East Kent Hospitals University NHS
NHS Foundation Trust

APRIL 2016

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
NHS Foundation Trust

Chief Executive's Summary

This is the first issue of the new integrated performance report and will present our performance in detail in each area but crucially will also show how they link together, how it translates from the board to the ward and also fits with the new priorities we have set for this year around patients, people, provision and partnerships. It will develop over time and therefore your thoughts on how this works for you will be gratefully received.

With regard to the overall picture, it is positive that the caring and safety domains still demonstrate a strong and positive position with regard to a number of the headline measures such as mortality rates and infection control but it is also clear that there is work to do to maintain and improve those whilst also addressing areas where performance has been lower such as with Mixed Sex Accomodation, VTE reporting and complaints. This will continue to be an area of focus for us and fits within the priorities for this year and is included within the Improvement Journey work to help us achieve our immediate goal of getting out of Special Measures when the CQC reinspect us later in the year.

There has been considerable work on the issues within the responsive and effective domains and there has been positive progress in terms of the new medical model at QEQM, the Operational Control Centre at WHH and SAFER roll out across the exemplar wards on each site. We have also done this during a time when activity has been higher than plan and last year and also with the additional challenge of industrial action so the progress is testament to the hard work of our staff working with our partners across the system. However, we have considerable more to do in areas such as 4 hour, cancer and RTT standards where we are not yet consistently achieving as we need to and this is a key element of our priorities this year. We have detailed plans set out to drive the necessary improvement and these will be monitored and managed through our established governance processes.

The focus on how we work is covered in the well lead domain as are the financial targets we have for the year. The month one position is as we expected and therefore on track for our control total although we are awaiting final confirmation of the agreed position for the year from NHSI. This has and will continue to be challenging as it requires us to make difficult decisions and substantial improvements on staffing costs and productivity and this will only be possible by us all working together with our partners across the system. This requires us to be clear about the priorities we have, provide the necessary support and development to our staff and also make changes to the way we work today and set and implement a clinical strategy for the future. All of this is underpinned by the cultural change and leadership development work and focus on staff wellbeing which are also key elements of our priorities this year.

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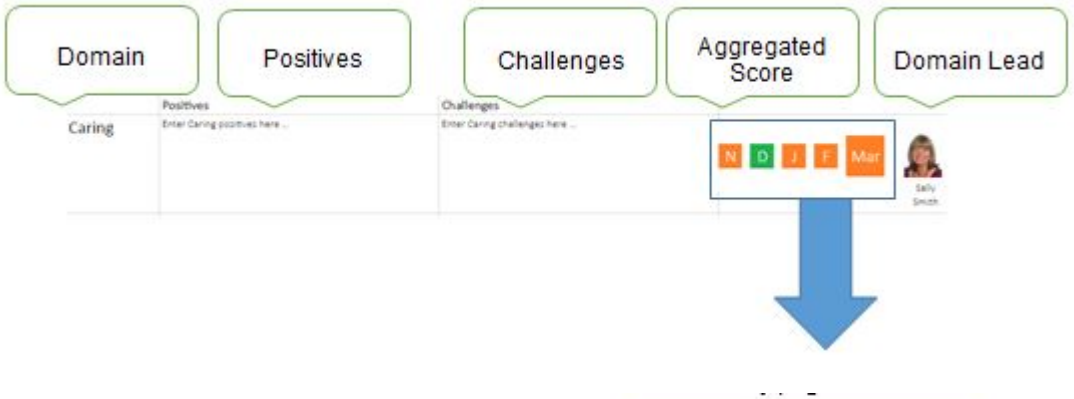
Understanding the IPR

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.

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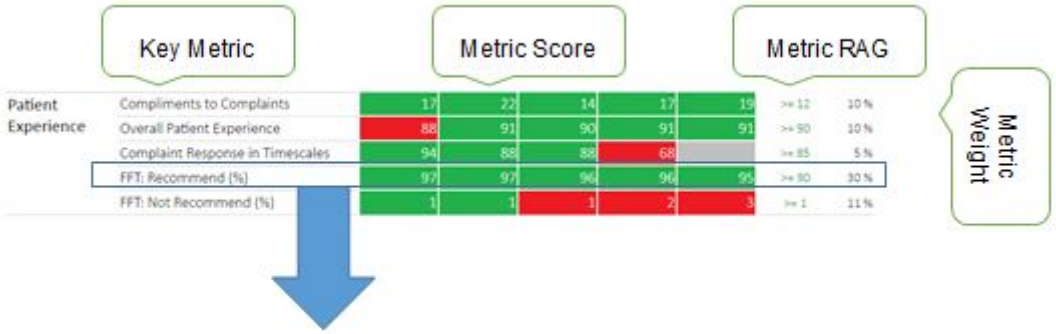
Understanding the IPR

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). 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. 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.

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Strategic Priorities

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Contents

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Headlines

	Positives	Challenges		
Caring	• Falls reduced • Falls rate below national average • No avoidable deep ulcers • FFT improved on March	• Mixed sex breaches, although high have reduced on last month • A rise in the number of complaints • A deterioration in meeting responses meeting the date agreed with client	D J F M Apr	 Sally Smith
Effective	• Clinical audit programme remains on plan • WHO checklist is consistently delivering • No cancelled operations on the day due to non-clinical reasons	• Bed occupancy remains high • Reportable delayed discharges of care remain high	D J F M Apr	 Jane Ely
Responsive	• There has been some improvement against the 4hour A&E standard • DM01 position is compliant	• Cancer two week wait and breast symptomatic did not meet the standard • 6 patients waited over 52 week for an elective procedure	D J F M Apr	 Jane Ely
Safe	• HSMR below national • Stable number of SIs reported • cDiff on trajectory • 0 MRSA infections reported in month	• VTE recording is being more closely managed with an action plan in place • Elective crude mortality has risen in month • Safety thermometer is slightly improved but still requires focus	D J F M Apr	 Paul Stevens
Well Led	• Improvement in nursing shift fill rates, both day and night • No cash borrowing requirement in month • Heads of Agreement for 2016/17 in place with CCGs and NHSE • No health and safety notices • New Board Integrated Performance Report	• Financial control total not yet agreed. Plan assumes £16.1m of STF, £20m CIPS and no readmissions fines • Increasing pay costs driven by higher employee NI and staff pay awards • continued high use of agency staff and breaches of framework and cap. £2.2m spent in April v £1.9m in March • Staff turnover stable at 11% but increasing level of vacancies from 8% to 9% • £2.8m deficit in month • Increase in uncoded spells (0 to 2%)	D J F M Apr	 Nick Gerrard

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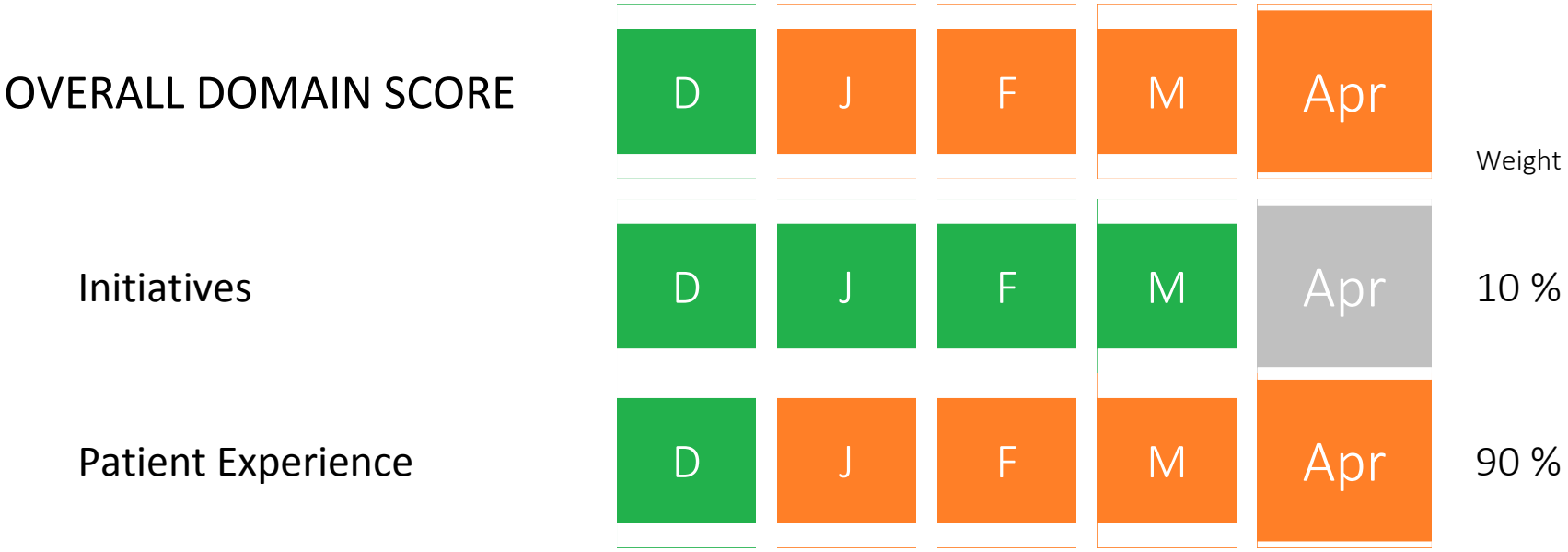
Caring



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Caring

		Dec	Jan	Feb	Mar	Apr	Green	Weight
Initiatives	Dementia Diagnosed CQUIN Delivered %	100	100	100	100		>= 100	17 %
	Heart Failure CQUIN Delivered %	100	100	100	100		>= 100	17 %
	COPD CQUIN Delivered %	100	100	100	100		>= 100	17 %
	Diabetes CQUIN Delivered %	100	100	100	100		>= 100	17 %
	75+ Frailty Pathway CQUIN Delivered %	100	100	100	100		>= 100	17 %
Patient Experience	Compliments to Complaints (#/1)	23	15	17	16	20	>= 12	10 %
	Overall Patient Experience %	91	90	91	91	91	>= 90	10 %
	Complaint Response in Timescales %	88	88	68	82	54	>= 85	5 %
	FFT: Recommend (%)	97	96	96	95	96	>= 90	30 %
	FFT: Not Recommend (%)	0.8	1.4	1.8	2.5	1.6	>= 1	11 %

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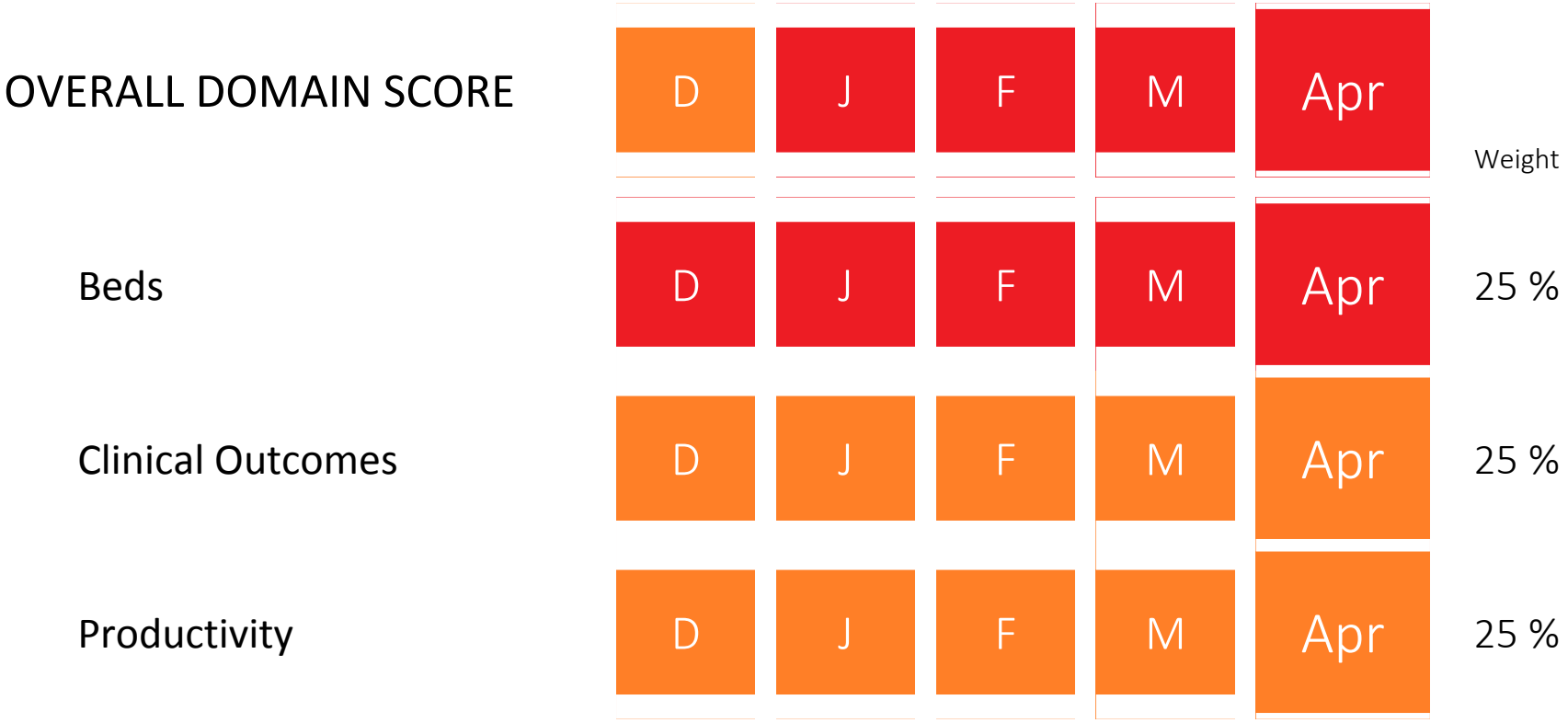
Effective



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Effective

		Dec	Jan	Feb	Mar	Apr	Green	Weight
Beds	Bed Occupancy (%)	95	109	112	107	103	<= 90	60 %
	IP - Discharges Before Midday (%)	19	19	19	19	18	>= 35	10 %
	DToCs (Average per Day)	55	65	62	71	78	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3	3	3	3		< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	16	16	17	17		< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	99	99	100	99	99	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	7	8	7	8	8	< 7	0 %
	DNA Rate: Fup %	7	8	7	8	8	< 7	0 %
	New:FUp Ratio (1:#)	1	1	1	1	1		0 %
Productivity	LoS: Elective (Days)	3	3	3	4	3		0 %
	LoS: Non-Elective (Days)	6	6	6	6	6		0 %
	Theatres: Session Utilisation (%)	81	82	81	82	82	>= 85	20 %
	Theatres: On Time Start (% 30min)	72	75	75	78	81	>= 90	10 %
	Non-Clinical Cancellations (%)	0	0	0	0	0	< 0.8	20 %
	EME PPE Compliance %	78	78	81	83	85	>= 90	20 %

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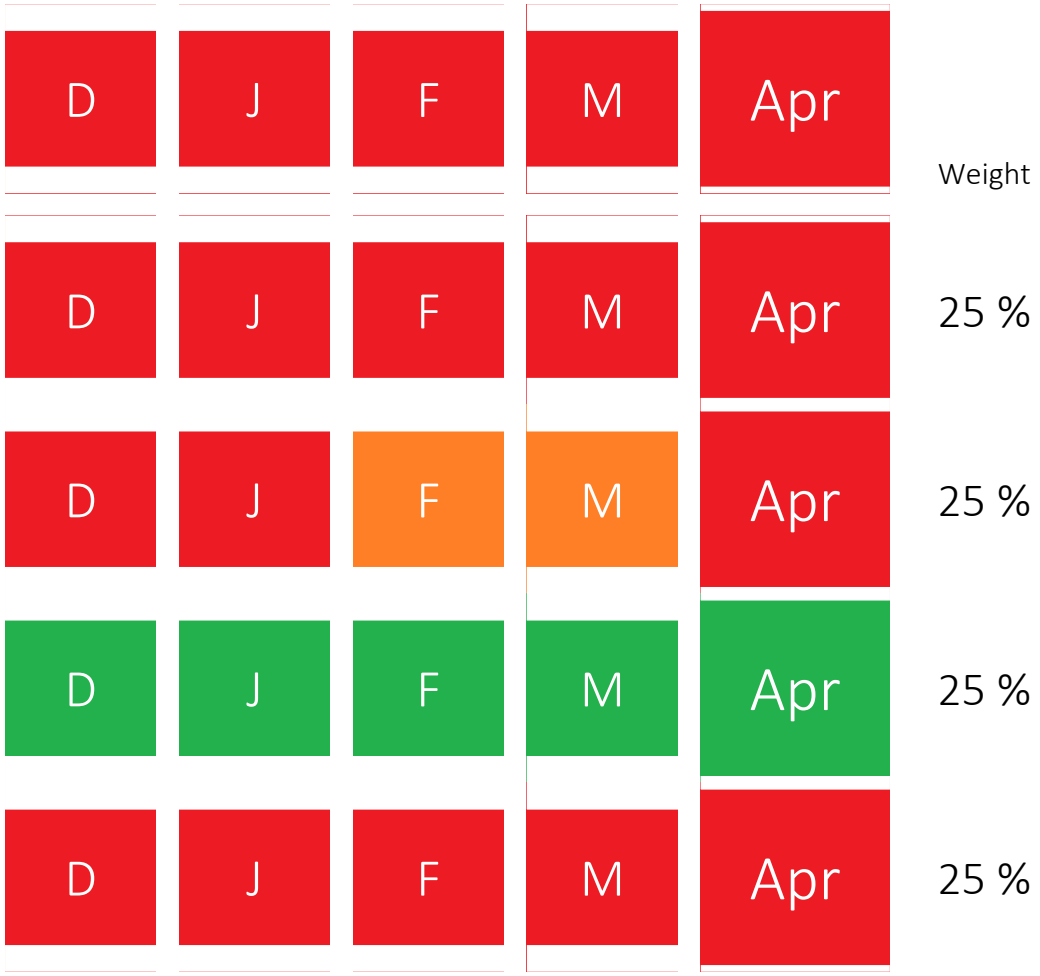
Responsive



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Responsive

		Dec	Jan	Feb	Mar	Apr	Green	Weight
A&E	ED - 4hr Compliance (%)	87.79	84.91	80.01	79.26	84.03	>= 95	100 %
Cancer	Cancer: 2ww (All) %	93.87	93.28	94.10	93.58	89.00	>= 93	10 %
	Cancer: 2ww (Breast) %	92.22	94.06	88.03	92.98	85.00	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	98.00	94.82	97.07	98.10	96.41	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	94.44	94.59	97.50	96.72	90.70	>= 94	5 %
	Cancer: 31d (Drug) %	98.44	86.17	100.00	100.00	98.25	>= 98	5 %
	Cancer: 62d (GP Ref) %	79.11	71.68	79.86	73.57	69.64	>= 85	50 %
	Cancer: 62d (Screening Ref) %	85.00	93.75	95.65	92.31	92.31	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	70.00	50.00	86.67	70.37	95.00	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.90	99.81	99.65	99.65	99.78	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	99.13	100.00	100.00	99.65	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	0 %
RTT	RTT: Incompletes (%)	88.82	90.10	89.17	89.27	88.56	>= 92	100 %
	RTT: 52 Week Waits (Number)	5	3	5	5	6	< 1	0 %

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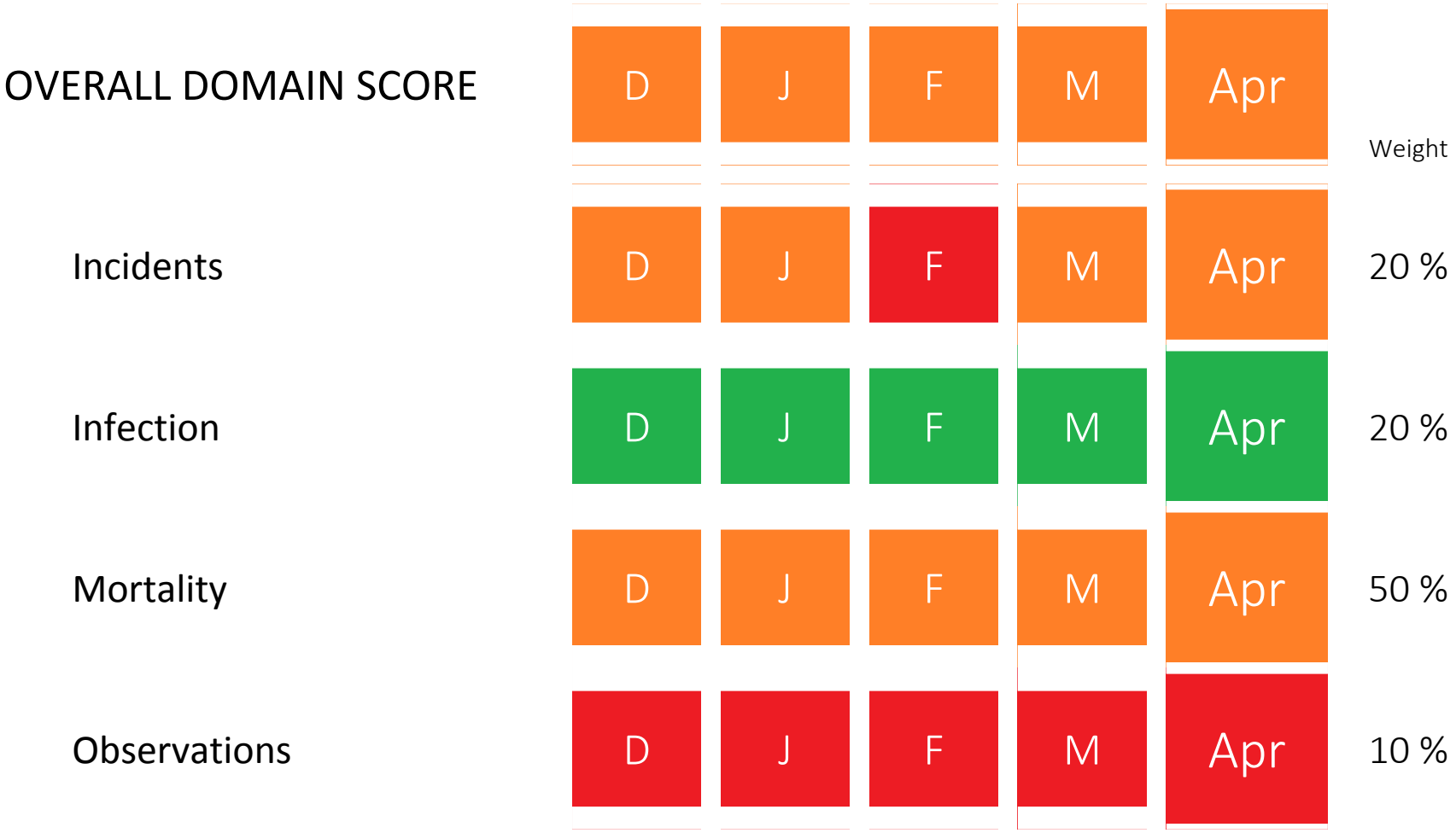
Safe



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Safe

		Dec	Jan	Feb	Mar	Apr	Green	Weight
Incidents	Mixed Sex Breaches	0	28	7	89	26	1	20 %
	Serious Incidents (STEIS)	8	9	7	4	4		0 %
	Harm Free Care: New Harms (%)	98	98	98	98	98	>= 98	10 %
	Clinical Incidents: Total	615	645	586	661	578		0 %
	Falls (per 1,000 bed days)	6	5	6	5	5	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.22	0.27	0.37	0.29	0.32	<= 0.15	10 %
Infection	Cases of MRSA (per month)	0	0	0	0	0	< 1	40 %
	Cases of C. Diff (Cumulative)	26	27	28	28	4	<= Traj	40 %
Mortality	HSMR (Index)	86	84				< 90	35 %
	Crude Mortality EL (per 1,000)	0.7	0.1	0.2	0.5	0.8	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	31	32	36	34	29	< 27.1	10 %
	RAMI (Index)	93	90	88			< 87.45	30 %
Observations	Cannula: Daily Check (%)	44.5	29.3				>= 50	10 %
	Catheter: Daily Check (%)	44.0	27.7				>= 50	10 %
	Central Line: Daily Check (%)	43.9	28.9				>= 50	10 %
	VTE: Risk Assessment %	86	84	83	82	79	>= 95	20 %
	Obs. On Time - 9pm-8am (%)	42	40	35	37		>= 90	25 %
	Obs. On Time - 8am-9pm (%)	45	43	40	41		>= 90	25 %

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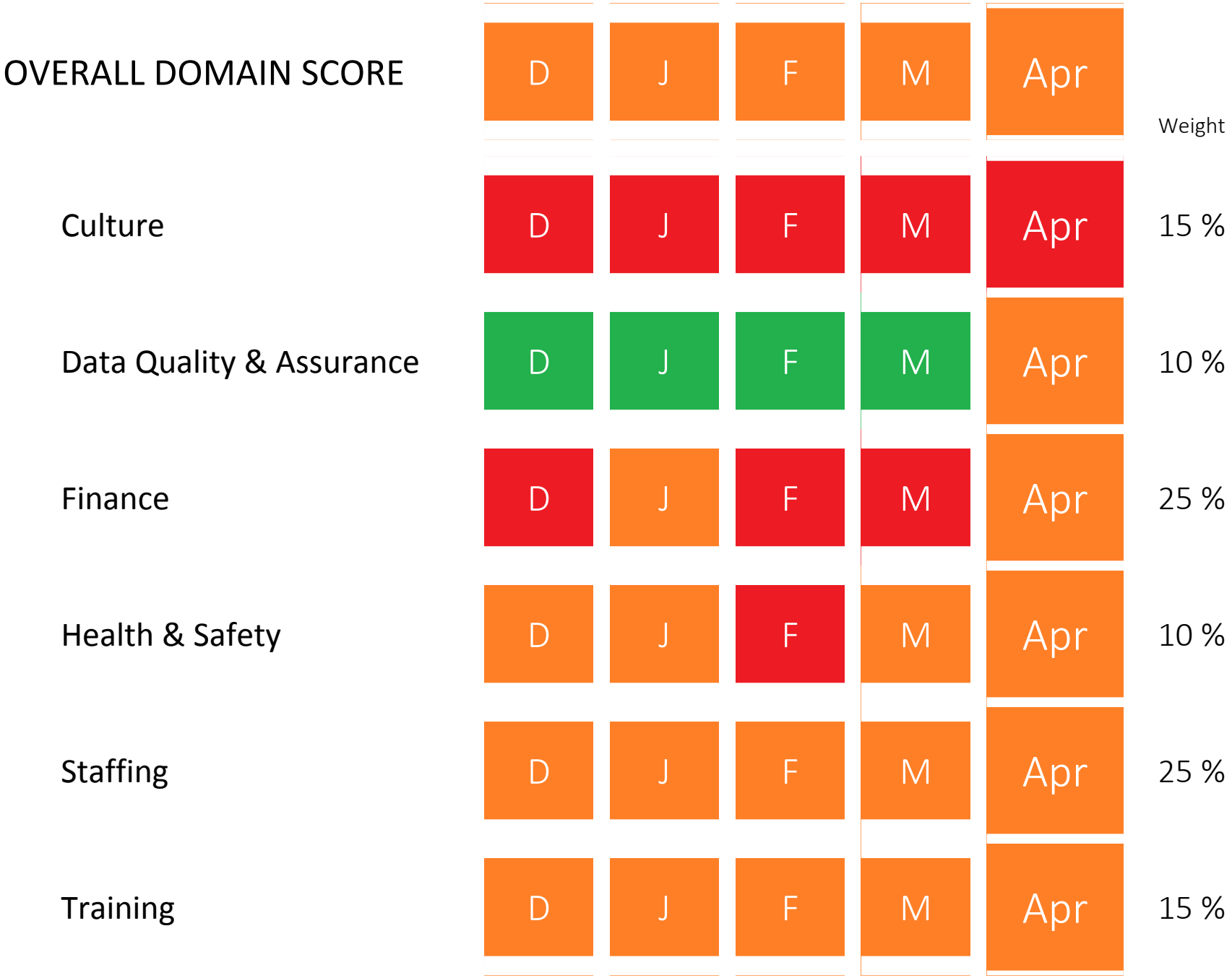
Well Led



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Well Led

		Dec	Jan	Feb	Mar	Apr	Green	Weight
Culture	Staff FFT - Work (%)	53	49	49	49	49	>= 67.2	50 %
	Staff FFT - Treatment (%)	76	76	76	76	76	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	1	2	2	2	2	< 4	25 %
	Valid NHS Number %	100	100	100	100	99	>= 99.5	40 %
	Uncoded Spells %	1	0	0	0	1	< 0.25	25 %
Finance	I&E £m	-3.6	1.2	-4.4	-3.6	-2.8	>= Plan	30 %
	Cash Balance £m	2.5	4.3	8.2	3.9	7.9	>= Plan	20 %
	Total Cost £m	-46.8	-46.7	-47.1	-50.1	-47.9	>= Plan	20 %
	Forecast I&E £m	-36.4	-36.4	-36.4	-35.4	-11.5	>= Plan	20 %
	Normalised Forecast £m	-46.0	-46.0	-46.0	-46.0	-16.6	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	1	3	4	0	0	<= 3	20 %
	Formal Notices	0	0	0	0	0	1	15 %
Staffing	Sickness (%)	3.7	3.7	3.8	3.8	4.4	< 3.3	10 %
	Staff Turnover (%)	10.4	11.4	11.3	11.2	11.2	< 7.4	15 %
	Vacancy (%)	8.0	8.4	8.2	8.0	8.8	< 10	15 %
	Shifts Filled - Day (%)	93	93	90	88	97	>= 97	15 %
	Shifts Filled - Night (%)	100	101	101	97	102	>= 97	15 %
	Agency %	14.7	15.7	16.9	18.8	16.3	<= 10	0 %
	NHSP Use % of Agency	68.2	66.1	68.6	57.1	100.0	> 90	0 %
Training	Appraisal Rate (%)	84.0	85.5	84.2	82.2	79.2	>= 90	50 %
	Mandatory Training (%)	85	85	86	87	88	>= 85	50 %

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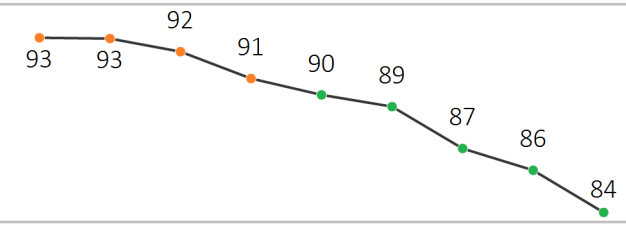
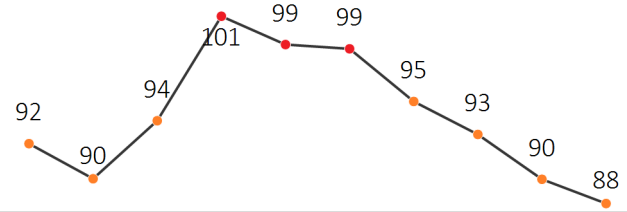
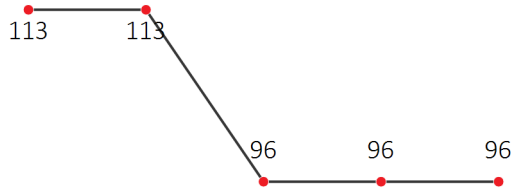
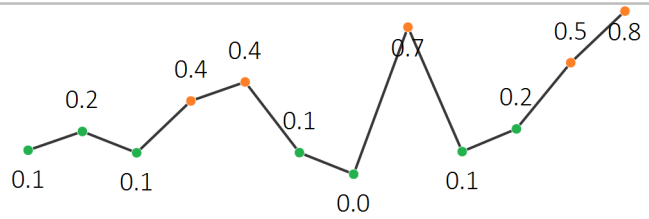
Strategic Theme: Patient Safety

Mortality

Apr	HSMR (Index)	89 (9.5%)		Hospital Standardised Mortality Ratios (HSMRs), via CHKS, compares the number of expected deaths with the number of actual deaths, in Hospital. The data is adjusted for factors statistically associated with hospital death rates and scores the number of secondary diagnoses according to severity (Charlson index).
Apr	RAMI (Index)	94 (5.3%)		Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, ICD10 diagnoses, OPCS procedures and discharge method is constructed.
Apr	SHMI	103 (2.8%)		Summary Hospital Mortality Indicator (SHMI) as reported via CHKS includes in hospital and out of hospital deaths within 30 days of discharge.
Apr	Crude Mortality EL (per 1,000)	0.3 (-28.9%)		The number of deaths per 1,000 elective admissions.

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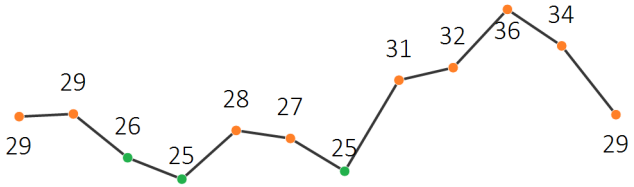
Strategic Theme: Patient Safety

Apr

Crude Mortality NEL (per 1,000)

29 (-2.8%)



The number of deaths per 1,000 non-elective admissions.

Comments: While HSMR is higher in comparison over the last 12 months to the previous period, it still remains well below the national level and has shown over the last seven months that the rate is falling. This trend is consistent with RAMI. Both HSMR and RAMI, if using up to date data would be above plan for April however because the methodology uses HES data, it will always be atleast two months in arrears. April Crude Mortality NEL has reduced again for a second consecutive month and is below last years rate. The SHMI recorded on the National Health & Social Care Information Centre is 1.02, this is an improving position but hidden behind the overall indicator there remain concerns over sepsis-related mortality. At the front door, despite the overcrowding in our emergency departments, screening for sepsis has improved again with 69% of all patients with a EWS of 4 or more screened with a similar performance on all 3 sites. Mean time to receipt of intravenous antibiotics was 58 minutes despite the issues with the ED 4hr standard.

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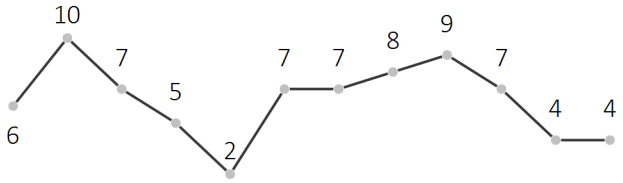
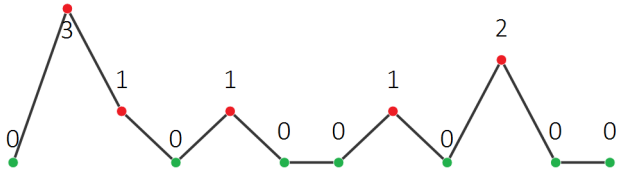
Strategic Theme: Patient Safety

Serious Incidents

Apr	Serious Incidents (STEIS)	76 (-9.5%)		Number of Serious Incidents. Uses validated data from STEIS.
Apr	Never Events (STEIS)	8		Monthly number of Never Events. Uses validated data from STEIS.

Comments:

Work continues to take place within divisions to improve the quality of the investigations and Duty of Candour actions to enable RCA completion within the 60 day deadline. The CCG have noted the quality of the RCAs have improved and the numbers of breaches have reduced. One case remains open that has been open for longer than a year but this is close to completion. The numbers of breached cases have dropped from 16 to 14 and work continues to ensure that the oldest cases will be closed first. One SI was downgraded.

There were four new SIs relating to:
- the colonoscopy pathway and delays in the process;
- an abdominal aortic aneurysm treatment delay;
- pregnancy screening scans;
- a child with tuberculosis.

Four serious incidents were required to be reported on STEIS in April. Six cases have been closed and three downgrades agreed in April; there remains 60 serious incidents open at the end of April. Over the last 12 months incident reporting has increased at all three main sites.

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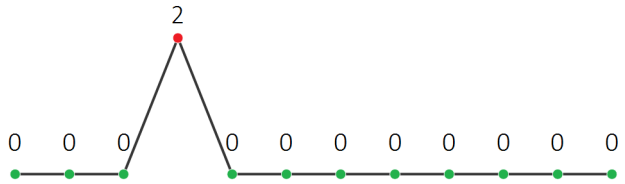
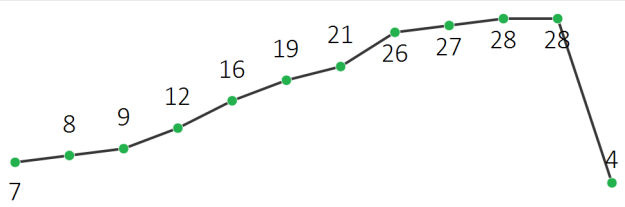
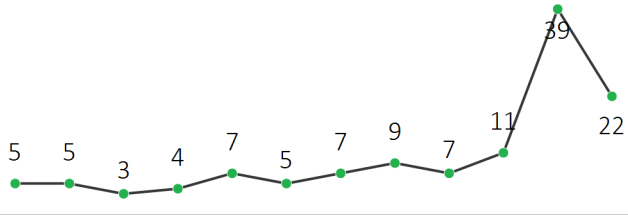
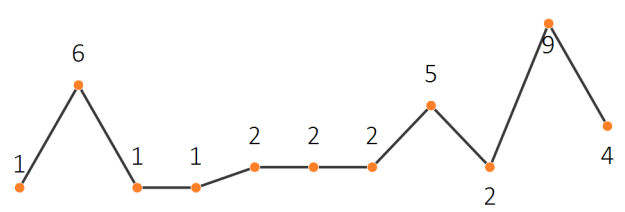
Strategic Theme: Patient Safety

Infection Control

Apr	Cases of MRSA (per month)	2 (100.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT.
Apr	Cases of C. Diff (Cumulative)	4 (-85.7%)		Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01)
Apr	E. Coli	124 (93.8%)		The total number of E-Coli bacteraemia recorded
Apr	MSSA	35 (66.7%)		The total number of MSSA bacteraemia recorded

Comments: The Trust finished the last financial year in a very positive position with regard to infection control. We still have MRSA bacteraemia rates that are lower than national, which continues with 0 in April. We ended the year with the lowest number of C.difficile cases to date in any one financial year and April position is on trajectory. In April we have seen a drop in the total number of E-coli and MSSA bacteraemias.

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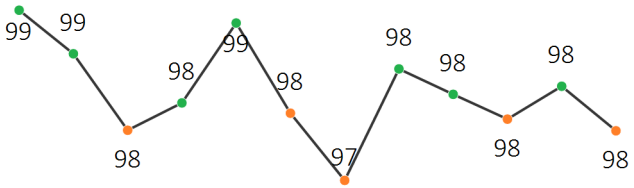
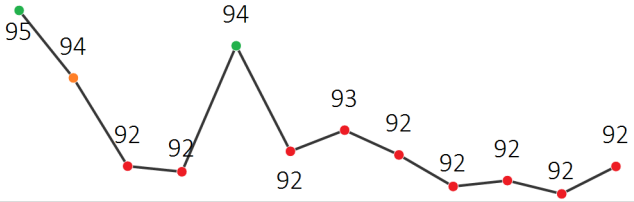
Strategic Theme: Patient Safety

Harm Free Care

Apr	Harm Free Care: New Harms (%)	98 (-0.3%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie free from: New pressure ulcers (categories 2 to 4); Injurious falls; New Urinary Tract Infection (UTI); New Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) or Other VTE) Data source - Safety Thermometer.
Apr	Harm Free Care: All Harms (%)	92 (-0.9%)		Percent of Inpatients deemed free from harm (ie free from old and new harm - Old and new pressure ulcers (categories 2 to 4); Injurious falls; Old and new Urinary Tract Infection (UTI); New Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) or Other VTE) Data source - Safety Thermometer.

Comments: Overall Harm Free Care relates to the Harms patients are admitted with as well as those they acquire in our care and remains below national average. However, Harm Free Care experienced in our care is higher than national average which means that our patients are receiving care that causes less harm than is reported nationally. There was a slight fall in April (97.8%) compared to March (98.2%). WHH maintained the same as last month at 97.9%, K&C reported a slight fall from 98.8% in March to 98.1% in April and QEQM also reported a slight fall from 98.0% in March to 97.4% in April.

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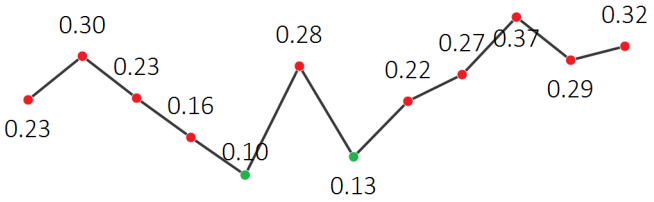
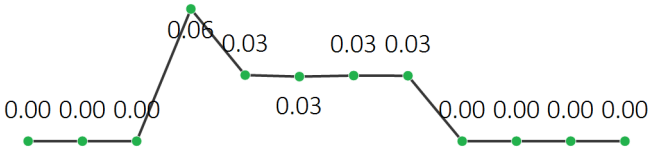
Strategic Theme: Patient Safety

Pressure Damage

Apr	Pressure Ulcers Cat 2 (per 1,000)	0.24 (-88.6%)		Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix.
Apr	Pressure Ulcers Cat 3/4 (per 1,000)	0.02 (-96.0%)		Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix.

Comments:

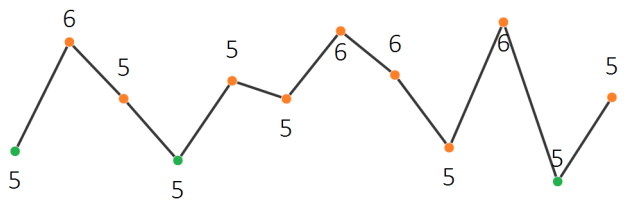
In April 16, a total of 34 acquired Category 2 pressure ulcers were reported and 11 were defined as avoidable due to learning in respect of aspects of the SKINS bundle. This is an increase from last month of 12 ulcers and 3 avoidable ulcers. Six of the eleven avoidable ulcers were located at the sacrum (1 at K & C, 2 at QEQM and 3 at WHH). As the 'Bottoms Up' campaign was commenced in November 2015 to reduce sacral ulcers, further time is required to fully drive through the campaign to full effect. The campaign is set to be re-launched at the Tissue Viability Link Nurse day in May and a stretch 30% reduction trajectory has been set. The TV team are also reviewing the data to identify specific areas of concern for targeted intervention. Extra tissue viability equipment has also been procured for each acute site during this April and the effect is currently being monitored.

There were no confirmed category three of four acquired pressure ulcers in April 16. There were 7 unstageable/deep tissue injury reported of which 3 were avoidable. Two avoidables occurred on Bishopstone ward (sacrum and heels) and one at WHH, CM1 (sacrum). Individual learning points have been identified and are being addressed. These include, limiting time upright sitting; improving documentation and reassessing pressure ulcer risk on change in patient condition and stepping up prevention plan appropriately.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Patient Safety

Falls

Apr	Falls (per 1,000 bed days)	5 (-91.9%)		Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix.

Comments:

National falls data indicates an average of 6.63/1000 bed days and a rate of falls with moderate or severe harm of 0.19/1000 bed days, our falls with moderate and severe harm rate was 0.18/1000 bed days in the National audit data.
Total of 168 falls across all sites in April, 2016. 47 at K&CH, 54 at QEQMH, 67 at WHH
3 falls resulted in fractures
1. 1 hip and clavicle fracture at QEQMH. A RCA has been held but the investigation team were unable to reach a decision about the fall being avoidable or unavoidable. The patient was medically fit for discharge and wanted to go home. He declined hip protectors and had capacity, was unsteady but wished to mobilise independently. His own decision was made on the balance of risk and independence.
2. 1 fall at WHH resulted in finger fractures. This was deemed avoidable as the patient was moved late at night and the falls risk assessment was incomplete.
3. 1 hip fracture at WHH was unavoidable as all measures were in place prior to and at the time of the fall.

The Fallstop! Project has been delayed due to a staffing crisis in the Falls Prevention Team. However, the team are planning a secondment opportunity for an Associate Practitioner and therapist to start the programme in the summer at WHH within UCLTC where comparable rates with the other sites are highest.

East Kent Hospitals University NHS
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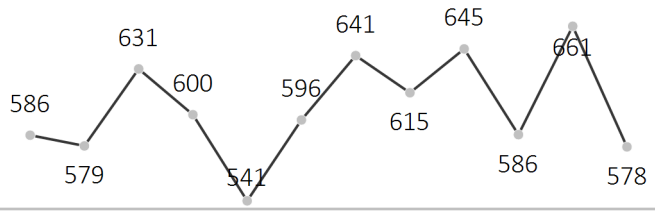
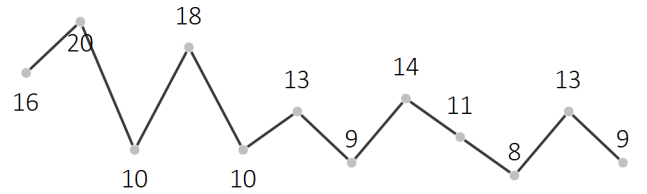
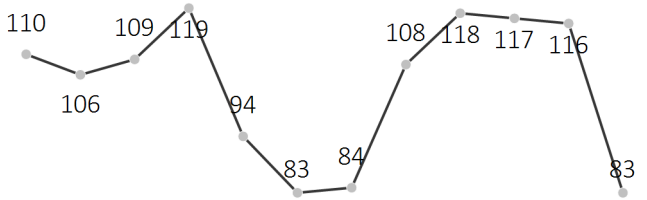
Strategic Theme: Patient Safety

Incidents

Apr	Clinical Incidents: Total	605 (12.0%)		Number of Total Clinical Incidents reported, recorded on Datix.
Apr	Blood Transfusion Errors	151 (-9.6%)		The number of blood transfusion errors sourced from Datix.
Apr	Medicines Mgmt. Incidents	1247 (1.9%)		The number of medicine management issues sourced from Datix.

Comments:

In Apr-16, eight incidents have been graded as death and five as severe harm. In addition, 22 incidents have been escalated as a serious near miss, of which 16 are still under investigation. The number of moderate harm incidents reported during Apr-16 is higher than in previous months [Apr-16: 73 compared with Mar-16: 48 and Apr-15: 27].
In April, there were nine blood transfusion errors reported (13 in Mar-16 and 16 in Apr-15). Themes included two suspected allergic reactions to blood products, two 'wrong blood in tube' incidents and two prescription/documentation errors (including traceability). Five incidents were graded no harm, three as low harm and one as moderate harm, in which the patient developed a high temperature, rigors and shortness of breath during transfusion of a second unit of a blood. The suspect unit has been returned to NHSBT for inspection. This incident is currently under investigation.
There were 83 medication incidents reported as occurring in April (116 in Mar-16 and 90 in Apr-15). Over the last 12 months there has been a gradual increase in reporting of medication incidents at QEH. A downward trend is showing for WHH and K&CH.

East Kent Hospitals University NHS
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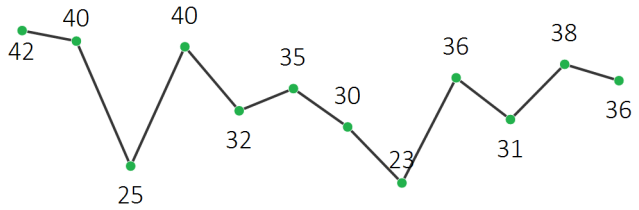
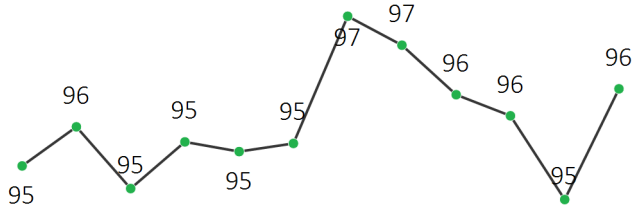
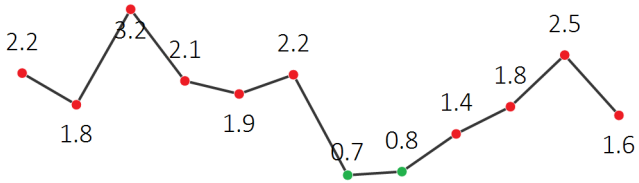
Strategic Theme: Patient Safety

Friends & Family Test

Apr	FFT: Response Rate (%)	34 (-19.6%)		The percentage of patients who responded to the Friends & Family Test
Apr	FFT: Recommend (%)	96 (1.6%)		Of those patients who responded to the Friends & Family Test and knew their opinion, would recommend the Trust
Apr	FFT: Not Recommend (%)	1.9 (-31.1%)		Of those patients who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust

Comments:

During April we received 9,280 responses in total. Overall 36% of eligible patients responded and 96% of them would recommend us to their friends and family and 1.6% would not. The total number of inpatients, including paediatrics who would recommend our services was 95% (93% in Mar-16). For A&E it was 79% (75% in Mar-16), maternity 95% (97% in Mar-16), outpatients 90% (91% in Mar-16) and day cases 94% (93% in Mar-16). The Trust star rating in February is 4.52 (4.48 in Mar-16).
The response rate for inpatients was 36% (38% in Mar-16), A&E 24%, (26% in Mar-16), maternity 33% (37% in Mar-16). (Please note as per DH guidelines only the Birth experience is given a response rate, FFT questions at other stages in the patient's pathway are not calculated or required nationally). The response rate for outpatients was 24% (26% in Mar-16) and 31% for day cases (35% in Mar-16). All areas receive their individual reports to display each month, containing the feedback left by our patients which will assist staff in identifying areas for further improvement. This is monitored and actioned by the Divisional Governance Teams.

East Kent Hospitals University NHS
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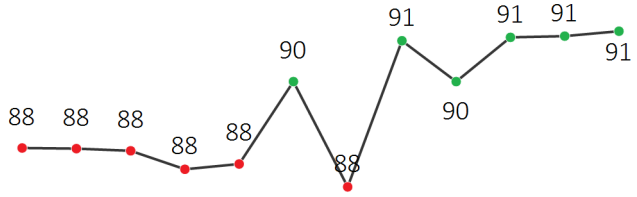
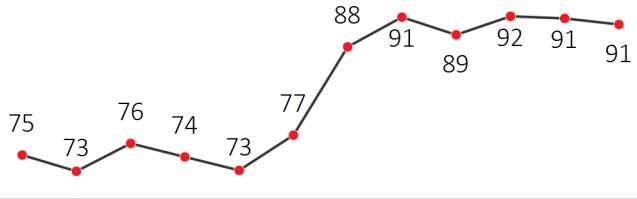
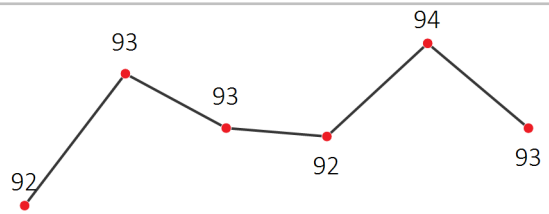
Strategic Theme: Patient Safety

Patient Experience 1

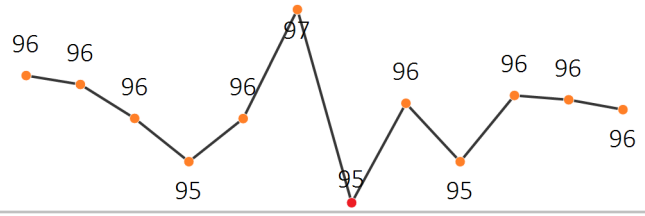
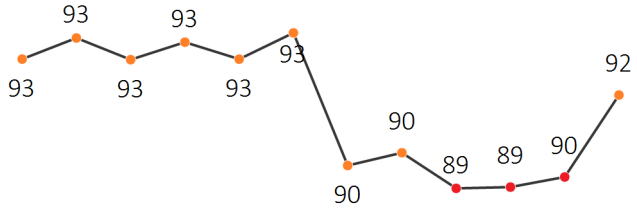
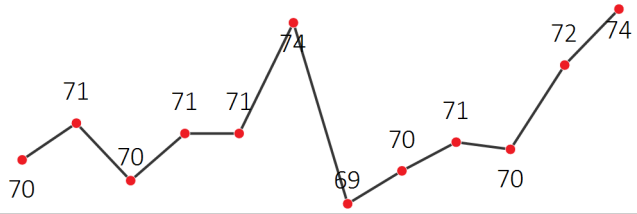
Apr	Overall Patient Experience %	90 (2.3%)		This provides an overall inpatient experience percentage by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1)
Apr	Care Explained? %	85 (13.7%)		Was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? This measures the percentage of inpatients who answered 'yes always' or 'yes sometimes' in response to the inpatient survey.
Apr	Care that matters to you? %	93		Did you get the care that matters to you?

Comments: Further work during June-16 will focus on improving response rates. Each ward reviews their real-time monitoring data regularly. This data is available via the ward dashboard and is updated frequently to ensure a valuable real time tool to capture patient experience and satisfaction feedback, to assist to identify any areas of concern and any areas of praise instantly and action can be demonstrated as needed. In Dec-15 the questions within the survey were updated to reflect the issues highlighted in the national inpatient survey to enable closer monitoring of improvement.
Questions related to involvement in care decisons, staff availability to discuss concerns and privacy in discussing treatement have been substituted for questions on explanation of care / treatment and pain control as they are areas where we perform less well. This information is also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information. This is monitored and actioned by the divisional governance teams.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 2

Apr	Respect & Dignity? %	96 (0.0%)		Overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? This measures the percentage of inpatients who answered 'yes always' or 'yes sometimes' in response to the inpatient survey.
Apr	Cleanliness? %	92 (-0.5%)		In your opinion, how clean was the hospital room or ward that you were in? This measures the percentage of inpatients who answered 'very clean' or 'fairly clean' in response to the inpatient survey.
Apr	Hospital Food? %	71 (0.3%)		How would you rate the hospital food? This measures the percentage of inpatients who answered 'very good' or 'good' in response to the inpatient survey.

Comments: Cleanliness scored fractionally down this month but remains higher than the preceding 5 months. Cleaning audit scores remain high at 98% overall.
Hospital food improved marginally from last month but remains RED if benchmarked against the PLACE scores. The Trust continues to work with SERCO to improve food standards and we have jointly won the Hospital Food Caterer of the Year Award. The Soft FM partnership board along with SERCO are going to look at potential alternative national metrics for food as it was felt 80% at Green was high compared to other sectors/providers.

East Kent Hospitals University NHS
NHS Foundation Trust

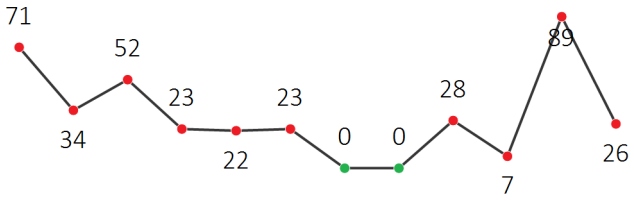
Strategic Theme: Patient Safety

Mixed Sex

Apr

Mixed Sex Breaches

375
(220.5%)



Number of patients experiencing mixed sex accommodation due to non-clinical reasons.

Comments:

During Apr-16, 4 non-justifiable incidents of mixed sex accommodation breaches occurred between WHH ED and CDU. This information has been reported to NHS England via the Unify2 system. There were 14 mixed sex accomodation occurences in total, affecting 68 patients. This shows a reduction from last month when there were a total of 18 occurrences affecting 111 patients. The remaining incidents occurred at K&C on the Kingston stroke unit (1), at QEQM on the Fordwich stroke unit (7) and the CCU (2) which are justifiable mixes based on clinical need. During Mar-16 reporting of mixed sex occurrences improved at the WHH. The Divisional Head of Nursing has addressed the high number of breaches in the Observation Bay in CDU by designating two separate bays that separate men and women to care for both the short stay and observation bay patients together.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Gaps & Overtime

Apr	Vacancy (%)	8.8 (5.8%)	9.5 9.5 9.4 9.8 9.1 9.1 7.8 8.0 8.4 8.2 8.0 8.8	% Vacant positions against Whole Time Equivalent (WTE)
Apr	Staff Turnover (%)	11.2 (-15.0%)	12.2 11.8 11.5 11.5 11.0 10.8 10.5 10.4 11.4 11.3 11.2 11.2	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training
Apr	Sickness (%)	3.7 (-2.2%)	3.6 3.6 3.6 3.6 3.6 3.6 3.6 3.7 3.7 3.8 3.8 4.4	% 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. Calculated cumulatively/YTD. % of FTEs lost through absence (as a % of total FTEs).
Apr	Overtime %	8.8	8.7 8.3 8.6 8.5 9.0 9.1 7.5 8.7 9.5 10.1	% of Employee's that claim overtime

Comments:

The key findings of a detailed analysis of staff turnover and sickness absence will be presented to the Strategic Workforce Committee (SWC) on 20th May 2016. It has identified that the highest percentage of leavers are 'Admin and Clerical' staff followed by Nursing and Midwifery staff. Turnover has remained at similar levels for the last few months. The highest reasons for voluntary resignation are 'other / unknown' following by relocation and then work life balance. Further work will be undertaken on the reasons for leaving, and reported to the SWC.

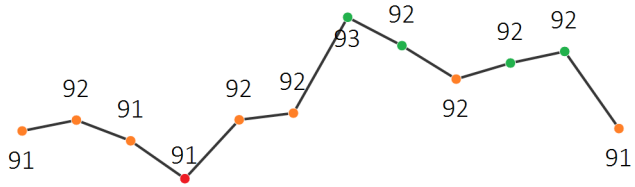
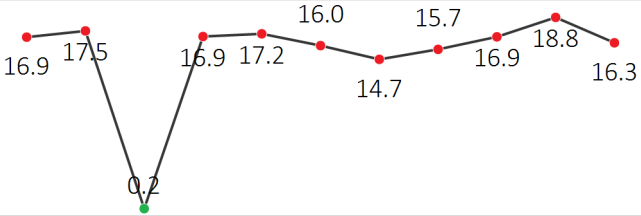
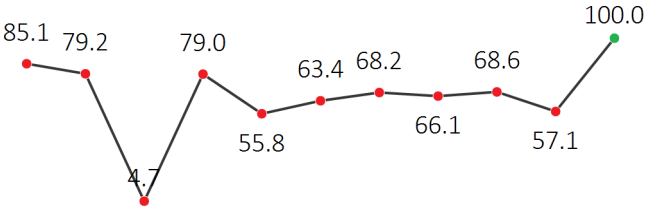
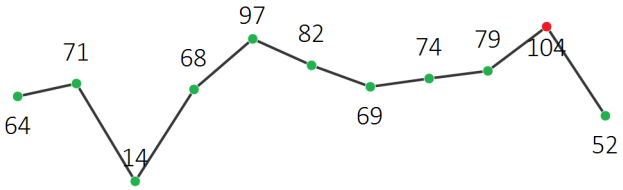
In terms of sickness absence, the analysis provides information on reasons for sickness absence in the first year of employment together with analysis on long and short-term absence. The predominant reason for short term absence is 'cold, cough, flu/influenza' followed by gastro-intestinal problems. Long term absence is anxiety /stress / depression followed by musculoskeletal problems. The Head of Occupational Health will be reporting to a future meeting of the SWC on work being undertaken to support and improve employee health and well being.

The Trust's vacancy rate is examined in detail at Executive Performance Reviews (EPRs) and SWC. We have seen a slight increase in vacancy due to adjustments made to budgets to reflect increases in establishments.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Temporary Staff

Apr	Employed vs Temporary Staff	92 (-0.4%)		Ratio showing mix of permanent vs temporary staff in post
Apr	Agency %	15.2		% of Employee's that are recruited through an agency
Apr	NHSP Use % of Agency	68.9		% of Employee's recruited through an agency that are NHSP
Apr	Agency Orders Placed	70		Total count of agency orders placed

Comments:

Reduction in agency spend is a key component of our cost improvement programme (£4.1m). There is an agency programme programme, led by the Head of Human Resources supported by the Service Improvement Team. The Trust monitors and reports on a weekly basis, all agency shifts that breach the agency framework and NHSI pay caps by occupational group and division.

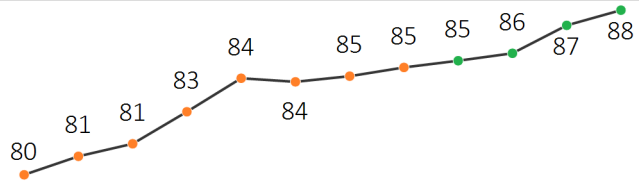
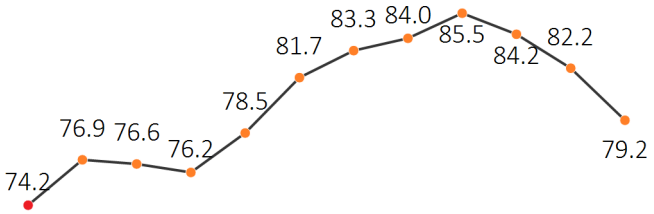
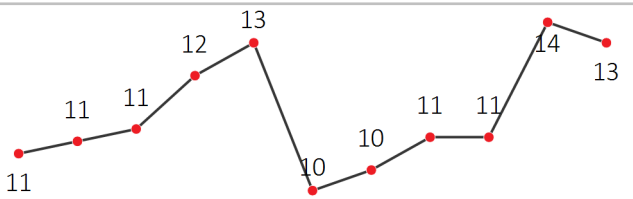
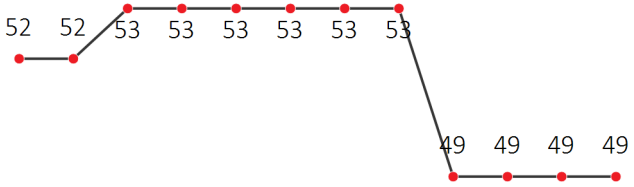
Divisions are held to account for delivery of their agency CIPs through EPRs.

The Trust has recently tendered for a new Bank partner.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Apr	Mandatory Training (%)	84 (6.5%)		The percentage of staff that have completed mandatory training courses, this data is split out by training course.
Apr	Appraisal Rate (%)	80.3 (6.1%)		Number of staff with appraisal in date as a % of total number of staff.
Apr	Time to Recruit	11 (5.2%)		Average time taken to recruit to a new role
Apr	Staff FFT - Work (%)	52 (8.6%)		Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission.

Comments:

Statutory training has risen to 87% which remains below the target of 90%, however it does compare favourably to other NHS organisations. There remains a significant risk in regard to statutory training compliance. In February 2016, 897 staff were identified as not completing one or more of the statutory training courses required. Action plans have been implemented by the divisional leadership team, and we have since seen a moderate reduction.

The Trust staff appraisal rate has declined as expected, as the majority of staff have their appraisals in April and May. I would anticipate this returning to compliant levels in June (reported in July).

We have seen a slight reduction in Staff FFT. Each Division has developed a 'Great Place to Work' plan that incorporates the feedback from the Staff FFT and the national NHS Staff Survey Results. The divisional plans will be presented to the SWC on 20th May 2016.

Further work needs to be undertaken to reduce the time to recruit new staff, and this will be monitored at future SWC meetings.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

4 Hour Emergency Access Standard

Key Performance Indicators

84.02 %

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Green
4 Hour Compliance	88.35%	87.99%	86.50%	88.46%	87.54%	87.00%	89.37%	87.79%	84.91%	80.01%	79.26%	84.02%	95%
12 Hour Trolley Waits	0	0	1	2	0	0	0	0	1	0	1	1	0
Left without being seen	3.14%	3.80%	3.88%	3.39%	2.79%	2.87%	3.06%	3.19%	2.87%	3.78%	4.20%	3.46%	<5%
Unplanned Reattenders	8.31%	9.13%	9.48%	9.39%	8.98%	8.80%	8.93%	8.71%	8.88%	8.97%	9.31%	8.89%	<5%
Time to initial assessment (15 mins)	94.5%	95.1%	94.9%	93.5%	94.9%	91.1%	89.5%	91.7%	93.3%	92.6%	91.1%	86.0%	90%
% Time to Treatment (60 Mins)	50.5%	47.6%	47.9%	53.3%	49.4%	51.0%	49.9%	50.3%	49.5%	43.5%	40.8%	46.1%	50%

Sustainability & Transformational Funding Trajectory (Submission 18th April 2016)

-1.2 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%	
Performance	84.02%												

Summary Performance

The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated, and then admitted or discharged in under 4 hours. This target was last revised by the Department of Health in 2010. When a decision to admit a patient from the emergency department is made, there is zero tolerance for waits of over 12 hours for admission to a ward.

Due to the Trust being unable to achieve compliance against the 4 Hour Standard, it has developed an urgent care recovery plan aimed at improving performance across the Trust. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

April performance against the 4 hour target was 84.02%, against a trajectory of 85.22% and a compliance target of 95%. April's performance level is improved compared to the February and March positions, with a higher proportion of patients seen within 4 hours. Analysis of the breach reasons shows a reduction in the proportion of breaches due to delays to be seen by a first clinician, (32% of all breach reasons, compared to 43% in March). This improvement in patients being seen by a clinical decision maker more promptly is also shown by the increased proportion of patients seen within 60 minutes, a sign of reduced overall waiting times for patients compared to recent months. There was a single 12 hour trolley wait breach in the month.

In April, the William Harvey Hospital (WHH) in Ashford showed a clear mid-month step change in performance, with the last 14 days of the month showing overall performance of 85% against the 4 hour compliance standard, contrasting against 71% for the first fortnight of the month. There was no notable change in the volumes of attendances to the site over this period of time, but it is noted that the last week of April saw fewer extended waits to be seen, and an increased proportion of patients first seen within 60 minutes (improved to 49% within 60 minutes compared to 31% in the first fortnight).

Improvements in Emergency Department performance are being pursued through the urgent care recovery plan, which has gone through a detailed review to identify areas which will improve performance the most. The 4 key areas and actions are as follows;

Priority 1- Improvements in ED

Team Based Working

- This pilot has been developed by the senior clinical team at QEQMH. Senior medical, nursing and support staff are allocated into teams who are responsible for specific areas of the Emergency Department with clinical responsibility for managing patients in those areas through their pathways.
- Implemented in April 2016. The pilot is being run between the hours of 12.00 – 18.00. There was an immediate positive impact with an improvement on the 60 minute standard from 31% to 48%, which resulted in more patients being seen by a clinician within 60 minutes of arrival in the department. 4hr compliance overall sees a 5% compliance increase for non-admitted patients during pilot hours moving from 81% to 86%.
- The hours of cover are being extended until 21.00 in May as staffing allows, however there are currently 4 speciality doctor vacancies which are being covered by locum doctors whilst recruitment is completed and this may impact on the department's ability to provide the service consistently. Nine new speciality doctors have accepted posts and will be arriving in the next 3 – 6 months.

Consultant Recruitment

- The Emergency Department is funded for 10 Emergency Medicine Consultants on each site. In 2015/16 there were 6 substantive consultants in post. There is a national shortage of Emergency Medicine Consultant and Specialist Registrars in training. An internal consultant development programme was implemented in 2015/16 to enable speciality doctors to be supported by a dedicated clinical supervisor and teaching programme, linked to the College of Emergency Medicine examination programme. The programme has been successful with 3 speciality doctors expected to be able to apply for substantive consultant posts within 1-2 years.
- Over the past year there have also been an additional 3 consultants have been recruited, with two of the applicants coming into post in September 2016.

Early Senior Intervention (ESI) project

- The senior clinical team at WHH have piloted an internationally recognised assessment process whereby self-presenting and ambulance patients are assessed by a senior doctor or nurse upon arrival in the Emergency Department. Patients will then be streamed to the appropriate pathway to ensure that timely and appropriate clinical care is provided and the sickest patients are seen and treated immediately.
- The ESO project has been accepted by the TIPs programmes (Teams Improving Patient Safety).
- Full roll out may require additional nursing staff to support the model and this has been included in the nursing workforce review which was completed in April 16.

Priority 2 - Re-launch of Acute Medical Model at QEQM.

- The Acute Medical Model was implemented as Phase 1 on 2 April 2016. The model has had an immediate positive impact on patient flow and has been fully supported by the clinical teams on site. The model is being evaluated on a weekly basis and managed through a project structure to ensure that the learning is captured and will be shared.
- Due to the model's success, plans are in place to roll out the model to WHH with the project group being established in May and implementation by the end of June 2016.

  Aims of model:

  - Strong MDT approach to managing patients pathway
  - Direct referrals to specialist teams within MDT board round/Careflow electronic referrals
  - Reduced LOS both short stay & specialist patients as indicated earlier in pathway
  - Improved flow across emergency floor / improved patient experience
  - Increasing use of emergency ambulatory care / improved management for primary care referrals

  Further developments/consideration

  - 7 day working
  - Recruit Acute Medical staffing team
  - Inclusion of Frailty team within model

Priority 3 - Implementation of SAFER

- SAFER has been implemented on Sandwich Bay and Minster Ward at QEQMH and Cambridge L and Cambridge J at WHH. The processes are becoming embedded with morning MDT ward rounds established.
- A discharge website is being developed to include information and policies relating to simple and complex discharges, SAFER tools and patient leaflets.
- Next steps include drop in training sessions for MDT staff around discharge, SAFER principles and patient flow. Developing a SAFER dashboard to monitor progress and improvements. Identify a consultant champion for each ward area and improve senior clinical engagement

Priority 4 - Site Management Arrangements

Operational Control Centres (OCC's)

- OCC's have been established on all three sites, with the major incident control centres now being formally co-located. The OCC's have quickly becoming established as information hubs for consultants, senior nurses and managers to provide and receive information.

Meeting Structures

- Trustwide video conferenced 'SITREP' meetings have been standardised with meetings being held at 08.00 and 16.00. Additional meetings may be requested according to site escalation status.
- Chaired by the Head of Clinical Operations, the site based meetings focussing on the provision of safe and effective emergency and elective patient flow, staffing issues and risk are held twice daily.
- The above meetings are also supported by a 12.30 SITREP telephone call to escalate emerging risks to the Head of Clinical Operations or Divisional Director for UCLTC.

Communication Systems

- QEQMH is piloting the use of mobile telephones using wi-fi to improve the network coverage.

Trajectory Confidence

April performance against the 4 hour target was 84.02%, against a trajectory of 85.22% . The new Acute Medical Model and Team Based Working models all had a positive impact on performance. The improvements gave confidence that the projects which have been developed and implemented by the clinical teams would provide the sustained improvement to patient experience, quality and flow.

The formalised meeting structure, improved discipline and information flows that the OCC's have delivered have also had a positive impact on performance, particularly at QEQMH where the meeting structure has been developed and become established. The QEQMH communication and meeting model is being rolled out to all sites.

The on-going risk to delivery of the trajectory is:

- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community. A high % of breaches of the 4 hour emergency access standard relate to patient flow and bed availability.
- High numbers of patients attending ED in the evenings who could be managed by primary care, in particular paediatric attendances.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

Cancer Compliance

Key Performance Indicators

69.64 %

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Green
62 day Treatments	70.31%	72.43%	64.84%	68.83%	69.76%	70.45%	70.89%	79.11%	71.68%	79.86%	74.53%	69.64%	>=85%
100 day breaches	113	116	85	86	130	87	75	57	64	65	61	42	<0
Demand: 2ww Refs	2,555	3,020	3,195	2,535	2,835	2,748	2,785	2,550	2,725	2,839	2,908	3,050	
2ww Compliance	94.24%	92.11%	90.32%	89.96%	95.05%	95.62%	94.52%	93.87%	93.28%	94.10%	93.59%	89.00%	>=93%
Symptomatic Breast	93.08%	87.50%	85.45%	80.52%	93.46%	94.12%	93.55%	92.22%	94.06%	88.03%	93.02%	85.00%	>=93%
31 Day First Treatment	91.84%	96.09%	90.64%	94.02%	93.17%	96.43%	97.48%	98.00%	94.82%	97.07%	98.14%	96.40%	>=96%
31 Day Subsequent Surgery	87.80%	92.31%	91.89%	92.86%	92.11%	94.44%	96.97%	94.44%	94.59%	97.50%	96.72%	90.48%	>=94%
31 Day Subsequent Drug	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.53%	98.44%	86.17%	100.00%	100.00%	98.25%	>=98%
62 Day Screening	94.44%	100.00%	96.15%	88.24%	86.27%	84.21%	86.36%	85.00%	93.75%	95.65%	92.59%	92.31%	>=90%
62 Day Upgrades	100.00%	100.00%	25.00%	33.33%	91.67%	66.67%	77.78%	70.00%	50.00%	86.67%	70.37%	95.00%	>=85%

Sustainability & Transformational Funding Trajectory

-4.56 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	74.20%	76.40%	77.60%	77.40%	82.70%	85.40%	85.00%	85.50%	85.20%	85.10%	85.40%	85.20%	Sept
Performance	69.64%												Sept

Summary Performance

The Trust's main priority within cancer services is to ensure our patients receive treatment within the appropriate timeframe. The national target which has been consistently difficult for the Trust to maintain is the 62-day referral to treatment, which is made up of three key components: following an urgent referral from their GP, patients should be seen by a clinician within 14 days. If the diagnosis is cancer, a decision to treat should be made as soon as possible, and treatment should begin within 31 days of agreeing this treatment. Over the patient's total pathway, treatment should be initiated within 62 days of the GP making the original urgent referral. There is a zero tolerance of patient waiting greater than 100 days for treatment, and Lead Clinicians now review each of these cases to identify causes and risk of harm to the patient. Where potential harm is identified, a full root cause analysis will be conducted and shared with our Clinical Commissioning Groups and internal governance boards.

Due to non-compliance of this 62-day standard over the past year, it is this target for which the Trust has developed an improvement trajectory as part of the Sustainability and Transformation Fund. The Trust has developed an internal plan to return to compliance, including revising capacity in outpatient clinics, re-launching multi-disciplinary team meetings and agreeing timed pathways and operation procedures. The Trust expects to deliver a compliant 62-day pathway by September 2016.

April performance against this standard is 69.64%, with 42 patients waiting 100+ days for their first treatment. The Trust delivered a total of 151.5 treatments, and 46 of those patients breached the 62 day timeframe. The Trust aggregate position is 4.56% behind the submitted recovery trajectory, and saw 6 more breaches than anticipated. The breaches are generally caused by either capacity shortfalls or delays in agreed pathways.

Priority 1 – Provide a named Executive Director responsible for delivering the national cancer waiting time standards.

The Trusts named Executive is Jane Ely (Chief Operating Officer).

Priority 2 – Deliver 62 day cancer wait performance reports for each individual cancer tumour pathway to the Trust Board.

The Trust Board receives a cancer briefing report submitted as part of the Chief Operating Officer's report on the Key Performance Standards. This report refers to monthly and quarterly performance for all the cancer standards (2WW, 31days and 62days) for each tumour site. As required the detail includes actions being taken to improve performance and on-going work with CCGs etc. In addition, the cancer tumour performance is discussed in detail at the bi-monthly Cancer Board attended by Executive members, Cancer Lead Clinicians, managers and the wider cancer MDT.

Priority 3 – Provide and adhere to a cancer operational policy which is approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.

The Operational Policy for Cancer is in its first version and has not yet been circulated to Cancer Board Members for ratification at the June Cancer Board. This document is a lengthy policy that includes information around the Access Policy, roles and responsibilities of key members of the Cancer and Leadership team along with the escalation policy. Detailed information around data quality, targets and Cancer standards are addressed. Written guidance on internal processes for MDT working is available within the document (including guidance around achieving the effective MDT). Cancer reporting mechanisms including the Cancer Dashboard is also evident within the document. A review of the MDT Coordinators

has taken place with a new management structure within the team. MDT coordination and Tracking roles have been separated to ensure PTL is validated on time and MDT work is safe, timely and effective. Due to high levels of sickness and turnaround within the team we have over-established the team with MDM coordinators. We are also going out to advert for an apprentice role within the tracking team. The team have all been re-trained and have met their competencies, led by the Macmillan Project manager.

Priority 4 – Maintain and publish a timed pathway, which is agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.

East Kent Hospitals University NHS Trust hosts the Kent and Medway Cancer Collaborative - which was previously the Kent and Medway Cancer Network. The collaborative continues to ensure that there are Kent and Medway wide (includes the Cancer Centre) Tumour site specific groups (TSSGs). The TSSGs review the cancer pathways on an annual basis and review the referral proforma, diagnostic tests and other milestones. These pathways are agreed with the SCN (and thus the CCGs). The Trust now has a live cancer dashboard to enable clinical and operational staff to view the cancer PTL as well as understand issues around tumour specific pathways. A list of key events to ensure teams can predict future delays and overcome these before they become an issue is developed within the Cancer Dashboard. As well as the PTL the dashboard will aim to have COSD data added so this is open and transparent.

Priority 5 – Maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.

Weekly PTL meetings have always taken place. We have revised the timetables with a new agreed escalation policy. The purpose of the meeting will be to ensure that the operational managers, clinical nurse specialist, Cancer data manager and MDM coordinator meet to discuss each tumour site and review the PTL. Breaches and other issues will be discussed in the weekly operational cancer performance meeting. These meetings have been superseded by the new Key Performance Indicator meetings, chaired by the Chief Operating Officer and Divisional Directors with the purpose of identifying and resolving pathway bottlenecks and key issues preventing achieving performance.

Priority 6 – Carry out root cause breach analysis for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching). These should be reviewed in the weekly PTL meetings.

Work has been undertaken with the Patient Safety Board and Governance leads. Each Monday a breach report with a summarised RCA section is sent to the MDT lead for their review. A Clinical Incident reporting form (DATIX) is also completed on the electronic reporting system. This is then reviewed within the Governance team for the Division concerned. The MDT Lead completes the RCA summary and finalises the electronic DATIX form deciding if a full Route Cause Analysis is required. This is then processed through the Trusts Governance procedures, led by the Governance team. Themes from the DATIX forms and Breach Reports are presented to the Patient Safety Board on a monthly basis and the Cancer Board Bi-monthly.

Priority 7 – Carry out capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality). There should also be an assessment of sustainable list size at this point.

It has been agreed for all tumour sites that the pathway timelines and key milestones are to be ratified within the specialty and at the cancer board - in line with revised NICE guidance. Following this we are to use the IST capacity and demand tool to calculate the capacity need to deliver the standard. We will ask to complete this in collaboration with the CCGs as the increase in cancer referrals is significant. Diagnostic capacity and first appointment capacity planning is already commenced.

Priority 8 – Set out an Improvement Plan for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.

The Trust has met with the CCGs and agreed to work collaboratively to ensure improvement against the 62 day standard. A recovery trajectory and action plan has been submitted and is reviewed monthly with the CCGs. Urology's trajectory has improved significantly and is no longer the Trusts main concern for delivery of the 62 day standard. The Urology department have made significant improvements to their pathway and a focus has been to ensure this improvement plan is shared with other specialties facing bottlenecks around their pathways. Sharing good practice has been encouraged. Colorectal remains a high risk for the Trust, mainly due to delays in Endoscopy booking which has been recognised at National level. Each tumour site has produced an action plan that will be reviewed weekly at KPI meetings. The Cancer Dashboard will highlight capacity, demand modelling and predictions for future issues therefore making a significant improvement in performance.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.78 %

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Green
Performance	99.81%	99.81%	99.92%	99.93%	99.73%	99.84%	99.86%	99.90%	99.81%	99.65%	99.65%	99.78%	>=99%
Waiting list Size	13,377	14,431	14,271	13,990	14,137	13,962	12,799	13,593	12,496	12,993	13,358	13,449	<14,000
Waiting > 6 Week Breaches	26	27	12	10	38	23	18	13	24	45	47	29	<60
Average Wait													<4

Sustainability & Transformational Funding Trajectory

0.70 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	99.08%	99.09%	99.15%	99.15%	99.13%	99.14%	99.13%	99.05%	99.10%	99.02%	99.03%	99.13%	Apr
Performance	99.78%												Apr

Summary Performance

The DM01 is a national monthly report of performance against the 6 week standard for 15 key diagnostic tests. These include Radiology (MRI, CT and Ultrasound), Audiology, Echocardiography, Neurophysiology and Cystoscopy. Around 13/14 thousand tests per month are measured against the 6 week standard. The Division support the pathways for all patients on an 18 week and Cancer pathway.

29 patients waited over the 6 weeks standards in April 16 – breakdown below

Computed Tomography - 9
Non-obstetric ultrasound - 9
Audiology - 1
Colonoscopy - 5
Gastroscopy - 5

Risks and Issues to sustainable performance

- Aging equipment and downtime, rebooking enabling patient choice is a risk mitigated by daily conference call across the Trust with full overview and management of slot availability and use of alternative sites.
- Increasing demand in modalities of CT MRI and Ultrasound
- Recruitment to key Consultant, Radiographer, Ultra sonographer and Nursing posts, with locums vacancies of Consultants in Radiology, Endoscopy and Neurophysiology
- Reduction to current workforce and outsourcing availability would dramatically reduce the ability to deliver and sustain the DMO1 position –it would further compromise the RTT and cancer standards
- National public drives in screening can drive capacity and demand issues particularly in Endoscopy. The volume of cancer related to endoscopy referrals this month is at unprecedented levels for the Trust and we are reporting serious incident in relation to the demand and impact this could have on waiting times.

What actions are we taking to mitigate and improve performance?

- Management and servicing of equipment managed closely. Serviced regularly to maximise use and work flow.
- Daily overview and mapping of demand to capacity – bi-weekly overview by senior team to ensure on track and mitigate any issues in month
- Additional lists being undertaken to include both extended days during the week and Saturday lists.
- Consultant workforce recruiting to 4 vacancies and reviewing the speciality Interest of posts including Breast. Interview May 16 and July 16 - NHS Locums in place to mitigate in interim.
- Developing Business case to convert locums to substantive whilst ensuring full productivity and maximise DPA time of all consultants
- Neurophysiology- Consultant vacancy - The Consultant is employed by EKHUFT on a sessional basis to carry out the diagnostic reporting until the post is recruited to. This allows us to continue to achieve compliance. The vacancy is being actively recruited to.
- Additional outsourcing of reporting and using I.S. for MRI and Ultrasound (as required) to support delivery.
- Full Review of demand by speciality and by Division and Direct Access flows – this is actively being shared with Divisions and CCGs
- Working with Cardiology to review their pathways and booking processes and enable Nurse led booking of requests and reduce bulk ordering of tests.
- Endoscopy – we will continue to manage with daily overview of all available capacity. We continue to offer Direct access and straight to diagnostic approaches.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

18 Week Referral to Treatment Standard

Key Performance Indicators

88.56 %

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Green
Performance	88.36%	86.76%	88.10%	88.14%	90.13%	92.06%	91.51%	88.82%	90.10%	89.17%	89.27%	88.56%	>=92%
52w+	5	7	8	8	15	12	3	5	3	5	5	6	0
Waiting list Size	42,519	45,029	44,706	42,508	42,577	40,125	39,842	41,178	42,239	42,791	43,000	44,620	<38,938
Backlog Size	4,950	5,962	5,321	5,042	4,201	3,186	3,384	4,604	4,181	4,634	4,614	5,105	<2,178
Demand: PC Referrals	15,106	16,465	17,105	14,454	15,950	16,435	15,692	14,296	14,979	15,882	16,190	16,343	<15,484
Demand: Additions to IP WL	3,001	3,560	3,412	2,849	3,220	3,474	3,578	3,118	3,358	3,565	3,582	3,452	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

Sustainability & Transformational Funding Trajectory

-0.47 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%	Sept
Performance	88.56%												Sept

Summary Performance

The NHS Constitution gives all patients the legal right to start their non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral; unless they choose to wait longer or it is clinically appropriate that they wait longer. To measure compliance against this constitutional right EKHUFT is monitored against the Percentage of Patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral, the Threshold for national compliance has been set at 92%. There is a zero tolerance for any patient waiting over 52 weeks for treatment to commence. All breaches undergo a full root cause analysis, the results are shared with our Clinical Commissioning Groups and themes and lessons learnt are cascaded through our divisional governance structure.

Throughout the last year the Trust has been unable to deliver performance against the national standard as the number of patients waiting for treatment significantly exceeded our capability to see and treat within 18 weeks of referral. The Trust has developed internal activity plans which address the imbalance, and delivery of these activity levels alongside primary care commitments to reduce demand will enable the Trust to successfully deliver the Trajectory over the course of the financial year, this has formed the basis of our Sustainability and Transformation Fund Improvement Trajectory. The Trust intends to deliver compliance against the national standard by September 2016.

In April performance against the 2016/17 standard was 88.2% and six patients had waited for treatment for more than 52 weeks as at the end of the month. Unplanned losses in capacity due to the four junior doctor strike days, plus significant localised medical sickness and vacancies have meant we have been unable to deliver the business plan in month one. The Trust continues to receive primary care demand at an unmanageable rate which if left unchecked will render the trajectory unachievable.

The Trust has developed four key priorities which address all of the issues detailed above and we will continue to work with our local commissioners to achieve the sustainability and transformational trajectories and comply with our NHS constitutional duty.

Priority 1 - Improve Pathway Management

Development of New Interactive Patient Tracking List – We have developed a new Interactive Patient Tracking System which will enable our Operational Teams to access to live data, ensuring all patients waiting for Treatment are being actively monitored and managed, it is anticipated that this will significantly reduce the risk of patients waiting in excess of 52 weeks for Treatment.

- The software is now in beta testing phase and it is expected to be in operational use before the end of June 2016.

Documented Timed Referral to Treatment Patient Pathways – Each specialty to map 18 week compliant pathways to enable us to unblock delays, monitor and hold ourselves to account to achievement of the RTT standard.

- Maxillo Facial and Colorectal and are due to be completed and presented by the end of May 2016,
- Full Implementation plan for the mapping of all specialities will be completed by end of June 2016.

Reinstate Patient Tracking List (PTL) meetings - Each divisional team has reintroduced a PTL meeting used to provide robust monitoring at patient level on weekly basis, this will greatly reduce the risk to patients waiting over 35 weeks for treatment to commence.

- All PTL meetings have been established

Priority 2 - Achieve the Outpatient Milestones

Demand Management – The health system acknowledges the Trust does not have the operational capacity to deal with the current demand, as such our local Clinical Commissioning Groups (CCGs) have committed to reducing referrals to East Kent in 2016/17.

- The CCGs have confirmed they have identified alternative providers to deliver Orthopaedic pathways in 2016/17, and the Trust is working with Primary Care colleagues to ensure this commences before the end of quarter one as planned.
- Referrals into the Trust over performed the plan by 12.5% in April; this level of demand will render the recovery plan unachievable and has been escalated to the Chief Executive and will be tabled for discussion at the next CCG Performance Meeting.
- The Trust has identified an alternative provider who will accept tertiary referrals for complex adult ear procedures. The Trust is now working with CCG to confirm funding approval and timescales.

Secure Additional Required Sessions – In 2016/17 the Trust will need to provide significant additional outpatient and theatre sessions to meet demand and achieve the required improvement against the RTT standard.

- All operational teams have been asked to secure additional capacity for the first two quarters of the year.
- Risk around continued support from nursing staff to accommodate additional capacity

Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste will be reported shortly.

Bring forward the Decision to Treat Date – Identifying patients who have passed the optimal point in patient pathway and securing decision or treatment capacity

- Weekly validation, monitored at the weekly Patient treatment tracker meeting
- Decision making tree to be developed to support patient management
- Endoscopy delays are extending the colorectal pathway, to mitigate this joint clinical colorectal and gastroenterology meetings established in May 2016. Agrred actions are logged and taken forward with the respective operational teams.

Priority 3 - Deliver the Efficiency Programme

Deliver Theatre Booking Magic Numbers – In collaboration with Medical Productivity & Clinical Service Redesign Specialists, Four Eyes Insight, the Trust has identified an efficiency opportunity of 5,000 operative procedures per annum.

- The Trust has developed key monitoring documentation and enhanced the booking procedures required to achieve the required Theatre efficiency target.
- It is expected the first results of these will be realised in June 2016.

6-4-2 Programme – The Trust has established a programme of work to reduce the number of Theatre sessions that are cancelled and not re-established.

- The Trust has developed future focused reports and established meetings to review underutilised and empty theatre sessions.
- Early indications support a step change reduction in empty sessions.

Priority 4 – Deliver recurrent demand substantively

Live view of current demand – Monitoring referrals on a weekly basis to identify outpatient and admitted capacity required to respond

Real time response – Developing a process to empower staff to address changes in demand, this will reduce delays in responding to unplanned or unexpected changes to patient flow.

- Agree a waiting list initiative authorisation process, to include weekly demand monitoring and risk management within in the established PTL meetings.

Substantive planning – identifying demand within core capacity to deliver within financial constraints

- Job planning clinical teams to deliver flexible sessions to achieve cross covering of clinical commitment during leave in outpatient and theatres.
- Explore moving cataracts from QEQM and WHH to Dover procedure theatre to release theatre capacity – June 2016
- Identified Ophthalmology sessions to transfer to extended days to release theatre capacity and provide cross cover – July 2016
- CCG have committed to providing Independent Sector capacity to transfer patients from the trust admitted waiting list, no timescales have been received from the CCG at present and as such the Trust should consider the continued use of the Independent Sector outsourcing to avoid whole system failure of the RTT Trajectory.

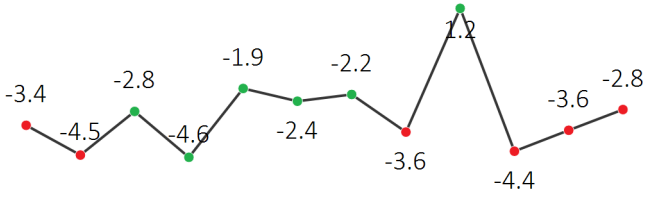
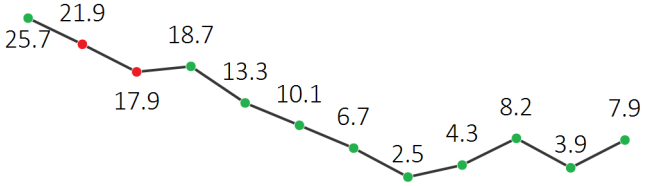
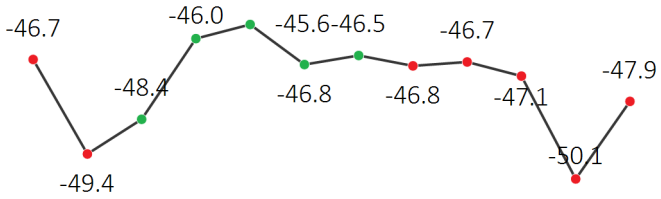
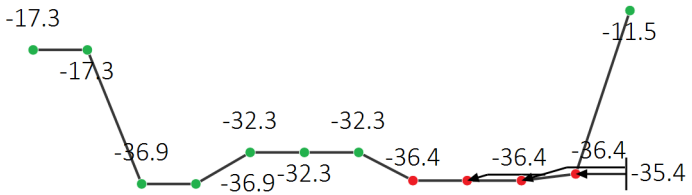
Closing the loop on business planning and accountability – Developing operational procedures and monitoring tools to ensure delivery of the Business Plan

- Develop, train and embed consultant session tracker models to ensure we achieve our substantive internal activity.
- Deliver business planning action plans at speciality level to be monitored weekly at the RTT meeting.
- Clear objective setting, monitoring and accountability at monthly 1-2-1 meetings.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Finance

Apr	I&E £m	-2.8 (-22.7%)		The graph shows the Income and Expenditure result for each month - the year to date is shown in the arrow. The year to date plan = £2.6m adjusted for "extra" CIPs.
Apr	Cash Balance £m	7.9 (105.4%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow.
Apr	Total Cost £m	-47.9 (-4.5%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month - the year to date is shown in the arrow.
Apr	Forecast I&E £m	-11.5 (-67.4%)		This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed.

East Kent Hospitals University NHS
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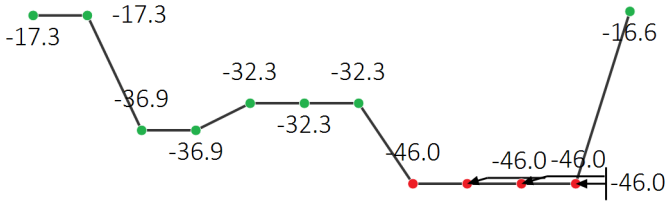
Strategic Theme: Finance

Apr

Normalised Forecast £m

-16.6
(-63.9%)



This shows the Normalised Income & Expenditure Forecast as at 31st March 2017.

Comments:

• The Trust ended 2015/16 with a reported £35.3m deficit, an increase of £27m over 2014/15. Compared to the prior year staffing costs increased by £16m (5.1%), clinical negligence insurance rose by £6m (60%), drugs costs by £2m (3.8%), and premises costs by £2m (11.8%). The Trust retained a positive cash balance of £3.8m at year end. The Trust is yet to agree a financial control total for 2016/17 and is in active discussion with NHS improvement. It is assumed that the Trust will receive £16m (non-recurrent) from the national Sustainability and Transformation Fund, although guidance is still awaited. The Major part of the Trust's activity is now on PbR contracts. At the end of April the Trust is reporting a deficit of £2.8m, consistent with a c£10m deficit for the year, and an improvement on the February and March deficits of £4.4m and £3.6m respectively. Agency costs are were disappointingly high, especially in Urgent Care, and further monitoring and controls are being put in place with the divisional teams. It is estimated that the impact of the two day junior doctor strike cost the Trust £0.3m in lost income. The Trust maintained a positive cash balance in month.

East Kent Hospitals University NHS
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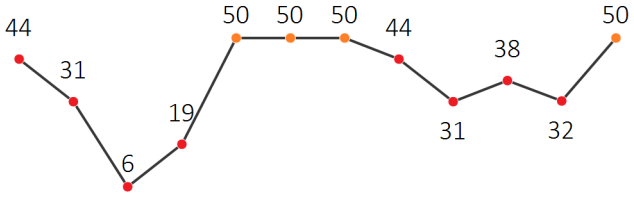
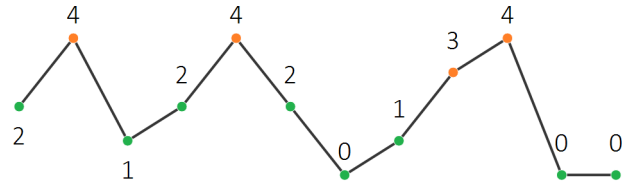
Strategic Theme: Health & Safety

Strategic Direction 1

Apr	Representation at H&S	444 (581.4%)		% of Clinical Divisions representation at the site Health & Safety Committee's
Apr	RIDDOR Reports (Number)	23 (666.7%)		RIDDOR reports sent to HSE each month
Apr	Formal Notices	0		Formal notices from HSE (Improvement Notices, Prohibition Notices)

Comments:

H&S Divisional representation has increased positively this month, reflecting the work being done to support Divisions, in identifying named leads
The Trust had no RIDDORs to report this month for the second month running
The Trust has had no formal notices from the HSE for the last 12 months.
Additional metrics as agreed by Board continue to be developed. Lost Time Accidents (LTA), a field is being entered onto Datix in May with communication being sent to staff in June. Between June and September we will monitor how this fields is being embedded. Risk Registers, this is being developed as part of the new risk governance systems being led by Helen Goodwin and due for roll out in Q2. Finally, numbers attending H&S training will be included in next month's report.

East Kent Hospitals University NHS
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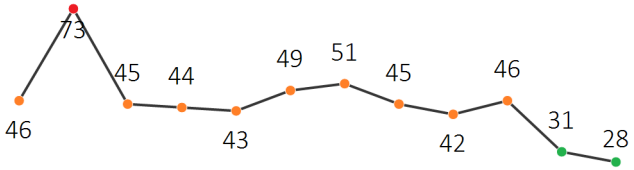
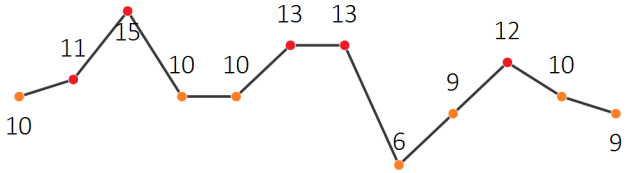
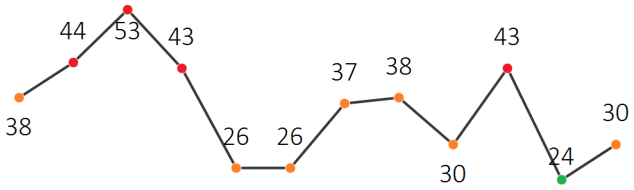
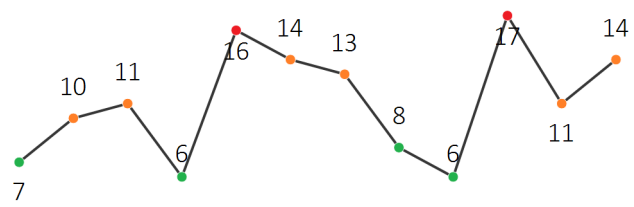
Strategic Theme: Health & Safety

Strategic Direction 2

Apr	Accidents	543 1162.8%		Accidents excluding sharps (needles etc) but including manual handling	★★☆
Apr	Fire Incidents	128 1728.6%		Fire alarm activations (including false alarms)	★★☆
Apr	Violence & Aggression	432 (819.1%)		Violence, aggression and verbal abuse	★★☆
Apr	Sharps	133 (682.4%)		Incidents with sharps (e.g. needle stick)	★★☆

Comments:

Accidents – remains the same as last month at 42 which is the lowest point for the last 12 month period
Violence & Aggression is slightly up this month at 30 but remains well below our highest point of 53 incidents, in August last year.
As agreed accidents involving Sharps has a separated entry in the IPR. The number of incidents for April remains consistent with the average over the last year.

East Kent Hospitals University NHS
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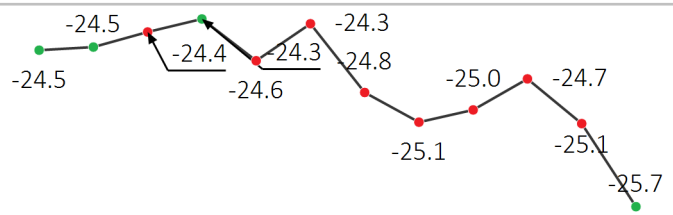
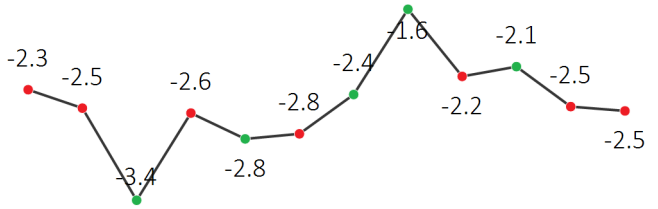
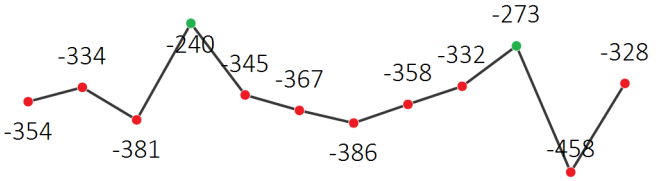
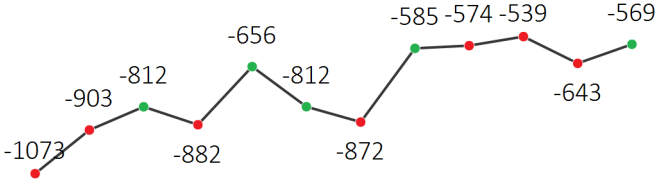
Strategic Theme: Use of Resources

Pay Independent

Apr	Payroll Pay £m	-25.7 (2.6%)		Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months - the current year to date is shown in the arrow.
Apr	Agency Spend £m	-2.5 (1.7%)		Agency and Medical/StaffFlow Locum spend by month YTD.
Apr	Additional sessions £k	-328 (-28.4%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months
Apr	Independent Sector £k	-569 (-11.6%)		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

Comments:

- Total pay spend (permanent, overtime, WLI, bank, locum and agency) in April was £28.6m against £27.7m in March. This increase was driven by higher employer NI, the A4C pay award, and payments relating to Easter bank holidays.
- Agency, Stafflow and locum spend was £2.2m in April against £1.9m in March. This was predominantly in UCLTC. The 'ceiling' set for 2016/17 is £20.1m although a request has been submitted to raise this to £23m
- Additional sessions in month were £0.3m, similar to the monthly average in 2015/16 when April was the lowest month. (£7.2m 2015/16).
- Use of the Independent Sector in April was £0.6m, marginally down on March and lower than the monthly average in 2015/16 of £0.75m (2015/16 £9.1m - £3m H&SCV beds, £2.5m Spencer Wing, £3.6m other IS)

East Kent Hospitals University NHS
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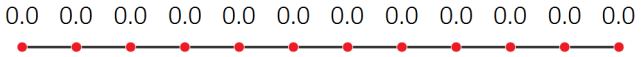
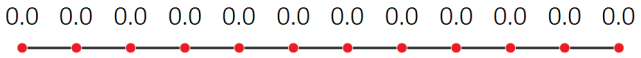
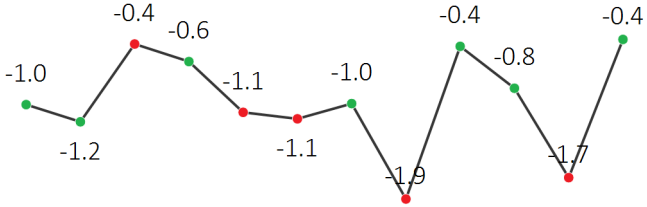
Strategic Theme: Use of Resources

Balance Sheet

Apr	CIPS £	0.0 (NaN)		Cost Improvement Programmes (CIPs) graph: ytd v plan plus forecast. Metric shows variance difference to plan %.
Apr	Cash borrowings £	0.0 (NaN)		Cash borrowings. The graph shows the total year to date cash borrowings - the latest cash borrowing total is shown in the arrow.
Apr	Capital position £m	-0.4 (-79.1%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The year to date plan = £14.27m (Annual Plan).

Comments:

- The CIP target for 2015/16 is £20m. In April the Trust is reporting delivery of £0.5m against a £0.6m target.
- Cash borrowings were £0 in April as planned. Discussions are continuing with NHSI in the profile over the rest of the year.
- Capital expenditure is on target against its annual plan. There have been no amendments to the programme

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Productivity

Apr	Clinical Productivity: Theatres	0.0	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Clinical Productivity graph: theatre sessions v plan.
Apr	Clinical Productivity: Outpatient	0.0	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Clinical Productivity graph: outpatient sessions v plan

Comments:

- The work with Four Eyes has now gone live with the key focus on securing reductions in additional sessions and use of IS.
- The theatres programme has contributed £32k in April.
- The outpatients programme is yet to contribute.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Improvement Journey

		Dec	Jan	Feb	Mar	Apr
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	87.79	84.91	80.01	79.26	84.03
MD03 - Maternity Capacity	Midwife:Birth Ratio (%)	27	28	29	31	29
MD06 - Pathway Flow	IP - Discharges Before Midday (%)	19	19	19	19	18
	DToCs (Average per Day)	55	65	62	71	78
MD07 - Medicines Management	Pharm: Fridges Locked (%)	88	88	83	90	92
	Pharm: Fridge Temps (%)	75	80	86	87	88
	Pharm: Drug Trolleys Locked (%)		100	99	100	98
	Pharm: Resus. Trolley Check (%)		92	94	91	85
	Pharm: Drug Cupboards Locked (%)		71	85	87	87
MD08 - Staffing Levels	Vacancy (%)	8.0	8.4	8.2	8.0	8.8
	Shifts Filled - Day (%)	93	93	90	88	97
	Shifts Filled - Night (%)	100	101	101	97	102
MD09 - Workforce Culture	Sickness (%)	3.7	3.7	3.8	3.8	4.4
	Appraisal Rate (%)	84.0	85.5	84.2	82.2	79.2
	Staff Turnover (%)	10.4	11.4	11.3	11.2	11.2
	Corporate Induction (%)	100	100	100	100	100
	Staff FFT - Work (%)	53	49	49	49	49
	Staff FFT - Treatment (%)	76	76	76	76	76
MD11 - Clinical Audit	Clinical Audit Prog. Audit	3	3	3	3	3
	Clinical Audit Review	3	3	3	3	3

MD12 - Environment	Cleanliness Audits (%)	98	99	98	98	98
MD13 - Equipment	EME Planned Maintenance (%)	78	78	81	83	
MD17 - Incident Reporting	Clinical Incidents: Total	615	645	586	661	578
MD18 - Policies & Procedures	Policies in Date (%)	66	73	77		
MD19 - Major Incident Planning	Major Incident Training (%)	33	31	29	27	28
MD22 - Agency Staffing	Unplanned Agency Expense	121	111	115	111	95
	Clinical Time Worked (%)	71	70	69	67	74
	Temp Staff (WTE)	202	230	218	216	
	Employed vs Temporary Staff	92	92	92	92	91
MD26 - Complaints Process	Complaint Response in Timescales %	88	88	68	82	54
MD30 - Medicines Management	Medicines Mgmt. Incidents	108	118	117	116	83

East Kent Hospitals University NHS
NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 4hr Compliance (%)	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge.	>= 95	100 %
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.	<= 90	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 28	30 %
	Extra Beds	Number of extra 'unfunded' beds available		0 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Outliers	Number of Bed Outliers in the Trust, where the intended use of the bed is used for another service		0 %
Cancer	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: 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: 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	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	Cleanliness Audits (%)	Cleaning Schedule Audits	>= 98	5 %
	Clinical Audit Prog. Audit	Agreed Clinical Audit programme meets national programme requirements	>= 3	5 %
	Clinical Audit Review	Review of the Clinical Audit Programme	>= 3	5 %

Clinical Outcomes	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. 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	5 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 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	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	PROMs EQ-5D Index: Groin Hernia	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Hip Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Knee Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	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.	< 2.75	20 %
	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.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Policies in Date (%)	All documents that are marked as policies are in date on the SharePoint system	>= 95	10 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission.	>= 67.2	50 %
Data Quality & Assurance	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings.	< 4	25 %

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).	< 0.25	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 %
	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.	< 7	0 %
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	0 %
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		0 %
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	0 %
	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 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month - the year to date is shown in the arrow. The year to date plan = £2.6m adjusted for "extra" CIPs.	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month - the year to date is shown in the arrow.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling	<= 40	15 %
	Fire Incidents	Fire alarm activations (including false alarms)	<= 5	10 %
	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices)	1	15 %
	Representation at H&S	% of Clinical Divisions representation at the site Health & Safety Committee's	>= 76	20 %

Health & Safety	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick)	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse	<= 25	15 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.		0 %
	Blood Transfusion Errors	The number of blood transfusion errors sourced from Datix.		0 %
	Clinical Incidents: Total	Number of Total Clinical Incidents reported, recorded on Datix.		0 %
	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.	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie free from old and new harm - Old and new pressure ulcers (categories 2 to 4); Injurious falls; Old and new Urinary Tract Infection (UTI); New Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) or Other VTE) Data source - Safety Thermometer.	>= 94	10 %
	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; New Urinary Tract Infection (UTI); New Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) or Other VTE) Data source - Safety Thermometer.	>= 98	10 %
	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix.		0 %
	Mixed Sex Breaches	Number of patients experiencing mixed sex accommodation due to non-clinical reasons.	1	20 %
	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS.	< 1	20 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls		0 %
	Pressure Ulcers Cat 2 (per 1,000)	Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix.	<= 0.15	10 %
	Pressure Ulcers Cat 3/4 (per 1,000)	Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix.	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS.		0 %
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	Blood Culture Training	Blood Culture Training compliance	>= 85	0 %
	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	< 1	0 %

Infection	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)	<= Traj	40 %
	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)	<= Traj	0 %
	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.	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	E Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	0 %
	E. Coli	The total number of E-Coli bacteraemia recorded	< 44	10 %
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	Hand Hygiene Competences	Hand Hygiene Training compliance for those with competences	>= 85	0 %
	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	0 %
	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	< 1	0 %
	MSSA	The total number of MSSA bacteraemia recorded	< 1	10 %
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	0 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	0 %
Initiatives	75+ Frailty Pathway CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	17 %
	COPD CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and improve referral rates to the Stop Smoking Service and to the Community Respiratory Team	>= 100	17 %
	Dementia Diagnosed CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to monitor the diagnosis for Dementia. Green = on target for case finding, assessment and referral to reach 90% for each indicator for 3 consecutive months, AND staff training on target for improvement, AND on target to provide support to carers	>= 100	17 %
	Diabetes CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	17 %
	Heart Failure CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and sustain EQ HF measures	>= 100	17 %

Mortality	Crude Mortality EL (per 1,000)	The number of deaths per 1,000 elective admissions.	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratios (HSMRs), via CHKS, compares the number of expected deaths with the number of actual deaths, in Hospital. The data is adjusted for factors statistically associated with hospital death rates and scores the number of secondary diagnoses according to severity (Charlson index).	< 90	35 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, ICD10 diagnoses, OPCS procedures and discharge method is constructed.	< 87.45	30 %
	SHMI	Summary Hospital Mortality Indicator (SHMI) as reported via CHKS includes in hospital and out of hospital deaths within 30 days of discharge.	< 0.95	15 %
Observations	Cannula: Daily Check (%)	The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-9pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 9pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults 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	Care Explained? %	Was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? This measures the percentage of inpatients who answered 'yes always' or 'yes sometimes' in response to the inpatient survey.	>= 98	4 %
	Care that matters to you? %	Did you get the care that matters to you?	>= 98	4 %
	Cleanliness? %	In your opinion, how clean was the hospital room or ward that you were in? This measures the percentage of inpatients who answered 'very clean' or 'fairly clean' in response to the inpatient survey.	>= 95	5 %
	Complaint Response in Timescales %	Audit due to commence in January - Percentage of controlled drugs signed off by two nurses	>= 85	5 %
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %

Patient Experience	FFT: Not Recommend (%)	Of those patients who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust	>= 1	11 %
	FFT: Recommend (%)	Of those patients who responded to the Friends & Family Test and knew their opinion, would recommend the Trust	>= 90	30 %
	FFT: Response Rate (%)	The percentage of patients who responded to the Friends & Family Test	>= 15	10 %
	Hospital Food? %	How would you rate the hospital food? This measures the percentage of inpatients who answered 'very good' or 'good' in response to the inpatient survey.	>= 85	5 %
	Number of Complaints	The number of complaints recorded per ward. Data source - Datix.		0 %
	Number of Compliments	The number of compliments recorded per ward. Data source - Patient Experience Team (Kayleigh McIntyre).		0 %
	Overall Patient Experience %	This provides an overall inpatient experience percentage by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1)	>= 90	10 %
	Respect & Dignity? %	Overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? This measures the percentage of inpatients who answered 'yes always' or 'yes sometimes' in response to the inpatient survey.	>= 98	2 %
	Returning Complaints	Number of complaints returned		4 %
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 Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 90	20 %
	Health Records Availability: Pt Care(%)	Healthcare records availability for patient care(%) (Incl short notice clinics) Complete, Source: Walk the floor Audits	>=98	5 %
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		0 %
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		0 %
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total non-clinical cancellations.	< 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.	< 5	10 %
	Pharmacy TTAs Dispensed (%)	The percentage of Discharge Prescriptions (known as TTAs, TTOs or EDNS) dispensed by Pharmacy before the time required on the ward	>= 80	0 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %

Productivity	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	20 %
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	< 1	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 %	% of Employee's that are recruited through an agency	<= 10	0 %
	Agency & Locum Spend	Total agency spend including NHSP spend		0 %
	Agency Orders Placed	Total count of agency orders placed	<= 100	0 %
	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	>= 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.	< 28	2 %
	NHSP Use % of Agency	% of Employee's recruited through an agency that are NHSP	> 90	0 %
	Overtime %	% of Employee's that claim overtime	<= 10	0 %
	Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
	Roster Effectiveness (%)	The time ward staff attribute to clinical duties as a % of the ward duty roster. Data source - eRoster.		15 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA)	>= 97	15 %
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 97	15 %
	Sickness (%)	% 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. Calculated cumulatively/YTD. % of FTEs lost through absence (as a % of total FTEs).	< 3.3	10 %
	Stability Index (excl JDs) %	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		0 %
	Stability Index (incl JDs) %	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		0 %
	Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training	< 7.4	15 %

Staffing	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Temp Staff (WTE)	Count of Temporary Staff in post	< 182	1 %
	Time to Recruit	Average time taken to recruit to a new role	<= 11	0 %
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Total Staff In Post (SiP)	Count of total staff in post		1 %
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %
	Vacancy (%)	% Vacant positions against Whole Time Equivalent (WTE)	< 10	15 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff.	>= 90	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	0 %
	EME Planned Maintenance (%)	Planned maintenance of EME managed medical equipment	>= 95	0 %
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	0 %
	Mandatory Training (%)	The percentage of staff that have completed mandatory training courses, this data is split out by training course.	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months	0	0 %
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD.	0	0 %
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The year to date plan = £14.27m (Annual Plan).	0	0 %
	Cash borrowings £	Cash borrowings. The graph shows the total year to date cash borrowings - the latest cash borrowing total is shown in the arrow.	0	0 %
	CIPS £	Essex P23 CIPS graph: ytd v plan plus forecast. Metric shows variance difference to plan %.	0	0 %
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		0 %
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		0 %
	Independent Sector £k	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	0	0 %
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months - the current year to date is shown in the arrow.	0	0 %

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

East Kent Hospitals University NHS
NHS Foundation Trust

Patient Safety Heatmap

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff
ACC - KCH A&E DEPARTMENT		4	2		2								
BIR - BIRCHINGTON WARD	95		2			148	100	100	100	42	95	1.7	88
BIS - BISHOPSTONE WARD	89	1	6		2	0	100	67	88	45	100	0.0	94
CATD - CATHEDRAL DAY UNIT					1								
CCU - CCU	100	1	1	4		0				96	97	0.0	94
CDU - CLINICAL DECISION UNIT				3									
CJ2 - CAMBRIDGE J2	100		11		1	0	100	100	98	15	89	0.0	88
CK - CAMBRIDGE K	96		1	1		0	91	85	96	63	95	1.2	101
CL - CAMBRIDGE L REHABILITATION	86	4	11			0	83	94	90	37	100	0.0	101
CLKE - CLARKE WARD	97	1	7		1	96				28	99	0.0	97
CM1 - CAMBRIDGE M1 SHORT STAY		2	4		4					27	100	0.0	
CM2 - CAMBRIDGE M2	95	2	6	1	1	102	98	96	100	50	100	0.0	98
CSF - CHEERFUL SPARROWS FEMALE	96	2	2		2	1	94	92	97	53	95	3.6	74
CSM - CHEERFUL SPARROWS MALE	100	1	1		1	0	89	90	93	44	94	0.0	80
DEAL - DEAL WARD	96	2	5	2	1	27	100	94	98	36	90	5.0	84
DSC - DAY SURGERY CENTRE					1								
DSSC - DAY SURGERY			2		1								
EKCC - EK CARDIAC CATHETER SUITE				1									
FF - FOLKESTONE	100					2							
FRD - FORDWICH WARD STROKE UNIT	96		5		1	1	100	100	100	45	100	0.0	92
HARB - HARBLEDOWN WARD	96	2	6		1	0	100	98	96	61	97	2.9	84
HARV - HARVEY WARD	100					0				75	100	0.0	
INV - INVICTA WARD	100		4			0	96	70	85	36	97	0.0	97
ITU - WHH ITU	100	5	1		1	0							90
KA2 - KINGS A2	100		1			0	90	90	97	76	98	0.0	104
KB - KINGS B	96	2	4			0	92	85	92	42	100	0.0	92
KBRA - BRABOURNE (KCH)	100	1				43				71	100	0.0	
KC - KINGS C1	100	1	4		1	0	98	89	91	39	90	4.8	94
KC2 - KINGS C2	100		2			0	95	95	97	69	99	0.0	93
KCDU - EMERGENCY CARE CENTRE	100				1	0	100	100	100	17	87	8.4	122

Apdx.

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff
KDF - KINGS D FEMALE	100	1	1			134	100	95	100	55	97	0.0	95
KDM - KINGS D MALE	100	2	2		1	0	88	93	95	55	98	0.0	
KEN - KENNINGTON WARD	100					1				15	100	0.0	91
KEND - ENDOSCOPY (KCH)					1								
KENT - KENT WARD	92	8	2			72	100	98	99	48	100	0.0	102
KHOM - KCH HOME WARD						0							0
KIN - KINGSGATE WARD	100				2	79							97
KING - KINGSTON WARD	95	1	8	1		1				36	92	0.0	102
KITU - KCH ITU	100	2	2		1	0							90
KNRU - EAST KENT NEURO REHAB UNIT		1	3										95
KXRY - X-RAY (KCH)			1										
MARL - MARLOWE WARD	100	1			2	147				31	100	0.0	93
MTMC - MOUNT/MCMASTER WARD	100	1	1			1	94	85	96	22	97	0.0	92
MW - MINSTER WARD	100	2	5			87				67	100	0.0	84
OPTH - OPHTHALMOLOGY SUITE			1		2								
OXF - OXFORD	85	1	5			0				26	100	0.0	
PAD - PADUA	100					0				21	97	1.4	
QAE - QEH A&E DEPARTMENT		16	4		8								
QCCU - QEH CCU	100	1	1			0	100	100	100	56	100	0.0	94
QCDU - QEH CDU	100	5	5		2	61	100	100	88				86
QHOM - QEH HOME WARD	100					0							0
QITU - QEH ITU	100				2	0							99
QSCB - QEH SPECIAL CARE BABY UNIT	100					0							98
QX - QUEX WARD	95		1			86	93	84	96	62	99	0.0	96
RAI - RAINBOW WARD	100				1	0				17	95	4.7	96
RST1 - RICHARD STEVENS 1 STROKE UNIT	100		2		3	0	100	100	100	40	96	0.0	90
RW - ROTARY WARD	100		2			2	93	95	98	43	100	0.0	93
SAN - SANDWICH BAY WARD	96	1	3		1	0	88	97	98	55	100	0.0	91
SAU - ST AUGUSTINES, THE REHAB. WARD	96		8		2	0	71	90	95	81	100	0.0	67
SB - SEA BATHING WARD	96					0	83	93	92	38	100	0.0	95
SBU - SEABATHING UNIT		6	3		1								
SCBU - THOMAS HOBBES NEONATAL UNIT	100					0							

Apdx.

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff
SEAU - SURGICAL EMERGENCY ASSESS WHH		1								98	98	0.0	
STM - ST MARGARETS WARD	100		3		1	12				19	100	0.0	98
TAY - TAYLOR WARD	100					65	98	91	98	76	100	0.0	82
TREB - TREBLE WARD	100		7		1	0	93	89	97	55	97	0.0	98
WAE - WHH A&E DEPARTMENT		22	2		11								
WCDM - WHH CDU MIXED		18	7		5		88	88	94				
WCDU - ***** DO NOT USE *****	100					3							
WDL - DISCHARGE LOUNGE WHH					1								
WHOM - WHH HOME WARD	100					0							239

East Kent Hospitals University NHS
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Human Resources Heatmap

	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term	Kent Pathology Partnership
Agency %	3.1	1.5	4.5	3.4	10.4	0.1	19.5	35.7	
Appraisal Rate (%)	88.6	88.5	68.7	46.6	80.2	80.1	77.1	73.8	
Employed vs Temporary Staff	90	89	92	96	94	92	93	91	
Mandatory Training (%)	92	95	89	78	84	91	86	88	
NHSP Use % of Agency	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
Sickness (%)	4.1	4.2	2.8	4.4	5.2	3.4	4.5	4.2	
Stability Index (excl JDs) %	86	85	89	87	90	91	90	89	33
Stability Index (incl JDs) %	86	83	89	87	86	91	84	85	33
Staff Turnover (%)	13.4	12.6	16.7	13.3	9.3	10.1	10.0	10.7	9.8
Vacancy (%)	10.4	10.6	11.4	5.8	7.7	8.4	7.4	9.5	

Apdx.