).

Of the 11 incidents 10 were graded as no harm and 1 as low harm.

Of the incidents 8 fell in Prescription/ Documentation error (including Traceability) category- of these 8 incidents 6 were traceability incidents- on further interrogation of the patient notes the traceability was found for 5 of these incidents. Staff have been spoken to and reminded that a DATIX should only be raised if the traceability is not found. The remaining two incidents were the transposition of labels on blood components both for the same patient. This was identified when the second unit was collected, the first unit had already been transfused, and the component was intended for this patient so there was no harm. The other incident was a newly qualified member of staff signing to say they had second checked a unit of blood however they had yet to receive their blood transfusion training. The training has now been given.
The remaining 3 incidents included the collection of two units of blood in a box designed for the transport of a single unit. The second unit was recalled by the laboratory and marked as out of temperature control and then disposed of. The recall of a unit of red cells from NHSBT and the last incident was delays by NHSBT in the provision of a washed platelet product.
Reporting by site: at 2 QEQM, 2 WHH and 7 at K&CH

Strategic Theme: Patient Safety

Friends & Family Test

Month	Measure	Value	Commentary
Sep	IP FFT: Response Rate (%)	36 (3.4%)	"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Sep	IP FFT: Recommend (%)	97 (0.1%)	
Sep	IP FFT: Not Recommend (%)	1.3 (-10.7%)	"Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

The Trust Score in September is 4.52 (4.55 Aug-19)

The three top positive themes for the trust;
- Care
- Staff attitude
- Implementation of care

The three top negative themes for the trust;
- Care
- Waiting times
- Staff Attitude

September Results;
Inpatients:
Recommendations: 97.44% (96.03% Aug-19)
Response rates: 39.14% (35.11% Aug-19)

Strategic Theme: Patient Safety

Maternity:
Recommendations: 99.13% (98.8% Aug-19)
Response rates: 20.53% (15.1% Aug-19)

Day Cases:
Recommendations: 95.01% (95.53% Aug-19)
Response rates: 25.08% (25.59% Aug-19)

ED:
Recommendations: 80.99% (81.51% Aug-19)
Response rates: 15.53% (16.09% Aug-19)

Outpatients:
Recommendations: 91.98% (92.36% Aug-19)
Response rates: 20.01% (21.04% Aug-19)

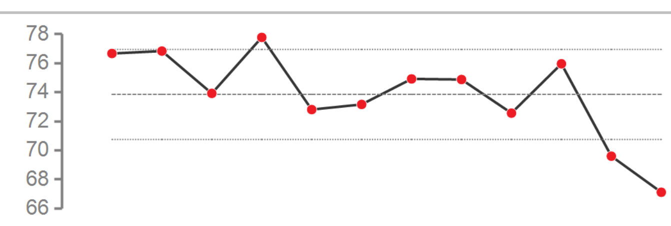
Recommendations;
Improved in inpatients and maternity but fell slightly in ED, outpatients and daycases. Response Rates;
Overall response rates improved in our inpatients and maternity units but fell in ED and outpatients but remained similar in day cases.

All areas receive their individual reports to display each month, identifying areas for further improvement. This is monitored and actioned by Care Group Governance teams.

Strategic Theme: Patient Safety

Patient Experience 1 - Inpatient Survey

IP Survey: Are you aware of nurse in charge of you each shift? (%)



IP Survey: Are you aware of nurse in charge of your care each shift? (%)

Highlights and Actions:

Patient Safety Experience 1 (Inpatient Survey)

Our inpatient survey enables our patients to record their experience in real-time and this month we received 660 completed inpatient surveys.

New questions were included within this local survey to reflect improvement priorities, with progress monitored through the Patient Experience Group. Patient experience is additionally reported per ward within the heat map and focused work continues to promote this reporting.

Patient experience has improved within these areas:

- Did you feel you received all the information you needed whilst you were in hospital?
- Has the staff explained your treatment and care to you in a way you could understand?
- How would you rate the quality of hospital food?
- Did you get sufficient help from staff to eat your meals?
- In your opinion how clean was the hospital room or ward?
- Overall, did you feel you were treated with respect and dignity while you were in the hospital?

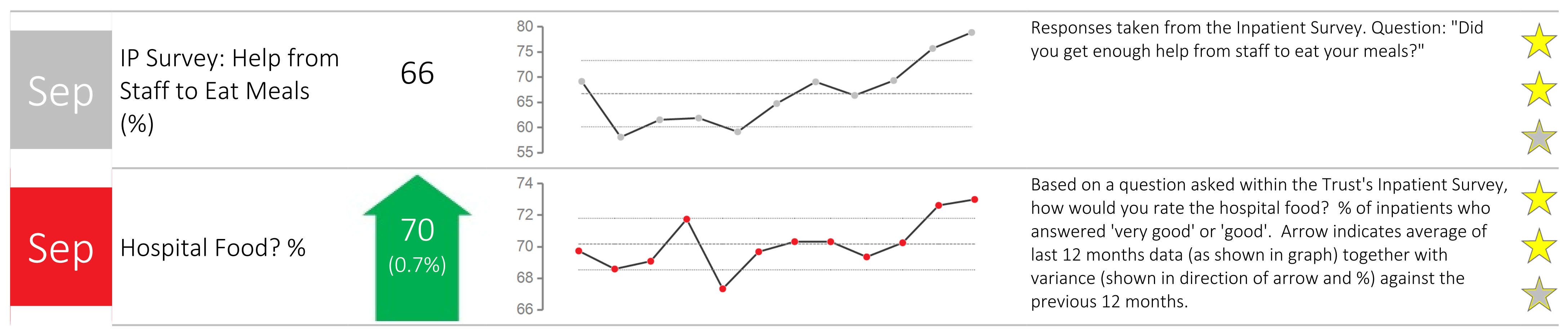
Areas in which patient experience has deteriorated;

- Are you aware of which nurse is in charge of your care each shift?
- Were you able to discuss your worries and fears?
- Were you offered a choice of food?
- Whilst in hospital did you share a sleeping area, bay or room with a patient of the opposite sex (N/A for ED, Intensive Care unit, Stroke unit and Cardiac care)
- Are you aware of how to raise your concerns or make a complaint?

Targeted work to further support patient experience will continue this work is integrated into our Improvement Plan for 2019/20.

Strategic Theme: Patient Safety

Patient Experience 2 - Inpatient Survey

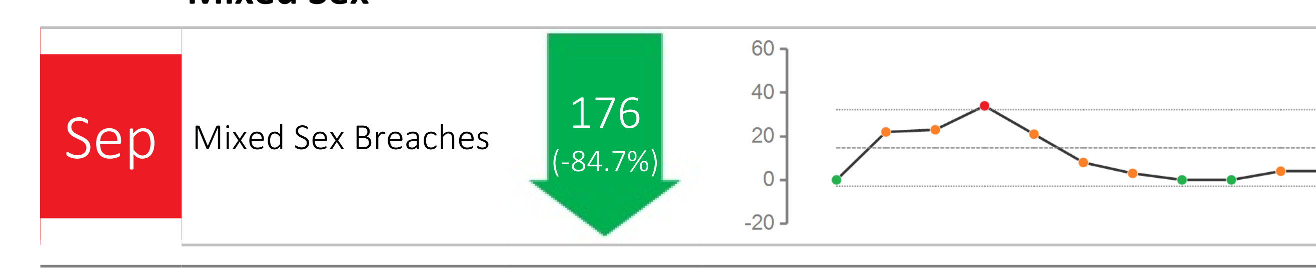


Highlights and Actions:

Patient experience is additionally reported per ward within the heat map and focused work continues to promote this reporting. All inpatient wards within the trust continue to report their performance (against the patient experience metrics) through the inpatient survey this month.

Strategic Theme: Patient Safety

Mixed Sex



"Number of patients experiencing mixed sex accommodation due to non-clinical reasons (un-justifiable). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

Mixed Sex Breaches

There were 38 mixed sex accommodation occurrences in total, affecting 239 patients. There is an increased of mixed sex reporting and these figures follow the new September 2019 National guidance

Incidence of mixed sex accommodation breaches has increased with 9 unjustified breach affecting 57 patients, within the WHH AMU linked to flow and capacity.

Justifiable Breaches -The remaining 29 occurrences in WHH; CCU, RSU and ITU, QEQM; Fordwich, ITU and K&C; ITU, affecting 182 patients, which were justifiable based on clinical need. This information has been reported to NHS England. Rigorous work continues in achieving compliance with the national definition of mixed sex accommodation

Actions:
- Increased focus to review develop and strengthen reporting in accordance with new September 2019 National guidance

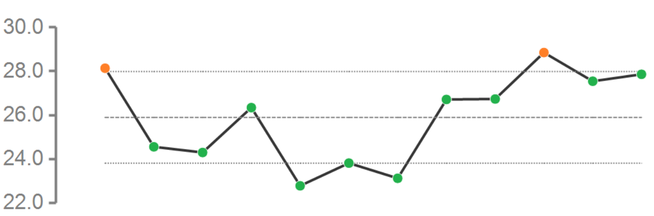
Strategic Theme: Patient Safety

Safe Staffing

Month	Measure	Value	Description
Sep	Shifts Filled - Day (%)	98 (-0.2%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Shifts Filled - Night (%)	98 (-2.1%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Care Hours Per Patient Day (CHPPD)	11.3 (-0.2%)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Strategic Theme: Patient Safety

Midwife:Birth Ratio (%)



The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.

Highlights and Actions:

Percentage fill of planned (funded establishment) and actual (filled shifts) by hours is required to be reported monthly by registered nurse and care staff, by day and by night, in line with National Quality Board expectations. Reported data is derived from the Healthroster system which shows an average overall fill rate of 98.7% compared to 99.6% in Aug-19.

Care Hours per patient day (CHPPD) relates actual staffing to patient numbers and includes registered staff and care staff hours against the cumulative total of patients on the ward at 23.59hrs each day during the month. CHPPD is similar to Aug-19 but slightly below the control limits. The range is from around 5.0 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required.

Further detail is provided in the appended paper submitted to the Quality Committee and reported by the Chair at Board of Directors.

Strategic Theme: Human Resources

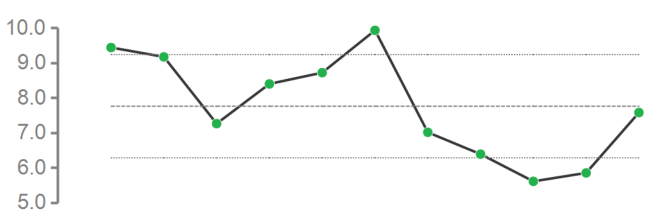
Gaps & Overtime

Month	Metric	Value (variance)	Description
Sep	Vacancy (Monthly) %	10.0 (-14.4%)	Monthly % Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Sep	Staff Turnover (%)	14.3 (3.5%)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Sep	Sickness (Monthly) %	4.1 (7.2%)	Monthly % of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the

Strategic Theme: Human Resources

Sep

Overtime %



% of Employee's that claim overtime.

Highlights and Actions:

Gaps and Overtime
The vacancy rate decreased to 10.0% (last month 10.2%) for the average of the last 12 months, which is an improvement on last month and last year. The monthly rate decreased slightly to 8.84% (down from 9.21%), mostly due to improvements in recruitment in the Urgent & Emergency Care and General & Specialist Medicine and CSS Care Groups. There are currently approximately 723 WTE vacancies across the Trust (750 WTE last month). More work is being undertaken to target hard to fill vacancies, particularly within nursing and Medical specialties. There are approximately 480 WTE candidates in the recruitment pipeline - i.e. those who have been offered positions and are gaining pre-employment clearances. This includes approximately 170 Nursing and Midwifery staff (including ODPs) and 90 Medical and Dental staff.

The Turnover rate, including Doctors in training, in month decreased to 14.3% (last month 14.5%), and the 12 month average was 14.3% (14.2% last month). Focus remains on hard to recruit roles to replace agency, but also to identify new ways and methods of attracting to hard to recruit roles. Exit data is reviewed to highlight any areas of concern.

The in month sickness absence position for August was 4.00% - which is an increase from 3.70% in July. The 12 month average increased to 4.1% (4.0% last month), and still shows an upward trajectory. Higher than normal short term sickness was observed across the QEQM and WHH wards, with an increase in D&V sickness absence. Work is underway between the Employee Relations team and HRBPs to look into areas of high sickness absence to ensure all cases are being managed effectively. Care Groups have developed sickness absence reduction plans, with a focus on long term sickness absence and an integrated approach to proactively managing absence with Occupational Health through case conferencing and regular contact. This includes supporting stress, anxiety and compassion fatigue through Respect & Resilience workshops, Mindfulness Courses and Mental Health First Aid training.

Overtime as a % of wte increased slightly last month, to approximately 8.00%, but remains on a downward trajectory for the last 12 months. The average over the last 12 months decreased from 8.2% to 7.7%% last month, and shows a downward trend. All metrics are reviewed and challenged at a Care Group level in the monthly Executive Performance Reviews.

Strategic Theme: Human Resources

Temporary Staff

Month	Indicator	Value	Description
Sep	Employed vs Temporary Staff (%)	90.1 (1.5%)	"Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Sep	Agency %	7.8 (12.6%)	% of temporary (Agency and Bank) staff of the total WTE
Sep	Bank Filled Hours vs Total Agency Hours	65 (13.2%)	% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff

Highlights and Actions:

Temporary Staff

Total staff in post (WTE) increased in September to 7462.36 (up from 7383.12 WTE in August), which left a vacancy factor of approx. 724 wte across the Trust.

The average percentage of employed staff vs temporary staff over the last 12 months increased to 90.1% (89.9% last month), and remains an improvement over the previous 12 months. As a result of this, the percentage of agency staff of the total WTE for the Trust decreased to approximately 7%, from 8% in the previous month. This was also partly as a result of an ongoing increase in Bank filled hours against total agency hours. The 12 month trend still shows an upward trajectory due to high agency usage in January to April 2019.

The percentage of hours filled by bank (NHSP) staff against agency staff remained on an upward trend for the 7th month running.

Agency costs are monitored at EPR and weekly agency meetings, the focus remains on recruiting substantively to the reduce the use of agency. The Agency Taskforce review strategies for reducing agency costs. Divisions are all now monitoring Agency use on a post by post basis through the agency reduction plans in Aspyre with support from HR and Improvement Delivery Teams. These plans identify detailed and specific actions to eliminate where possible spend on agency.

Strategic Theme: Human Resources

Workforce & Culture

Month	Metric	Value (variance)	Description
Sep	Statutory Training (%)	93 (0.7%)	"The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months. "
Sep	Appraisal Rate (%)	78.1 (0.8%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Time to Recruit	11 (-19.8%)	"Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

Workforce & Culture

Average Statutory training 12 month compliance remains on an upwards trajectory, and was 93% in month for September. This remains above the target of 85%. Care Groups are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements. All Care Groups, with the exception of UEC, have over 90% average compliance on statutory training.

The Trust staff average appraisal rate increased for the 3rd month to 80% in month for September (78% in August). Surgery & Anaesthetics (86%) and Surgery Head, Neck & Breast (91%) are above the 85% target. Care Groups are working on plans to complete outstanding appraisals as well as to avoid a further drop in appraisal rates for those due to be renewed in coming months.

The average time to recruit is 10 weeks, which is an improvement on the previous 12 months. The 12 month average time to recruit remains 11 weeks, but the annual average remains on a downward trajectory. The Resourcing Team are on track to reduce time to recruit to below 8 weeks to ensure recruitment time meets the demands of our services. To support this reduction, the team are now fully established and Advisors have been allocated to Care Groups to support improvements.

Activity vs. Internal Business Plan

Key Performance Indicators

Sep

	Sep-19				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	13,854	13,871	(-17)	0%	91,421	87,561	3,860	4%	91,421	86,379	5,042	6%	<=0%
Referral Non-Primary Care	14,363	12,335	2,028	16%	96,745	86,405	10,340	12%	96,745	87,266	9,479	11%	<=0%
OP New	18,359	17,395	964	6%	110,483	105,086	5,397	5%	110,483	108,167	2,316	2%	>=0%
OP Follow Up	39,248	38,959	289	1%	241,080	237,850	3,230	1%	241,080	237,319	3,761	2%	>=0%
Elective Daycase	5,804	5,772	32	1%	37,766	36,802	964	3%	37,766	37,693	73	0%	>=0%
Elective Inpatient	974	1,310	(-336)	-26%	6,740	7,587	(-847)	-11%	6,740	7,684	(-944)	-12%	>=0%
A&E	19,808	18,391	1,417	8%	118,919	111,383	7,536	7%	118,919	111,215	7,704	7%	>=0 & <5%
Non-Elective Inpatient	6,952	6,817	135	2%	44,556	42,019	2,537	6%	44,556	40,306	4,250	11%	>=0 & <5%
Chemotherapy	1,321	1,230	91	7%	8,039	7,448	591	8%	8,039	7,234	805	11%	>=0%
Critical Care	1,729	1,768	(-39)	-2%	10,699	10,961	(-262)	-2%	10,699	10,808	(-109)	-1%	>=0%
Dialysis	7,043	6,697	346	5%	44,143	41,591	2,552	6%	44,143	40,714	3,429	8%	>=0%
Maternity Pathway	1,089	1,061	28	3%	6,680	6,745	(-65)	-1%	6,680	6,754	(-74)	-1%	>=0%
Pre-Op Assessments	2,271	2,976	(-705)	-24%	16,840	21,284	(-4,444)	-21%	16,840	20,179	(-3,339)	-17%	>=0%
Diagnostic	473,543	453,809	19,734	4%	2,894,879	2,786,587	108,292	4%	2,894,879	2,744,022	150,857	5%	<=0%
Other	4,682	4,768	(-86)	-2%	30,251	31,430	(-1,179)	-4%	30,251	30,166	85	0%	>=0%

September 2019

Summary Performance

Elective Care

In September Primary Care referrals were on plan with the YTD variance remaining at 4% above planned levels. Rapid Access referrals remain below planned levels YTD (-2%), however routine referrals remain above planned levels generating a YTD variance of 4% (+2,848). Non Primary Care referrals are 12% above planned levels YTD.

The Trust achieved the outpatient New plan in month with appointments 6% above planned levels and remain above plan YTD (+5%). YTD Underperformances were seen in Ophthalmology (-723), Maxillo Facial (-608), Urology (-568), and Ear, Nose & Throat (-544).

The Trust over-performed the follow up plan in September by 289 patients with the YTD variance remaining at +1%. YTD underperformances remain in Physiotherapy (-1,295), Ear, Nose and Throat (-985) and General Medicine (-650).

Daycase admissions achieved the plan and delivered for the fifth consecutive month generating a YTD performance 3% above plan (+964). Underperformances were seen in key elective specialties Maxillo Facial, Ophthalmology, General Medicine, General Surgery and Pain Management.

Elective Admissions are 11% (-847) behind the plan YTD with General Medicine (-443), Trauma and Orthopaedics (-384) and General Surgery (-134) contributing to the largest underperformance.

Non Elective Care

Attendances to the Emergency Departments across the Trust continued to be above plan at +8% in month and +7% year to date. Emergency admissions are also +2% in month and 6% above plan year to date. Emergency activity in 19/20 is up by 11% when compared to 18/19.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	6,146	7,210	-15%	-1,064
101 - Urology	3,122	4,128	-24%	-1,006
301 - Gastroenterology	3,855	4,492	-14%	-637
191 - Pain Management	1,084	688	57%	396
400 - Neurology	3,048	2,408	27%	640
120 - Ear, Nose & Throat	5,976	5,325	12%	651
110 - Trauma & Orthopaedics	5,912	5,255	13%	657
330 - Dermatology	8,274	7,609	9%	665
104 - Colorectal Surgery	5,250	4,540	16%	710
340 - Respiratory Medicine	3,520	2,249	56%	1,271
Total	**91,421**	**87,561**	**4%**	**3,860**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	14,041	16,861	-17%	-2,820
800 - Clinical Oncology	4,923	5,657	-13%	-734
430 - HCOOP	1,032	1,435	-28%	-403
650 - Physiotherapy	6,842	6,399	7%	443
300 - General Medicine	2,109	1,656	27%	453
101 - Urology	4,586	3,790	21%	796
100 - General Surgery	3,031	1,904	59%	1,127
502 - Gynaecology	4,575	3,293	39%	1,282
130 - Ophthalmology	10,070	8,142	24%	1,928
340 - Respiratory Medicine	9,056	1,454	523%	7,602
Total	**96,745**	**86,405**	**12%**	**10,340**

OP New

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	10,584	11,307	-6%	-723
140 - Maxillo Facial	3,652	4,260	-14%	-608
101 - Urology	4,066	4,634	-12%	-568
120 - Ear, Nose & Throat	6,441	6,985	-8%	-544
650 - Physiotherapy	10,143	9,549	6%	594
215 - Paediatric ENT	722	118	514%	604
420 - Paediatrics	4,593	3,919	17%	674
330 - Dermatology	7,426	6,740	10%	686
502 - Gynaecology	7,585	6,606	15%	979
110 - Trauma & Orthopaedics	8,834	7,560	17%	1,274
Total	**110,483**	**105,086**	**5%**	**5,397**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
650 - Physiotherapy	30,621	31,916	-4%	-1,295
120 - Ear, Nose & Throat	8,034	9,019	-11%	-985
300 - General Medicine	373	1,023	-64%	-650
800 - Clinical Oncology	22,650	22,033	3%	617
290 - Community Paediatrics	11,977	11,277	6%	700
101 - Urology	11,452	10,544	9%	908
655 - Orthoptics	4,716	3,800	24%	916
502 - Gynaecology	7,905	6,894	15%	1,011
330 - Dermatology	10,538	9,303	13%	1,235
361 - Renal	10,535	9,199	15%	1,336
Total	**241,080**	**237,850**	**1%**	**3,230**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
140 - Maxillo Facial	1,047	1,292	-19%	-245
130 - Ophthalmology	2,361	2,519	-6%	-158
300 - General Medicine	10,246	10,404	-2%	-158
100 - General Surgery	740	880	-16%	-140
191 - Pain Management	955	1,090	-12%	-135
110 - Trauma & Orthopaedics	2,454	2,297	7%	157
800 - Clinical Oncology	3,347	3,154	6%	193
101 - Urology	4,297	3,976	8%	321
410 - Rheumatology	659	55	1093%	604
301 - Gastroenterology	1,028	384	168%	644
Total	**37,766**	**36,802**	**3%**	**964**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	615	1,058	-42%	-443
110 - Trauma & Orthopaedics	1,542	1,926	-20%	-384
100 - General Surgery	414	548	-24%	-134
503 - Gynaecology Oncology	158	213	-26%	-55
120 - Ear, Nose & Throat	296	347	-15%	-51
400 - Neurology	128	170	-25%	-42
320 - Cardiology	72	112	-36%	-40
420 - Paediatrics	177	132	34%	45
811 - Interventional Radiology	149	76	95%	73
101 - Urology	1,474	1,352	9%	122
Total	**6,740**	**7,587**	**-11%**	**-847**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	11,291	12,252	-8%	-961
420 - Paediatrics	3,594	4,477	-20%	-883
560 - Midwifery	986	1,368	-28%	-382
100 - General Surgery	3,193	3,543	-10%	-350
110 - Trauma & Orthopaedics	1,979	2,130	-7%	-151
501 - Obstetrics	2,517	2,662	-5%	-145
301 - Gastroenterology	218	353	-38%	-135
101 - Urology	2,395	2,157	11%	238
430 - HCOOP	4,042	3,744	8%	298
180 - Accident & Emergency	9,228	3,974	132%	5,254
Total	**44,556**	**42,019**	**6%**	**2,537**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	2894879	2786587	4%	108,292
A&E	118919	111383	7%	7,536
Pre-Op	16840	21284	-21%	-4,444
Dialysis	44143	41591	6%	2,552
Other	30251	31430	-4%	-1,179
Chemotherapy	8039	7448	8%	591
Critical Care	10699	10961	-2%	-262
Maternity Pathway	6680	6745	-1%	-65

4 Hour Emergency Access Standard

Key Performance Indicators

78.42%

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
4 Hour Compliance (EKHUFT Sites) %*	80.89%	81.74%	79.36%	74.20%	73.85%	78.23%	77.13%	81.22%	81.40%	81.35%	80.23%	78.42%
4 Hour Compliance (inc KCHFT MIUs)	83.88%	84.50%	82.25%	77.93%	77.56%	81.53%	80.54%	84.26%	84.65%	84.61%	83.81%	82.13%
12 Hour Trolley Waits	0	0	0	0	0	0	0	0	0	0	0	1
Left without being seen	3.09%	2.77%	3.03%	3.02%	3.56%	3.67%	4.03%	3.49%	3.83%	3.70%	4.50%	3.90%
Unplanned Reattenders	9.82%	9.56%	9.46%	9.59%	9.82%	9.83%	10.70%	9.98%	9.94%	9.54%	9.69%	9.60%
Time to initial assessment (15 mins)	71.4%	70.9%	65.0%	66.3%	66.3%	65.6%	66.9%	68.3%	69.2%	69.5%	75.3%	85.0%
% Time to Treatment (60 Mins)	50.7%	52.7%	48.7%	50.5%	47.9%	44.9%	44.0%	45.9%	45.0%	46.2%	44.5%	43.7%

2019/20 Trajectory (NHSI return)

-6.86 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Trajectory	76.4%	81.9%	85.6%	84.2%	86.6%	85.3%	89.7%	92.1%	91.0%	84.9%	87.5%	86.2%
Performance	77.1%	81.2%	81.4%	81.4%	80.2%	78.4%						

The above table shows the ED performance, including the health economy MIU activity and also with EKHUFT only performance.

Summary Performance

September performance for the organisation against the 4 hour target was 78.42%; against the NHS Improvement trajectory of 85.3%. This represents a reduction in performance compared to the previous month of 1.81% (from 80.23%), and an increase compared to the same month last year (77.15% in 2018). There was a single 12 Hour breach in September. The proportion of patients who left the department without being seen reduced to 3.9%. The unplanned re-attendance position remains high at 9.60%. Time to treatment within 60 minutes remained below 50% at 43.7% for the month.

Issue

- Continuing increase in number of patients attending ED (7% above plan)
- Lack of timely patient flow due to high number of >7+ and >21+ day patients and also the high number of DTOC patients.
- External care package and community bed capacity is limited and is preventing discharge
- Internal delays relating to high demand for diagnostics such as echo are increasing LOS
- Managing increased activity within current ED footprint.

Action

- Weekly review of all > 7+ day patients to facilitate simple discharges and prevent patients becoming complex discharges.
- National weekly >21+ day Long Length of Stay Reviews, MDT approach focussing on resolving internal and external delays.
- Ambulance handover delay Improvement plan implemented with monthly monitoring and improvement.
- ED Improvement plan has been revised and being implemented with an agreed estates redesign plan.
- Improve patient streaming to primary care, minor injuries, ambulatory assessment units to reduce the risk of over crowding in ED.

Timescale

- ED Improvement plan was refreshed in August 2019. Implementation plan in progress and the Improvement plan is updated monthly.

September 2019 | National A&E Benchmarking

East Kent Hospitals University NHS Trust ranked 129 of 158 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2019-20/

100%
95%
90%
85%
80%
75%
70%
65%
60%

Target (95%)

Target Hit | Target Missed | RVV

Cancer Compliance

Key Performance Indicators

79.70 %

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Green
62 Day Treatments	75.85%	70.95%	82.08%	68.21%	76.88%	81.56%	79.13%	80.18%	72.94%	82.80%	80.22%	79.70%	>=85%
>104 day breaches	9	4	8	10	8	7	10	6	3	7	1	2	0
Demand: 2ww Refs	3,533	3,326	2,691	3,452	3,276	3,355	3,250	3,483	3,249	3,749	3,235	3,413	3167 - 3501
2ww Compliance	83.43%	93.29%	96.73%	96.52%	98.31%	97.87%	97.72%	96.53%	96.16%	98.02%	98.31%	97.83%	>=93%
Symptomatic Breast	68.46%	83.33%	95.00%	97.22%	98.31%	92.76%	93.64%	93.81%	86.32%	96.27%	96.00%	97.26%	>=93%
31 Day First Treatment	97.40%	97.07%	97.66%	95.63%	97.73%	96.06%	97.54%	95.72%	92.83%	97.66%	94.28%	97.67%	>=96%
31 Day Subsequent Surgery	93.33%	100.00%	97.22%	97.78%	96.49%	94.74%	84.91%	94.12%	91.07%	100.00%	74.58%	94.23%	>=94%
31 Day Subsequent Drug	99.19%	98.06%	98.85%	98.28%	97.27%	100.00%	100.00%	99.18%	99.07%	100.00%	98.32%	100.00%	>=98%
62 Day Screening	87.50%	85.71%	87.50%	100.00%	76.92%	82.61%	100.00%	91.89%	73.33%	97.14%	88.89%	92.31%	>=90%
62 Day Upgrades	80.77%	90.00%	70.00%	84.00%	86.67%	76.47%	80.00%	85.71%	72.00%	73.91%	63.64%	87.72%	>=85%

2019/2020 Trajectory

-6.28 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Green
STF Trajectory	85.52%	85.71%	85.33%	85.96%	86.31%	85.97%	85.71%	86.19%	86.06%	85.71%	85.51%	85.65%	Apr
Performance	79.13%	80.18%	72.94%	82.80%	80.22%	79.70%							Apr

A Cancer Recovery Plan is in place with an aim to improve performance and ensure that the cancer standards are sustainably delivered across all tumour sites.

62 Day Performance Breakdown by Tumour Site

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
01 - Breast	73.9%	72.4%	89.2%	67.4%	84.3%	86.0%	90.0%	76.7%	63.8%	81.5%	78.8%	77.8%
03 - Lung	52.2%	59.4%	93.5%	64.5%	81.8%	93.3%	58.3%	65.5%	76.5%	46.2%	50.0%	56.0%
04 - Haematological	50.0%	71.4%	75.0%	38.5%	33.3%	62.5%	72.7%	54.5%	80.0%	62.5%	66.7%	63.6%
06 - Upper GI	70.6%	64.7%	100.0%	61.1%	75.0%	60.9%	83.3%	69.4%	59.3%	83.3%	82.4%	67.6%
07 - Lower GI	84.8%	41.4%	57.1%	62.9%	73.8%	64.7%	61.5%	72.7%	53.3%	78.6%	77.1%	63.2%
08 - Skin	100.0%	91.7%	96.7%	94.9%	98.2%	100.0%	95.7%	98.1%	97.4%	97.0%	91.7%	91.7%
09 - Gynaecological	69.7%	100.0%	80.0%	80.0%	71.4%	76.5%	80.0%	78.6%	80.0%	93.8%	80.0%	75.0%
10 - Brain & CNS										100.0%		
11 - Urological	70.5%	67.8%	78.4%	64.8%	81.1%	76.2%	85.5%	87.5%	74.2%	91.0%	87.9%	88.2%
13 - Head & Neck	100.0%	50.0%	85.7%	52.4%	42.1%	92.6%	35.7%	33.3%	41.2%	44.4%	58.3%	66.7%
14 - Sarcoma	100.0%		100.0%	50.0%	50.0%		100.0%	0.0%	66.7%		100.0%	100.0%
15 - Other	0.0%		33.3%	0.0%	40.0%	25.0%	0.0%	33.3%	33.3%		0.0%	100.0%

Summary Performance

Cancer performance continues to improve overall and the redesign/improvement work is well underway.

September 62 day performance is currently 79.70% against the improvement trajectory of 85.97%, validation continues until the beginning of November in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,713 and there were 2 patients waiting 104 days or more for treatment or potential diagnosis.

Significant improvement plans are in place on all tumour sites and cancer pathways with initiatives are continuing to show improvement. The Cancer Improvement Plan is shared with NHSI and also the Clinical Commissioning Group (CCG) monthly.

Support for additional capacity has been provided via Alliance funding and support to workforce via MacMillan Cancer Charity.

2ww referrals have continued to increase with 3413 being received in month. The daily reviews of 2ww and 73 day + patients are continuing and enabling Director level escalations and actions to be progressed. The number of long waiting patients is decreasing overall due to a continued focus on escalation to ensure that patients pathways are being progressed.

There were two 104 day breaches in September:

Patient 1 – Patient was removed from the pathway in month with no malignancy found.

Patient 2 – Patient has surgery planned at a tertiary centre in October 2019, which has now been completed.

Issues:

- Providing sufficient capacity to meet fluctuating 2 ww demand.
- Ensuring patients are treated within 31 days
- Achieving the 62 day pathway, particularly in Lung, Lower GI and Gynaecology

Action:

- Patient Service Centre is providing a 6 day booking service which will improve booking patients within 48 hours of referral being received.
- Specialities are reviewing their capacity daily to meet the fluctuating 2ww demand, with escalation in place.
- Timed pathway reviews are ongoing with clinical leads
- Daily and weekly Director led confirm and challenge meetings continue.

Timescale:

- Cancer Improvement Plan updated – September 2019.

August 2019 | National 62 Day Cancer Benchmarking

East Kent Hospitals University NHS Trust ranked 83 of 153 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/Cancer Waiting Times Data Extract (Provider) Provisional

100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%

Target (85%)

Target Hit   Target Missed   RVV

*National Data is reported one month in arrears

18 Week Referral to Treatment Standard

Key Performance Indicators

81.62 %

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Green
Performance	74.89%	72.16%	72.42%	76.10%	77.89%	80.03%	79.15%	80.66%	82.06%	82.46%	81.81%	81.62%	>=92%
52w+	120	102	74	38	27	8	3	4	3	2	1	3	0
Waiting list Size	55,610	54,492	53,171	50,134	48,743	48,696	45,867	46,359	46,293	45,292	46,121	46,544	<38,938
Backlog Size	13,966	15,170	14,662	11,984	10,776	9,723	9,564	8,964	8,307	7,946	8,389	8,554	<2,178

2019/2020 Trajectory

1.62 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Green
Performance Trajectory	78.00%	79.00%	80.00%	80.00%	78.00%	80.00%	81.00%	82.00%	79.00%	80.00%	81.00%	82.00%	
Performance	79.15%	80.66%	82.06%	82.46%	81.81%	81.62%							

3

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Green
52w Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	Apr
Performance	3	4	3	2	1	3							

The 18 week performance is above the agreed trajectory, with an increase of (3) 52 week wait patients in month. There has been a small increase of backlog size in month.

52 week patient breaches:

Patient 1 - General Surgery – patient pathway was delayed due to patient cancellations at the start of the pathway and patient choice. Patient has agreed appointment in October.
Patient 2 - Gynae – Patient choice to delay pathway due to overseas holiday. Patient now booked for November and is unable to attend at an earlier date.
Patient 3 - Gynae – Complex patient pathway, now referred to UGI surgeon.

Issue:

- Large amount of long waiting patients.
- Waiting list size has grown.
- Waiting list needs detailed management to maintain compliance as processes are not sustainable.
- Specialities such as Ophthalmology, Max Fax, Urology and ENT are under performing against plan for New appointments and Physiotherapy, ENT and General Medicine under performing against plan for Follow Up appointments.

Actions:

- All patients over 40 weeks are reviewed to ensure each patient has an appointment/admission plan in place and to reduce the risk of a 52 week breach.
- Challenged specialities have improvement plans which are either in place, such as Ophthalmology or being developed.

Timescale:

- Complete Speciality RTT improvement plans by end of November 2019

August 2019 | National RTT Benchmarking

East Kent Hospitals University NHS Trust ranked 133 of 171 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2019-20/Incomplete Provider

100%
95%
Target (92%)
90%
85%
80%
75%
70%

Target Hit Target Missed RVV

*National Data is reported one month in arrears

6 Week Referral to Diagnostic Standard

Key Performance Indicators

98.69 %

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Green
Performance	99.31%	99.65%	99.56%	99.72%	99.49%	99.59%	99.29%	99.45%	99.60%	99.42%	99.08%	98.69%	>=99%
Waiting list Size	12,820	13,329	12,235	12,949	14,210	15,058	15,517	15,228	15,548	14,887	14,825	13,614	<14,000
Waiting > 6 Week Breaches	88	46	54	36	73	61	110	84	62	86	137	178	<60

2019/20 Trajectory

-0.41 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF Trajectory	99.11%	99.11%	99.11%	99.11%	99.11%	99.10%	99.10%	99.10%	99.11%	99.11%	99.11%	99.11%
Performance	99.29%	99.45%	99.60%	99.42%	99.08%	98.69%						

Summary Performance

The standard has not been met for September with a compliance of **98.69%.** As at the end of the month there were 178 patients breaching which prevented achievement of the standard. This was mainly in colonoscopy and flexi sigmoidoscopy. An Endoscopy Improvement Plan has been put in place.

Summary Actions

Issue:

- Endoscopy do not have sufficient capacity to meet increasing demand.
- Endoscopy booking office require additional resource to maximise capacity and meet increasing demand.
- Endoscopist capacity does not meet demand.

Action:

- Endoscopy Improvement Plan has been implemented.
- Daily conference calls to monitor demand and capacity, and progress efficient booking.
- Weekly Director led endoscopy performance review.
- Workforce plan monitored weekly for nursing and medical staff recruitment.

Timescale:

- Improvement plan completed September 19.
- Identify additional administrative staff to support booking by October 19.

Strategic Theme: Finance

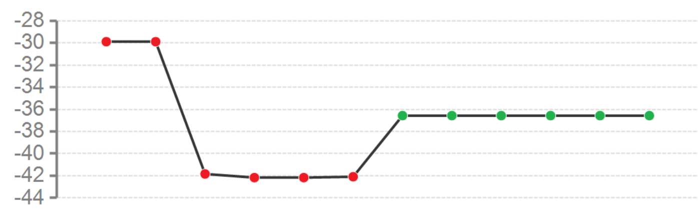
Finance

Month	Measure	Value	Commentary
Sep	I&E £m (Trust Only)	-18.4 (7.0%)	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.The significant I&E movement in October 2018 is caused by a £34.3m impairment due to revaluation of Trusts assets prior to transfer to 2Gether which is excluded from our NHSI I&E performance evaluation.
Sep	Cash Balance £m (Trust Only)	15.5 (75.2%)	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Total Cost £m (Trust Only)	55.4 (0.6%)	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.Mth 7 includes a £34.7m impairment, see I&E note above.

Strategic Theme: Finance

Forecast £m

-36.6
(0.0%)



This shows the Normalised Income & Expenditure Forecast as at 31st March of the relevant financial year. The arrow shows latest monthly figure together with % variance against the last month reported.

Highlights and Actions:

The Trust generated a consolidated deficit in month of £4.0m which £0.5m better than the planned position. This brought the year-to-date (YTD) position to a £19.2m deficit which was £1m better than plan. The year-end forecast remains in line with the planned position of a consolidated £37.5m deficit excluding technical adjustments.

The main drivers of the in-month position were:

• Non-Clinical income over performance of £2.2m primarily due a £1m cash donation relating to the Harmonia Village bringing ytd donations to £1.9m, this does not count towards the Trust's I&E control total. Additional benefits were from AMD drug income from Spencer Wing following a change in billing practice and additional income for Stroke projects and ACAT convergence funding totalling £0.9m.

• Clinical income over performance of £0.3m primarily due to NHSE specialised commissioned services which was £0.5m above plan in month due to high cost drugs expenditure, non-delivery of QIPP and a recent agreement for NICU income which has generated a £0.6m gain to Women and Children's Care group.

• Non-pay overspend of £0.3m primarily due to further supplies and services which have transferred to the Operated Healthcare Facility contract, offset by the reduction in purchase of healthcare from external organisations which is favourable to plan in September by £0.4m, reflecting positive work by care groups to minimise outsourcing of surgical activity.

• A pay overspend of £0.6m mainly due to medical agency staffing due to continued operational pressures. This was partially offset by a review of accrued agency shifts on the new Trust booking system which contributed to a reduction in agency spend of £1.0m. CIP schemes relating to agency staff are behind plan in September by £0.4m and £0.7m behind plan YTD.

The East Kent CCG aligned incentive contract (AIC) remains financially beneficial to EKHUFT, with a year-to-date benefit of £1.3m as compared to a PbR activity based contract.

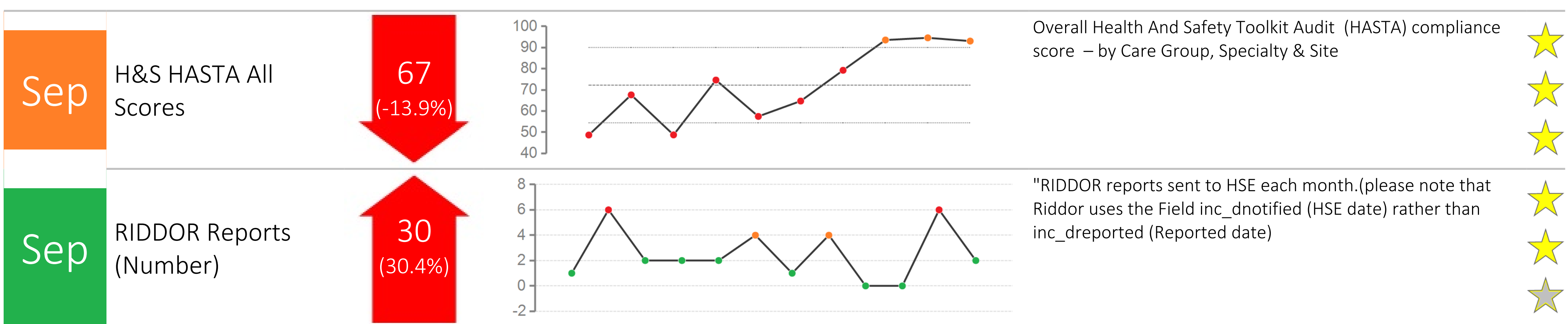
While the financial position in September remains positive, the level of CIP delivery increases significantly throughout the year therefore continued focus on development and delivery of savings efficiencies is crucial to deliver our I&E plan.

This focus on delivering the financial position is being maintained by a combination of monthly Executive Performance Review meetings and Confirm and Challenge meetings led by the COO and FD. Additionally EKHUFT has developed an internal Financial Special Measures framework to ensure all areas of the Trust are appropriately challenged and supported to deliver their financial plans.

The Trust's cash balance at the end of September was £15.5m which is £12.1m above plan due to the timing of large value receipts. The Trust borrowed £4.5m in September therefore total Trust borrowings increased to £108m which will require paying back when the Trust is delivering a surplus.

Strategic Theme: Health & Safety

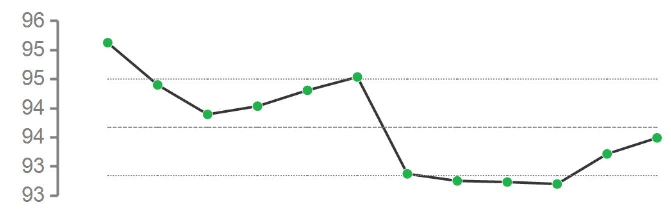
Health & Safety 1



Strategic Theme: Health & Safety

Sep

Health & Safety Training



H&S Training includes all H&S and risk avoidance training including manual handling

Highlights and Actions:

Health and Safety 1 Commentary
HASTA Audits September 2019
Scores for the 19/20 HASTA uploaded achieved 93.6 % cumulatively in September 2019.
COSHH Assessments achieved 100%
COSHH Controls achieved 100%
COSHH Inventory achieved 100%
COSHH Assessments achieved 100%
It should be noted that the HASTA audits planned for Q3 and Q4 will take place in those areas that scored lower scores in 2017/18 and although a lot of work has taken place in these areas to improve Health and Safety standards and compliance there may be a dip in the current level of compliance.

RIDDOR
There were 2 RIDDOR reportable incidents to the HSE recorded for September 2019.
1 was due to a member of staff falling over a stool and being absent from work for >7days
1 was due to the fire in William Harvey Microbiology which met the HSE electrical fire reporting requirement.

HEALTH AND SAFETY MANDATORY TRAINING

Health and Safety Mandatory Training achieved 93.5% attendance in September 2019. Health and Safety Staff Surveillance achieved 100% in September 2019.

Strategic Theme: Health & Safety

Health & Safety 2

Month	Indicator	Value	Description
Sep	Accidents	497 (27.4%)	Number of Accidents that have occurred, excluding sharps (needles etc) but including manual handling. Data Source: DATIX
Sep	Violence & Aggression	491 (-6.5%)	Number of cases of Violence, aggression and verbal abuse raised towards Staff. Data Source: DATIX
Sep	Sharps	184 (12.9%)	Number of Incidents raised involving use of sharps (e.g. needle stick). Data Source: DATIX

Strategic Theme: Health & Safety

Highlights and Actions:

Accidents

In September 2019 there were 48 accidents.
7 were due to injuries sustained from sharp objects
7 were slips and falls
6 were due to falling plasterwork, ceilings etc
5 were due to exposure to bodily fluids
4 were due to staff being hit by a moving object
3 were due to staff bumping into a stationery object
3 were due to staff falling from a height
2 were due to staff coming into contact with a cold substance
2 were due to staff members collapsing at work
2 were due to exposure to radiation
2 were due to staff trapping their hands in doors
1 was due to a patient moving while having a procedure which injured the staff member
1 was due to staff coming into contact with a harmful substance
1 was due to staff suffering an electric shock
1 was work related stress

Violence and Aggression

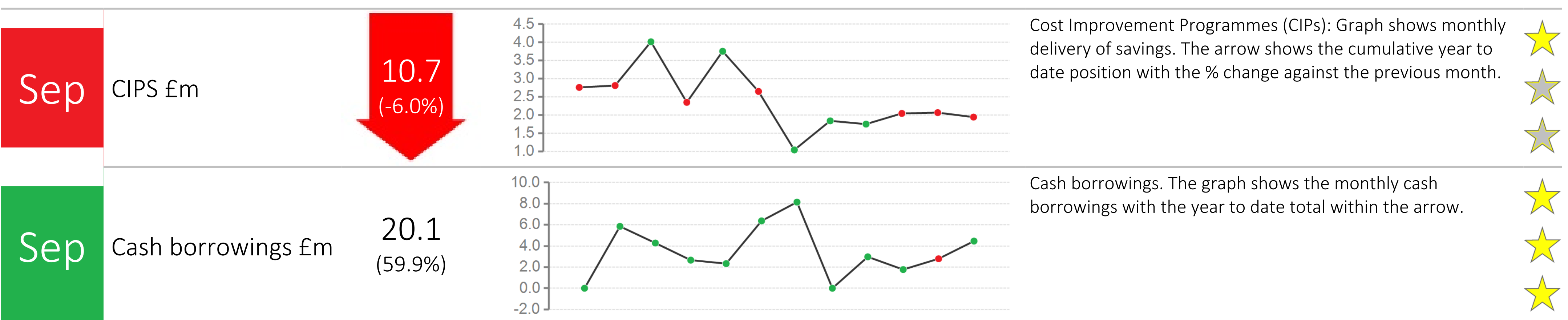
In September 2019 there were 42 incidents reported which was an decrease of 6 incidents when compared with August's data.
Patient behaviour - physical assaults on staff = 11
Patient behaviour - aggression to a member of staff = 24
Staff behaviour towards another member of staff = 1
Visitor of other/person's behaviour t a member of staff = 5
Smoking within Trust building = 1
The Trust's MAYBO training is now in place for 2019/20 with spaces for 200 staff to attend. There are also 3 conflict resolution training sessions in place per month.

Sharps
The number of sharps incidents recorded for September 2019 was 19.
16 were due to needle stick injuries when the sharp or needle was used
2 were due to contact with an unused sharp
1 was recorded as a near miss.

The Strategic Health and Safety Team are currently reviewing the reporting of sharps incidents to ensure the Trust is looking at robust data from datix reported incidents. This may mean an increase of reported incidents in future IPRs.

Strategic Theme: Use of Resources

Balance Sheet

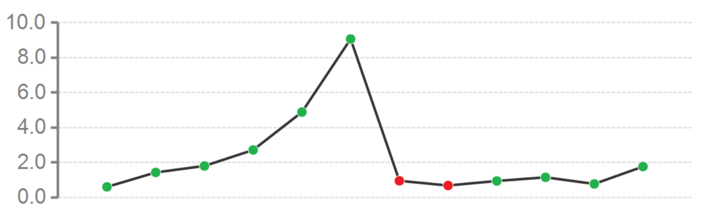


Strategic Theme: Use of Resources

Sep

Capital position £m

6.3
(128.7%)



Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow.

Highlights and Actions:

DEBT
Total invoiced debtors have decreased in month by £2.5m to £14.5m, which represents a reduction of over £10m from the start of the financial year. The largest debtors at 30th September were East Kent Medical Services and 2gether Support Solutions, although progress has been made in recent months streamlining processes to minimise inter-company debt and this balance has reduced from previous levels.

CAPITAL
Total capital expenditure at the end of September is £6.2m which is £1.3m (20%) below plan. The main drivers are delays in identifying & prioritising schemes within the Patient Environment Investment Committee (PEIC) and the T3 ICT project spend being behind planned levels. It is anticipated that this expenditure will be back in line with the planned profile by the end of Q3.

CASH
The Trust’s cash balance at the end of September was £15.5m which is £12.1m above plan due to the timing of large value receipts.

FINANCING
The Trust borrowed £4.5m in September therefore total Trust borrowings increased to £108m which will require paying back when the Trust is delivering a surplus.

£1.9m of interest has been incurred year-to-date in respect of the drawings against working capital facilities.

Strategic Theme: Use of Resources

Pay Independent

Month	Measure	Latest (variance)	Description
Sep	Payroll Pay £m	30.1 (1.4%)	Payroll Pay (Permanent+Overtime). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Agency Spend £m	2.2 (-33.1%)	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Independent Sector £k	427 (9.4%)	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Highlights and Actions:

Pay performance is adverse to plan in September by £0.6m driven by overspends in mainly medical agency staffing due to continued operational pressures combined with backdated pay awards.

Total expenditure on pay in September was £33.5m, a decrease of £0.5m when compared to expenditure in August mainly driven by a review of accrued agency shifts on the new Trust booking system which contributed to a reduction in agency spend of £1.0m.

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge, for only Acute Sites (K&C, QEQM, WHH, BHD). No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 95	1 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	>= 0 & <92	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	>= 0 & <35	30 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	IP Spells with 3+ Ward Moves	Total Patients with 3 or more Ward Moves in Spell	Lower is Better	
Cancer	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %

Clinical Outcomes	4hr % Compliance from Presentation to Stroke Ward	4hr % Compliance from Presentation to Stroke Ward, as per BPT	Higher is Better	
	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist to ensure completion. After each procedure, the recovery staff check that each of the surgical checklists have been carried out. This compliance monitors against a random set of 10 patients each day from this process.	>= 99	10 %
	FNoF (36h) (%)	% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database - selecting 'Prompt Surgery%'. Reporting one month in arrears to ensure upload completeness to the National Hip Fracture Database.	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90 & <90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	>= 0 & <2.75	20 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90 & <90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>= 95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90 & <90	5 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	>= 0 & <15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Staff FFT - Work (%)	"Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 60	50 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.		40 %
Data Quality & Assurance	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	>= 0 & <0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %

Data Quality & Assurance	Valid GP Code	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	>= 0 & <7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments	>= 0 & <2.13	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	>= 0 & <7	
Diagnostics	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
Finance	Cash Balance £m (Trust Only)	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 5	20 %
	I&E £m (Trust Only)	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.The significant I&E movement in October 2018 is caused by a £34.3m impairment due to revaluation of Trusts assets prior to transfer to 2Gether which is excluded from our NHSI I&E performance evaluation.	>= Plan	30 %
	Total Cost £m (Trust Only)	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.Mth 7 includes a £34.7m impairment, see I&E note above.	>= 0	20 %
	Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March of the relevant financial year. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
Health & Safety	Accidents	Number of Accidents that have occurred, excluding sharps (needles etc) but including manual handling. Data Source: DATIX	>= 0 & <40	15 %
	Sharps	Number of Incidents raised involving use of sharps (e.g. needle stick). Data Source: DATIX	>= 0 & <10	5 %
	H&S HASTA All Scores	Overall Health And Safety Toolkit Audit (HASTA) compliance score – by Care Group, Specialty & Site	>= 95	
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	RIDDOR Reports (Number)	"RIDDOR reports sent to HSE each month.(please note that Riddor uses the Field inc_dnotified (HSE date) rather than inc_dreported (Reported date)	>= 0 & <3	20 %

Health & Safety	Violence & Aggression	Number of cases of Violence, aggression and verbal abuse raised towards Staff. Data Source: DATIX	>= 0 & <25	10 %
Incidents	Clinical Incidents closed within 6 weeks (%)	Percentage of Clinical Incidents closed within 6 weeks		
	Clinical Incidents: Minimal Harm			
	Clinical Incidents: Severe Harm			
	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.	>= 98	20 %
	Medication Incidents with Harm	Number of Medication Incidents recorded on Datix with a Moderate/Severe/Death Harm		
	Medication Missed Critical Doses	Number of missed doses for critical drugs / medications		
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls		0 %
	Pressure Ulcers Cat 3/4 (per 1,000)	"Number of category ¾ hospital acquired pressure ulcers per 1,000 bed days. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	Serious Incidents (STEIS)	"Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	All Pressure Damage: Cat 2	"Number of all (old and new) Category 2 pressure ulcers. Data source - Datix."	>= 0 & <1	
	Blood Transfusion Incidents	"The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Clinical Incidents: Moderate Harm			
	Clinical Incidents: No Harm	"Number of Non-Clinical Incidents, recorded on DATIX, per 10,000 FTE hours. Bandings based on total numbers of incidents (corporate level) is: Score1: <= 140, Score2: > 140 & <= 147, Score3: > 147 & <= 155, Score4: > 155 & <= 163, Score5: > 163"		
	Clinical Incidents: Total (#)	"Number of Total Clinical Incidents reported, recorded on Datix.		
	Falls (per 1,000 bed days)	"Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <5	20 %
	Falls: Total	"Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix."	>= 0 & <3	0 %

Incidents	Harm Free Care:All Harms (%)	"Percent of inpatients deemed free from harm as measured by the Safety Thermometer audit ie free from old and new harms: - Old and new pressure ulcers (categories 2 to 4) - Injurious falls - Old and new UTI - Old and new DVT, PE or Other VTE. Data source - Safety Thermometer (old and new harms)."	>= 94	10 %
	Medication Missed Doses	Number of missed medication doses recorded on Datix		
	Medicines Mgmt. Incidents	"The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Never Events (STEIS)	"Monthly number of Never Events. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."	>= 0 & <1	30 %
	Serious Incidents Open	Number of Serious Incidents currently open according to Datix		
Infection	Bare Below Elbows Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95 & <95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	Cases of C.Diff (Cumulative)	"Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01)."		40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	>= 0 & <1	40 %
	MSSA	"The total number of MSSA bacteraemia recorded, post 48hrs.	>= 0 & <1	10 %
	C. Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	>= 0 & <1	
	C. Diff Infections (Post 72h)	"The number of Clostridium difficile cases recorded at greater than 72h post admission. Data source - VitalPAC (James Nash)."	>= 0 & <1	0 %
	Commode Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95 & <95	
	E. Coli	"The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <44	10 %
	E. Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	>= 0 & <44	
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	>= 0 & <1	
Mortality	Crude Mortality NEL (per 1,000)	"The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <27.1	10 %

Mortality	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.	>= 0 & <90	35 %
	Number of Deaths that were >50% Avoidable	Number of deaths that were more than 50% likely to have been Avoidable (Categories: 'Definitely Avoidable','Strong evidence of avoidability','Probably avoidable (more than 50:50)')		
	SHMI	"Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data."	>= 0 & <0.95	15 %
	Number of SJR's Completed	Number of Structured Judgement Reviews (Mortality Case Record Reviews) completed		
Observations	VTE: Risk Assessment %	"Adults (16+) who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant."	>= 95	20 %
Patient Experience	A&E FFT: Not Recommended (%)	A&E FFT: Not Recommended (%)		
	A&E FFT: Recommended (%)	A&E FFT: Recommended (%)		
	AE Mental Health Referrals	A&E Mental Health Referrals		
	Complaints acknowledged within 3 working days	Complaints acknowledged within 3 working days		
	Complaints Closed 61 - 90 Days	Number of Complaints closed in month that were open between 61 and 90 Days		
	Complaints received with a 45 Day time frame agreed	Number of complaints received with a agreed time frame of 45 days		
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	IP FFT: Recommend (%)		>= 95	30 %
	IP FFT: Response Rate (%)	"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 22	1 %
	IP Survey: Help from Staff to Eat Meals (%)	Responses taken from the Inpatient Survey. Question: "Did you get enough help from staff to eat your meals?"		3 %
	A&E FFT: Response Rate (%)	A&E FFT: Response Rate (%)		

Patient Experience	Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	15 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Complaints Closed <= 30 Days	Number of complaints closed in month that were open for less than 30 days		
	Complaints Closed > 90 Days	Number of Complaints closed in month that were open for more than 90 Days		
	Complaints Closed 31 - 60 Days	Number of Complaints closed in month that were open between 31 and 60 Days		
	Complaints received with a 30 Day time frame agreed	Number of complaints received with an agreed time frame of 30 days		
	Compliments	Number of compliments received	>= 1	
	IP FFT: Not Recommend (%)	"Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <2	30 %
	IP Survey: Are you aware of nurse in charge of you each shift? (%)	IP Survey: Are you aware of nurse in charge of your care each shift? (%)	>= 89	4 %
	Maternity FFT: Not Recommended (%)	Maternity FFT: Not Recommended (%)		
	Maternity FFT: Recommended (%)	Maternity FFT: Recommended (%)		
	Maternity FFT: Response Rate (%)	Maternity FFT: Response Rate (%)		
	Mixed Sex Breaches	"Number of patients experiencing mixed sex accommodation due to non-clinical reasons (un-justifiable). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	Number of Complaints	"The number of Complaints recorded overall . Data source - Patient Experience Team"		
Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use – allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Compliance	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 80 & <80	
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.	Lower is Better	

Domain	Indicator	Description	Target	Weight
Productivity	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.	Lower is Better	
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	>= 0 & <5	10 %
	Theatres: On Time Start (% 15min)	The % of cases that start within 15 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	>= 0	
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency & Locum Spend	Total agency spend including NHSP spend		
	Agency Orders Placed	"Total count of agency orders placed.	>= 0 & <100	
	Agency Staff WTE (Bank)	WTE Count of Bank Hours worked		
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	"Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 92.1	1 %
	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	>= 0 & <28	2 %
	Overtime (WTE)	Count of employee's claiming overtime		1 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %
	Stability Index %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		
	Staff Turnover (Midwifery)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Midwives. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	

Staffing	Time to Recruit	"Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
	Total Staff Headcount	Headcount of total staff in post		
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	>= 0 & <100	5 %
	Vacancy (Nursing) %	"% Vacant positions against Whole Time Equivalent (WTE) for Nurses. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
	1:1 Care in labour	The number of women in labour compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	>= 99 & <99	
	Agency %	% of temporary (Agency and Bank) staff of the total WTE	>= 0 & <10	
	Agency Filled Hours vs Total Agency Hours	% hours worked which were filled by the NHSP against the total number of hours worked by agency staff		
	Agency Staff WTE (NHSP)	WTE Count of NHSP Hours worked		
	Bank Filled Hours vs Total Agency Hours	% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff		1 %
	Bank Hours vs Total Agency Hours	% hours worked by Bank (Staffflow) against the total number of hours worked by agency staff		
	Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.		
	NHSP Hours vs Total Agency Hours	% hours worked by NHSP against the total number of hours worked by agency staff		
	Overtime %	% of Employee's that claim overtime.	>= 0 & <10	
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %
	Sickness (Monthly) %	Monthly % of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 3.3 & <3.7	10 %
	Staff Turnover (%)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	15 %

Staffing	Staff Turnover (Medical)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Medical Staff. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
	Staff Turnover (Nursing)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Nurses. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Vacancy (Medical) %	"% Vacant positions against Whole Time Equivalent (WTE) for Medical Staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
	Vacancy (Midwifery) %	"% Vacant positions against Whole Time Equivalent (WTE) for Midwives. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
	Vacancy (Monthly) %	Monthly % Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	15 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	
	Statutory Training (%)	"The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months. "	>= 85	50 %

Data Assurance Stars

Not captured on an electronic system, no assurance process, data is not robust

Data is either not captured on an electronic system or via a manual feeder sheet, does not follow an assured process, or not validated/reconciled

Data captured on electronic system with direct feed, data has an assured process, data is validated/reconciled