East Kent Hospitals University NHS
NHS Foundation Trust

JUNE 2016

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
NHS Foundation Trust

Chief Executive's Summary

Summary:
We are now at the end of the first quarter and so we can begin to see the position for the year. The following are the key headlines from the report.

- The Trust has continued to experience exceptionally high levels of urgent care demand during June with pressures at both WHH and QEQM.
- Despite significant work and some progress, the planned trajectories for A&E, cancer and RTT were not delivered in Q1
- The new Urgent Care Centre model at K&C went live during June and is operating well with up to 40 patients per day
- the Trust saw an improvement to its financial run rate in June but considerably more progress must be made over the balance of the year if this is to prove sustainable
- during June we continued to work on our clinical strategy presenting clear proposals to a consultant forum and three staff forums on each site in early July
- work on the Kent & Medway STP has continued at pace with national conversations taking place in July
- the cultural change focus continues with an emphasis on embedding the key patient, people, partnerships and provision objectives and the most recent Friends and Family data suggests improvement across the Trust which is positive but we will continue to focus on this as a fundamental foundation of our improvement work.

Quality and Safety:
I and the executive team have undertaken a number of site walkabouts during June and would commend all staff on the care and commitment that they give to all of our patients in what are often challenging circumstances. In June we responded to 94% of complaints within the required time and our Friends and Family Test results show a marked improvement in patient satisfaction. Harm free care in June was measured at its highest ever level. We do however continue to face challenges with mixed sex accommodation breaches, and ensuring that all our staff communicate effectively with patients and caters. Ensuring that VTE assessments are completed and that infection control policies and practice are adhered to at all times continues to receive high level attention.

The highest priority focus continues to be given to the Trust's quality and safety improvement journey. The work of the innovation hubs on each sites continues to be highlighted receiving particular attention from the Secretary of State for Health when he visited WHH. We are also preparing for our CQC re-inspection in September which will give us an opportunity to showcase the progress made since last year but also reaffirm our commitment and plans to make further sustained improvements.

Performance and activity:
Demand for services continues to run at unprecedented levels, testing the Trust's capacity to deliver the required levels of activity and its target trajectories.

A&E: the Trust achieved 85.38% in June and continues to move forward all aspects of the improvement plan alongside system partners. In quarter one the Trust has missed the A&E trajectory in all months. This is in the main due to unprecedented and consistent high levels of A&E attendances and admissions and increased acuity across all sites. Demand to the end of June 2016 was 4.1% above the same period last year. In addition to this non-elective admissions are 6.8% above the same period last year having a significant impact on patient flow and therefore impeding A&E's ability to function optimally. High numbers of delayed transfers of care, average of 62.28 per day compared to 47.07 previous year, are also having an adverse impact on flow. The Trust has a detailed action plan in place to recover this position and is working closely with ECIST and East Kent Health Economy partners in order to implement the agreed actions. We envisage a significant improvement in performance over quarter two as these actions are implemented however this is heavily dependent on our ability to successfully recruit to a number of posts and the levels of attendances/admissions slowing or reducing. In order to maintain compliance with our trajectory moving forward there needs to be sufficient system wide capacity made available through the winter months and into quarter four.

RTT: performance fell to 87.57% in June from 89.27% in May. The high number of referrals, notably in Orthopaedics and Gynaecology, is causing concern and is being discussed with commissioners. Theatre productivity improvements are mitigating some of the impact together with use if the independent sector in Orthopaedics, Ophthalmology and Dermatology, but delivery of the trajectory remains a serious challenge and a risk. Endoscopy capacity continues to be a concern but plans in place to increase capacity through the appointment of two additional consultants in September 2016, this will stabilise the service and enable them to meet demand moving forward.

Following a dedicated operational planning week, a recovery plan has been put in place to address some of the capacity issues and improve the position moving forward. Whilst we do not think

this will recover the aggregate position to 92% by September 2016 as per our original trajectory we are aiming for 90% by September and achievement of the 92% standard, at aggregate level, by March 2017.
Key areas of risk for this standard are the continuation of high levels of primary care referrals into Orthopaedics, Gynaecology and Maxillo Facial.

Cancer: The Trust achieved its STF trajectory for the month of May 2016 but failed to achieve in April and June. There has been a focus on reducing the number of long waiting patients (>100 days) during quarter one which is continuing into July and August. Due to this clearance performance has deteriorated below the original estimation however we firmly believe that this is the correct clinical course of action for our patients. There remain bottlenecks with specific diagnostic tests such as histopathology, radiology, endoscopy & hysteroscopy, there are actions taking place to address these however these are dependent on recruitment of key staff members and prioritisation of patients on cancer pathways. It should be noted that this prioritisation could have an adverse effect on routine patients and therefore affect those patients on an RTT pathway. Whilst we are unlikely to achieve the trajectory during July and August we continue to work towards achievement of the trajectory and therefore compliance with the 85% standard in September 2016.

Diagnostics: this trajectory was achieved in June despite high levels of demand and we expect that to continue for the remainder of the year.

Workforce:
Progress continues to be made with improving recruitment and retention across the Trust. The importance of overseas staff to the Trust and the wider NHS cannot be overstated and a clear message has been given to all staff on this vital roll.

The Trust's cultural and leadership programmes continue with a comprehensive senior leadership programme under development with outside support and this will help to augment the crucial cultural change programme.

A key workforce measure is to reduce agency and locum spend which are impacted by above plan levels of activity and the high number of vacant medical staff posts, particularly in medicine. For the year to Q1 agency costs are £6.2m at an average of £2.1m per month. Medical staff costs make up 58% of the spend with Nursing accounting for 30%. 58% of the total spend is in the Urgent Care and Long Term Conditions Division. During 2015/16 the monthly spend per quarter averaged £2.5m, £2.9m, £2.2m and £2.2m respectively. The Trust ceiling for 2016/17 is set at £23m, requiring further reductions in year.

Finance and Resources:
The Trust’s monthly I&E deficit has reduced in June for the fourth consecutive month to £0.6m driven by higher income (£46.8m v average per month Apr/May £45.6m), and lower non pay costs (£17m v average per month Apr/May £17.4m).

The Trust is awaiting confirmation of its control total for 2015/16 from NHSI but is, in the meantime, working to the Trust Board approved control figures which includes £16.1m of STF funds in the forecast together with an assumption of £20m of CIPS and limited fines and penalties. This continues as a high risk. The forecast year end position is a £10m to £12m deficit with a normalised forecast position of £27.6m highlighting the removal of the STF funding and a non recurrent £0.5m of other income together with the forecast I&E deficit.

The Trust is continuing to discuss its cash requirements with NHSI and to the end of Q1 had accessed £7.7m of its interim credit facility.

The year end forecast will be impacted by:

- continuing operational and workforce pressures
- access to the STF through the delivery of key trajectories
- further discussion with NHSI
- Crystalisation of income, CQUIN, activity and CIPS delivery risks and opportunities
- Temporary staff costs, driven by operational pressures and critical staff shortages,

Of the CIPS target of £20m, forecast delivery as at 30 Jun-16 is £16.7m or £13.3m risk adjusted. This has been escalated to Turnaround Board and urgent mitigation is being worked on with the Divisions to identify additional schemes in Workforce and Agency as well as Income opportunities due to the above-plan activity and over-performance that impacts on the Trust ability to reduce associated workforce and agency costs.

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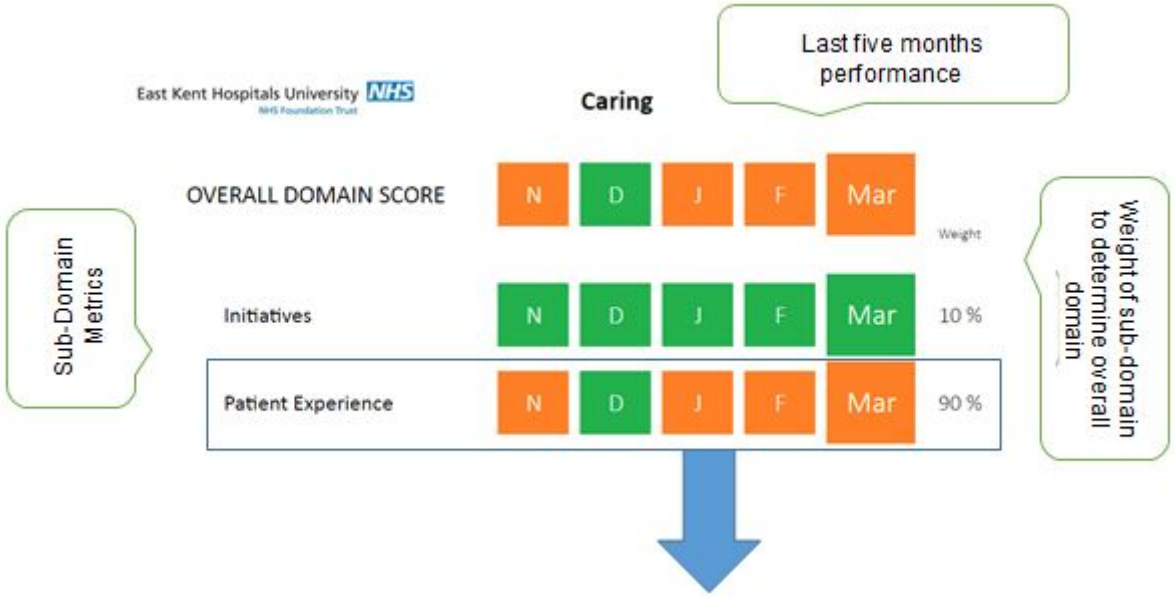
Understanding the IPR

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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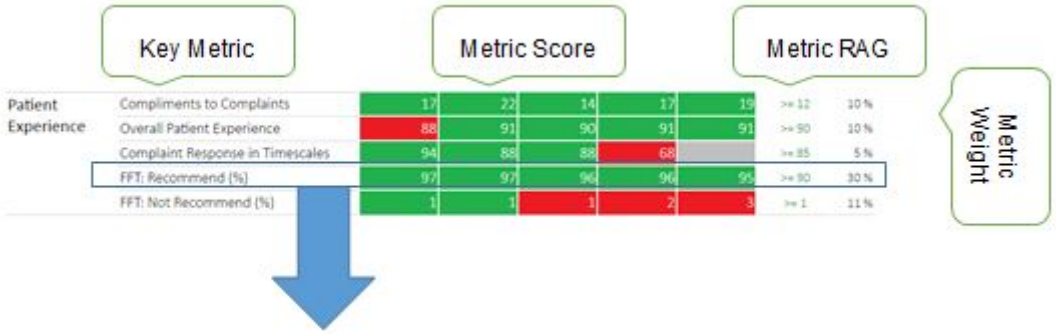
Understanding the IPR

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). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.

All RAGs are banded as Green, Amber and Red. 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	We responded to 94% of our complainants within timescale this month, which is the highest it has been this year; We have seen an increase in patient satisfaction as per the friends and family test and a decrease in the number no recommending the Trust; We are reporting a higher level of harm free care compared to previous months, with new harm free care also having risen; We have reported a reduction in avoidable category 2 pressure ulcers this month and no avoidable deep ulcers; We continue to see a rise in incident reporting which is indicative of an open culture and willingness to report.	We reported mixed sex breaches this month, although less than in previous months. This still requires focussed work; Our rate of falls has risen this month compared to last month, the team are commencing the 'Fallstop' campaign in September; Improvements are still needed on ensuring patients understand their care and that we make sure we understand more clearly what matters to them as individuals.	F M A M Jun  Sally Smith
Effective	Further improvement in bed occupancy from 101% to 98% Theatre session utilisation improved from 83% to 85% Slight improvement in NEL readmissions Equipment compliance maintained	DTOCs have not reduced from the average levels seen in May (62) which is well above levels at the same time last year. On time theatre starts stuck below 80%	F M A M Jun  Jane Ely
Responsive	Cancer 2 week wait (All) has improved from 88.48% to 94.50% Diagnostic waiting time standards met	ED 4 hour wait improved in month to 85.38% but remains below trajectory. Cancer 31 day wait deteriorated. Cancer 62 day GP referral wait reduced to 75.49% 18 week RTT pathway standard has deteriorated for the third month running to 87.57% as against 89.27% in March Number of 52 week waits increased to 14	F M A M Jun  Jane Ely
Safe	Harm free care and in particular new harms is better than any time this calendar year to date (98.5% harm free) and category 2 pressure ulcer rate has also improved. Infection control remained positive and mortality indices remain good.	Falls rate has risen this month (5.83/1000 bed days) and although VTE assessment recording has marginally improved this remains a key area for improvement.	F M A M Jun  Paul Stevens
Well Led	- mandatory training improved to 87% - small reduction in agency usage - no new health and safety issues - monthly financial performance improved to £0.6m deficit	- staff turnover rate increased from 11.3% to 11.8% - vacancy rates increased from 9.2% to 9.7% - sickness levels increased from 3.8% to 4.0% - level of uncoded spells increased	F M A M Jun  Matthew Kershaw

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Caring

	F	M	A	M	Jun	Weight
OVERALL DOMAIN SCORE						
Patient Experience	F	M	A	M	Jun	90 %

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Caring

		Feb	Mar	Apr	May	Jun	Green	Weight
Patient Experience	Compliments to Complaints (#/1)	17	16	16	13	12	>= 12	10 %
	Mixed Sex Breaches	7	89	26	0	11	1	10 %
	Overall Patient Experience %	91	91	91	91	91	>= 90	10 %
	Complaint Response in Timescales %	68	82	54	84	94	>= 85	5 %
	FFT: Recommend (%)	96	95	96	97	98	>= 90	30 %
	FFT: Not Recommend (%)	1.8	2.5	1.6	1.5	1.0	>= 1	10 %

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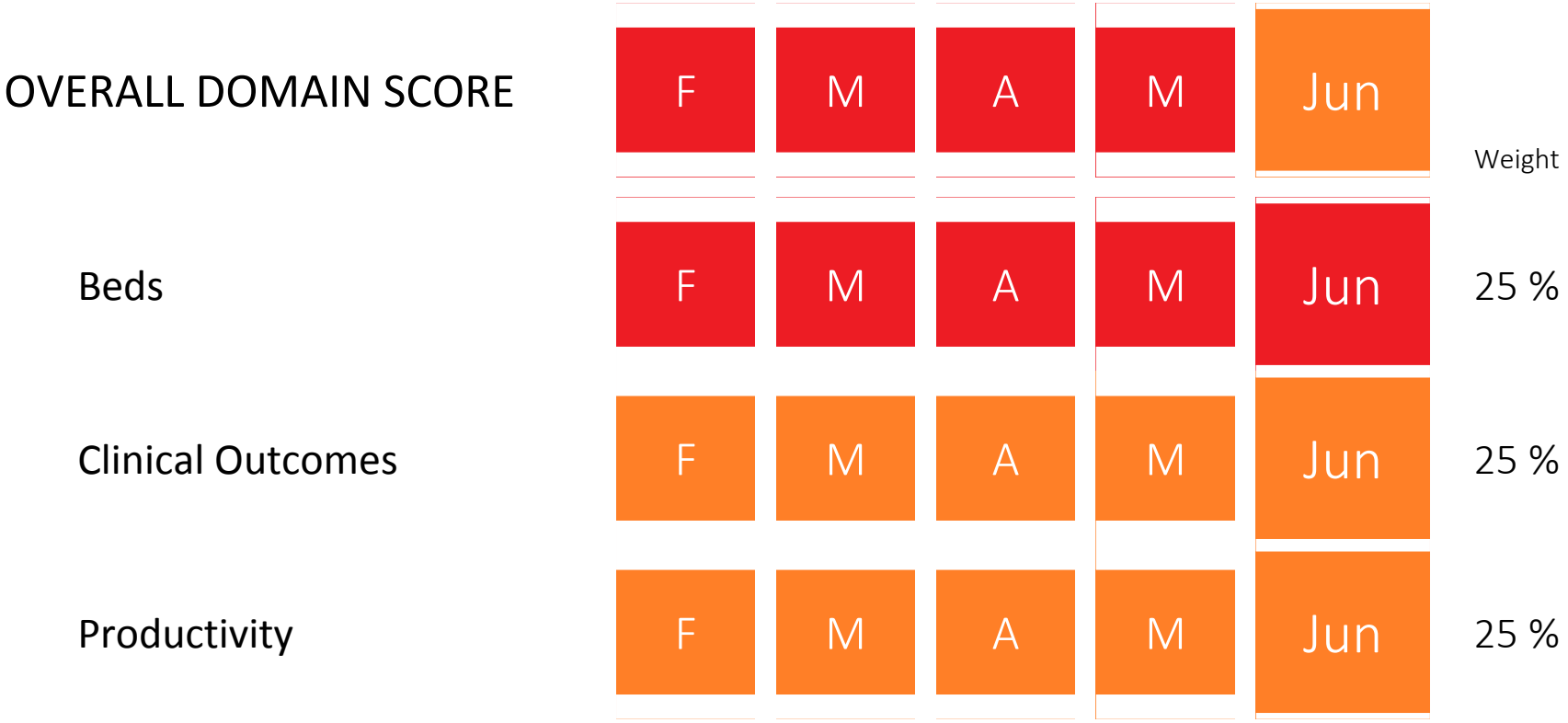
Effective



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Effective

		Feb	Mar	Apr	May	Jun	Green	Weight
Beds	Bed Occupancy (%)	112	107	103	101	98	<= 90	60 %
	IP - Discharges Before Midday (%)	17	16	16	16	16	>= 35	10 %
	DToCs (Average per Day)	62	71	78	62	62	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3	3	3	3	3	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	17	17	17	17	16	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	100	99	100	99	99	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	6.7	7.9	7.7	8.0	8.1	< 7	0 %
	DNA Rate: Fup %	6.6	7.9	8.1	9.0	8.1	< 7	0 %
	New:FUp Ratio (1:#)	0.8	0.8	0.7	0.7	0.7		0 %
Productivity	LoS: Elective (Days)	3.1	3.5	3.3	3.2	2.7		0 %
	LoS: Non-Elective (Days)	6.1	6.1	6.0	5.7	6.3		0 %
	Theatres: Session Utilisation (%)	81	82	82	83	85	>= 85	25 %
	Theatres: On Time Start (% 30min)	75	78	81	78	79	>= 90	10 %
	Non-Clinical Cancellations (%)	0.3	0.3	0.1	0.0	0.0	< 0.8	20 %
	EME PPE Compliance %	81	83	85	85	85	>= 90	20 %

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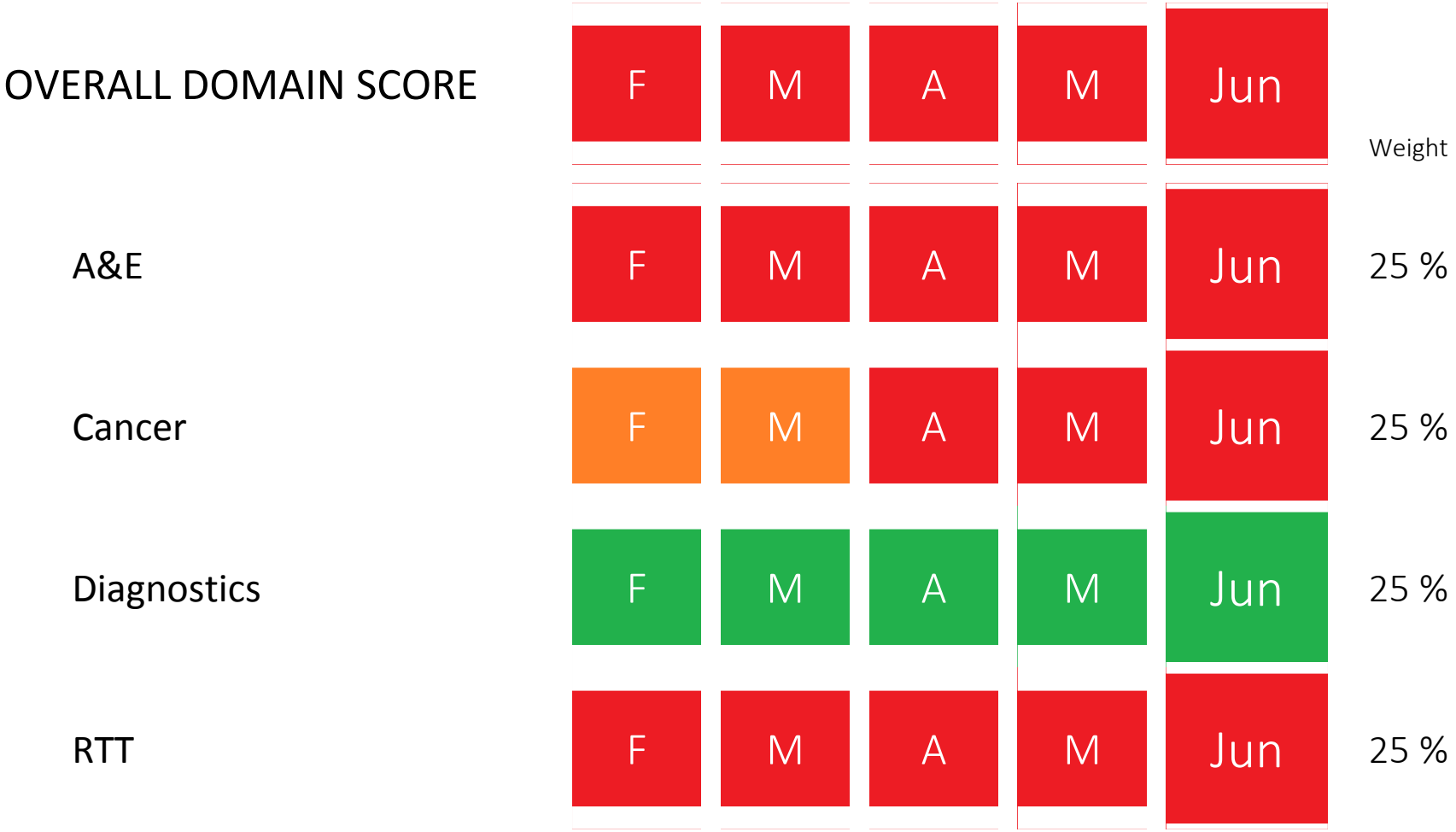
Responsive



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Responsive

		Feb	Mar	Apr	May	Jun	Green	Weight
A&E	ED - 4hr Compliance (%)	80.01	79.26	84.03	82.68	85.38	>= 95	100 %
Cancer	Cancer: 2ww (All) %	94.10	93.58	89.25	88.48	94.50	>= 93	10 %
	Cancer: 2ww (Breast) %	88.03	92.98	85.00	83.73	93.38	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	97.07	98.10	96.11	96.31	94.64	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	97.50	96.72	91.49	88.24	86.67	>= 94	5 %
	Cancer: 31d (Drug) %	100.00	100.00	98.25	98.95	100.00	>= 98	5 %
	Cancer: 62d (GP Ref) %	79.86	73.57	71.04	79.20	75.89	>= 85	50 %
	Cancer: 62d (Screening Ref) %	95.65	92.31	92.86	93.10	100.00	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	86.67	70.37	100.00	57.14	100.00	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.65	99.65	99.78	99.87	99.86	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	100.00	99.65	100.00	100.00	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	0 %
RTT	RTT: Incompletes (%)	89.17	89.27	88.56	87.89	86.81	>= 92	100 %
	RTT: 52 Week Waits (Number)	5	5	6	9	17	< 1	0 %

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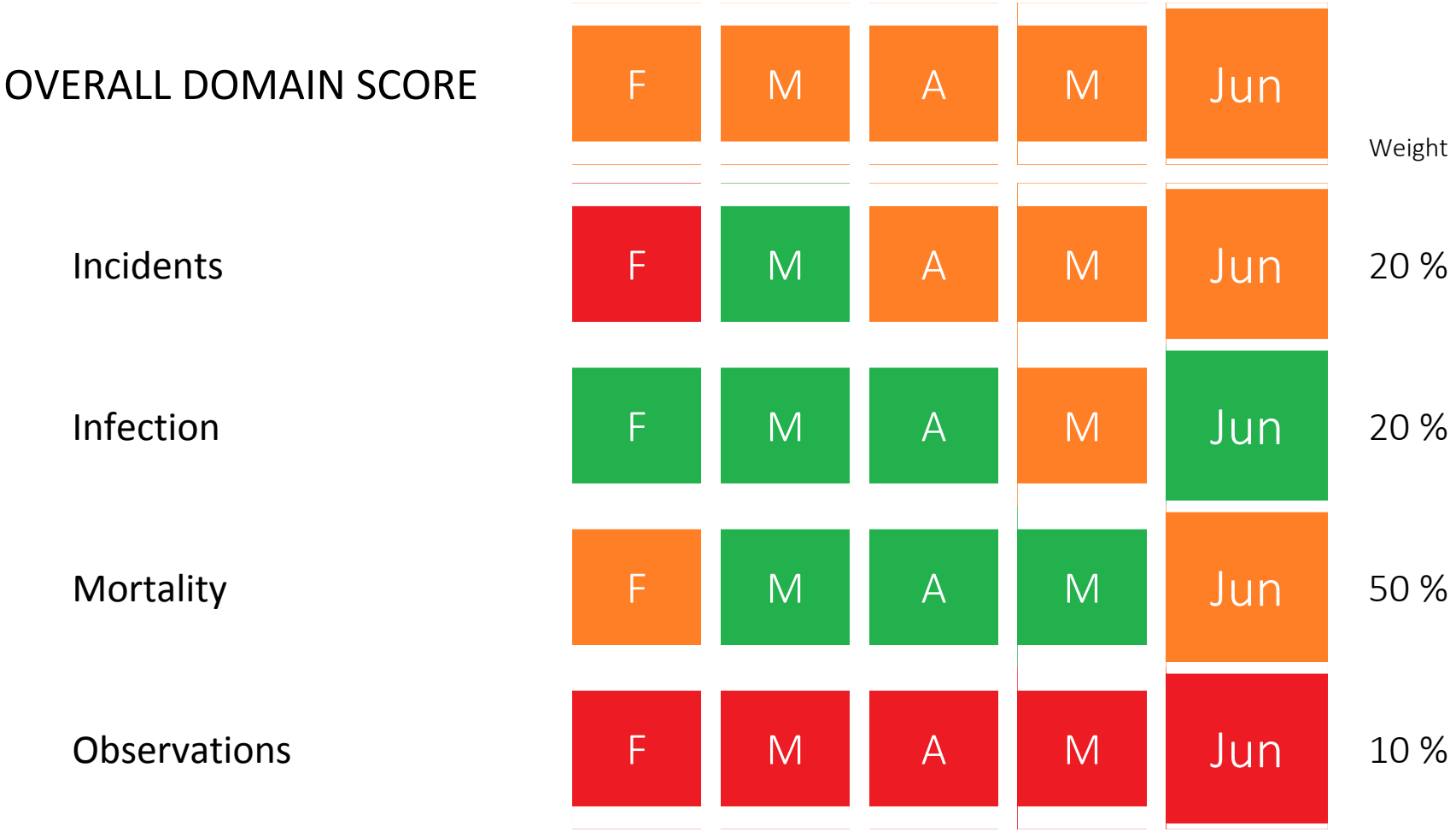
Safe



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Safe

		Feb	Mar	Apr	May	Jun	Green	Weight
Incidents	Serious Incidents (STEIS)	7	4	4	7	12		0 %
	Harm Free Care: New Harms (%)	97.9	98.2	97.8	97.7	98.5	>= 98	20 %
	Falls (per 1,000 bed days)	5.86	4.81	5.35	4.94	5.83	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.37	0.29	0.32	0.37	0.26	<= 0.15	10 %
	Clinical Incidents: Total (#)	1268	1347	1225	1306	1341		0 %
Infection	Cases of MRSA (per month)	0	0	0	1	0	< 1	40 %
	Cases of C. Diff (Cumulative)	28	28	4	8	11	<= Traj	40 %
Mortality	HSMR (Index)	85	84				< 90	35 %
	Crude Mortality EL (per 1,000)	0.2	0.5	0.8	0.7	0.5	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	36	33	29	26	26	< 27.1	10 %
	RAMI (Index)	88	86	84	84		< 87.45	30 %
Observations	VTE: Risk Assessment %	83	83	80	84	85	>= 95	20 %
	Obs. On Time - 9pm-8am (%)	35	36				>= 90	25 %
	Obs. On Time - 8am-9pm (%)	40	41				>= 90	25 %

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Well Led

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Well Led

		Feb	Mar	Apr	May	Jun	Green	Weight
Culture	Staff FFT - Work (%)	49	49	58	58	58	>= 67.2	50 %
	Staff FFT - Treatment (%)	76	76	78	78	78	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	1	2	2	2	2	< 4	25 %
	Valid NHS Number %	100	100	99	99	99	>= 99.5	40 %
	Uncoded Spells %	0	0	0	0	1	< 0.25	25 %
Finance	I&E £m	-4.4	-3.6	-2.8	-1.9	-0.6	>= Plan	30 %
	Cash Balance £m	8.2	3.9	7.9	8.5	8.5	>= Plan	20 %
	Total Cost £m	-47.1	-50.1	-47.9	-48.0	-47.4	>= Plan	20 %
	Forecast I&E £m	-36.4	-35.4	0.0	-11.0	-11.0	>= Plan	20 %
	Normalised Forecast £m	-46.0	-46.0	-16.6	-27.6	-27.6	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	4	0	0	0	0	<= 3	20 %
	Formal Notices	0	0	0	1	0	1	15 %
Staffing	Sickness (%)	3.8	3.8	3.9	3.8	4.0	< 3.3	10 %
	Staff Turnover (%)	11.3	11.2	11.2	11.3	11.8	< 7.4	15 %
	Vacancy (%)	8.2	8.0	8.8	9.2	9.7	< 10	15 %
	Shifts Filled - Day (%)	90	88	97	101	98	>= 97	15 %
	Shifts Filled - Night (%)	101	97	102	105	103	>= 97	15 %
	Agency %	16.9	18.8	16.3	18.3	18.1	<= 10	0 %
	NHSP Use % of Agency	68.6	57.1	100.0	100.0	100.0	> 90	0 %
Training	Appraisal Rate (%)	84.2	82.2	79.2	70.0	73.1	>= 90	50 %
	Mandatory Training (%)	86	87	88	79	87	>= 85	50 %

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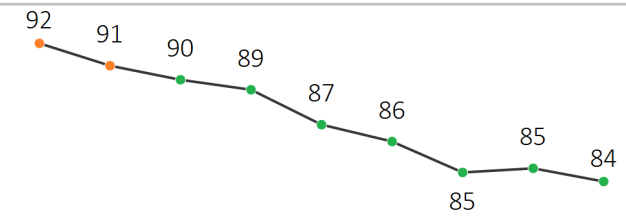
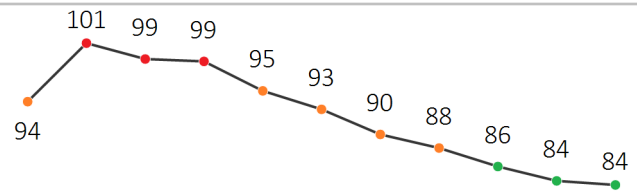
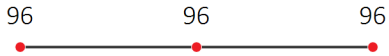
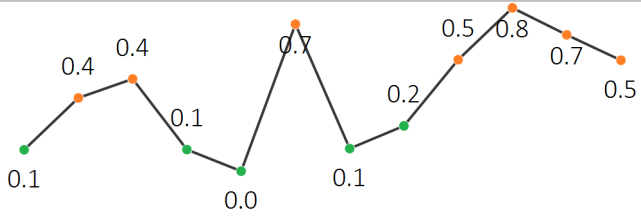
Strategic Theme: Patient Safety

Mortality

Jun	HSMR (Index)	88 (-5.6%)		Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data together with variance against previous
Jun	RAMI (Index)	92 (1.0%)		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, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	SHMI	96 (-6.6%)		Summary Hospital Mortality Indicator (SHMI) as reported via CHKS includes in hospital and out of hospital deaths within 30 days of discharge. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Crude Mortality EL (per 1,000)	0.4 (-7.4%)		The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

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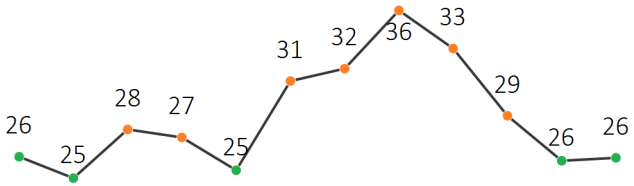
Strategic Theme: Patient Safety

Jun

Crude Mortality NEL (per 1,000)

29
(-6.4%)



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

Comments: All of the mortality indices we monitor either remain good or have improved further. The national SHMI is 100, 34.5% of all deaths in the last period reported (January 2015 - December 2015) occurred after discharge from hospital. Delving into the data behind that SHMI score fracture neck of femur is again positive with observed deaths of 65 versus expected 85.9, other positive areas include pneumonia (668 observed versus 713.7 expected) and urinary tract infection (122 observed versus 149.8 expected). On the negative side deaths from sepsis remain above expected (360 observed versus 312.8 expected) and cardiovascular deaths and deaths from acute myocardial infarction are marginally higher than expected together with deaths from carcinoma of the lung and colon.
The mortality steering group has been established and members of the group are piloting mortality review tools to evaluate which to recommend for standardised reviews across the Trust

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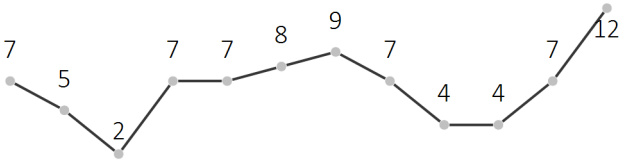
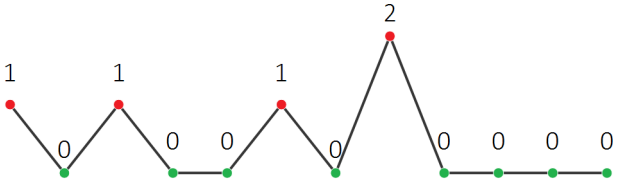
Strategic Theme: Patient Safety

Serious Incidents

Jun	Serious Incidents (STEIS)	79 (-8.1%)		Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Jun	Never Events (STEIS)	5 (66.7%)		Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments: Total open SIs on STEIS June 2016: 72 (including 12 new). 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 numbers of breached cases have dropped from 12 to 11 and work continues to ensure that the oldest breached cases will be submitted first, along with work to prevent the newer cases from breaching. No cases have now been opened for longer than a year and there are currently four cases open between six to ten months.

There were 12 new SIs:
five cases regarding maternity incidents affecting baby only
four treatment delays (endocarditis, colonoscopy, endoleak and ophthalmology)
suboptimal care of the deteriorating patient (renal transplant patient)
surgical procedure (parastomal hernia repair)
allegation of abuse (relating to basic care)

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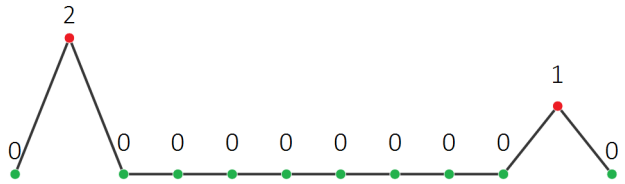
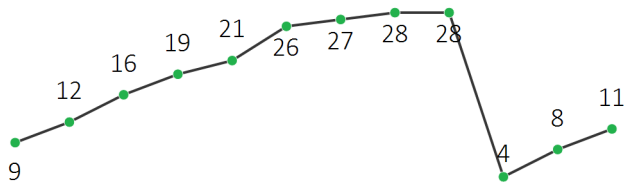
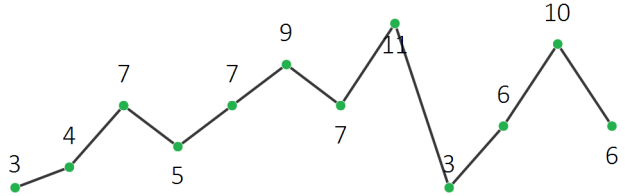
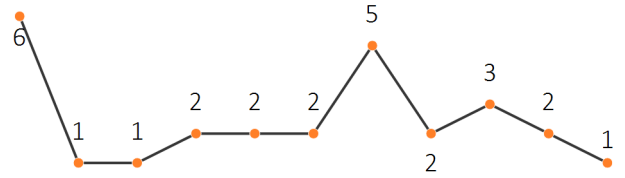
Strategic Theme: Patient Safety

Infection Control

Jun	Cases of MRSA (per month)	3		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Jun	Cases of C. Diff (Cumulative)	11 (37.5%)		Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Position in arrow shows YTD cumulative position and variance against previous month. Graph shows last 12 months, noting that C. Diff is reported as a cumulative YTD position, which explains the drop from 28 (as at March-
Jun	E. Coli	78 (21.9%)		The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	MSSA	27 (58.8%)		The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

The MRSA attributable bacteraemia numbers for 2015-16 were in total 2 cases, which gives us a rate of 0.6/100,000 bed days which is below the national average of 0.9 /100,000 bed days. The past decade has seen a remarkable fall in MRSA infections in UK hospitals as national MRSA bacteraemia rates in 2005-06 were 17.7/100,000 bed days. For many years EKHUFT has followed a policy of screening all in patients for MRSA colonisation. In 2014 guidance from the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) working group recommended a return to selective screening of patients in "high risk" specialties including vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, orthopaedics/trauma, and all intensive care units (adult/paediatric ICUs, Neonatal Intensive Care Units, High dependency units, Coronary Care Units). EKHUFT in common with many acute trusts around the country have thus far chosen to continue with universal screening of hospital admissions and have abandoned screening only for selected low risk groups such as day surgery.

Please note that the C.Diff 'graph' is cumulative from the beginning of the financial year ie year to date we have had a total of 11 cases, whereas the MRSA, MSSA and E.coli graphs indicate numbers each month. E.Coli appears highly variable month to month but our rate appears to be increasing (2014-15 national data compared with 2015-16 national data), it is not yet clear (apart from our elderly demography) exactly why that is.

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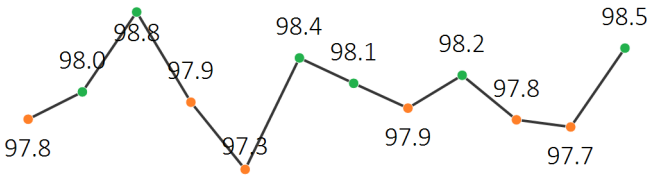
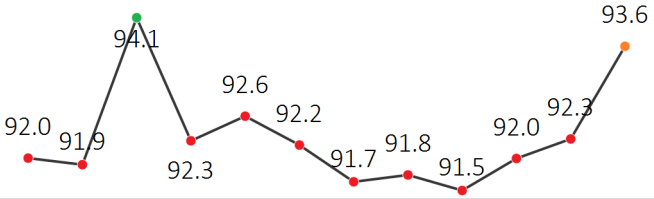
Strategic Theme: Patient Safety

Harm Free Care

Jun	Harm Free Care: New Harms (%)	98.0 (-0.4%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12
Jun	Harm Free Care: All Harms (%)	92.3 (-1.1%)		Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.

Comments:

Overall Harm Free Care (HFC) relates to the Harms patients are admitted with as well as those they acquire in our care. HFC improved in June to 93.6% compared to 92.3% in May but remains below both the overall national average of 94.16% and the acute hospitals only national average of 94.06%. This means our patients are admitted with a higher level of harm than the national average for acute hospitals. There is as expected a wide variation across the divisions with specialist achieving 99.4%, surgical 93.8% and UCLTC 90.7%.

The measure directly relating to harm experienced in our care (Harm Free Care: New Harms only) has gone up to 98.5% (better than the national average which means that our patients are receiving care that causes less harm than is reported nationally.

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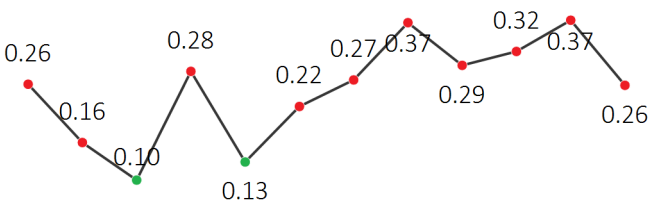
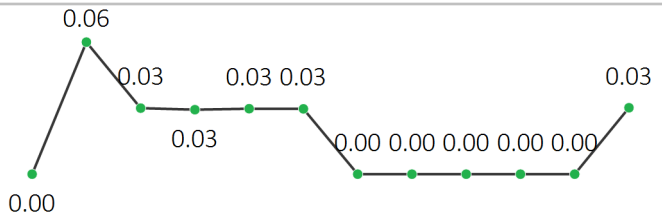
Strategic Theme: Patient Safety

Pressure Damage

Jun	Pressure Ulcers Cat 2 (per 1,000)	0.25 (-64.4%)		Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Pressure Ulcers Cat 3/4 (per 1,000)	0.02 (-86.1%)		Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: In June 16, at total of 21 category two pressure ulcers were reported and 8 were defined as avoidable. This is a decrease of eleven ulcers and three avoidable ulcers from last month. Following the re-launch of the 'Bottoms Up' campaign, there has been a reduction in sacral/buttock ulcers by eighteen from last month. Three of these were avoidable, a decrease of three from last month. Of the other avoidable ulcers, two were related to medical devices (splint and nasal specs). The other avoidable ulcers occurred at the ankle or spine where there was lack of sufficient evidence of preventative care. The Tissue Viability team will continue to feedback to the frontline teams to highlight learning points.
There were no confirmed category three of four acquired pressure ulcers in June 16. However, there were 9 unstageable/deep tissue injury reported of which two are confirmed as avoidable. Seven of these incidents affected the lower limb and four the sacrum. Two patients developed sacral and heel ulcers. Avoidable ulcers occurred on Cambridge K and Cambridge M1 wards with lack of evidence for sufficient prevention identified. Multidisciplinary meetings are to be undertaken to identify specific learning.

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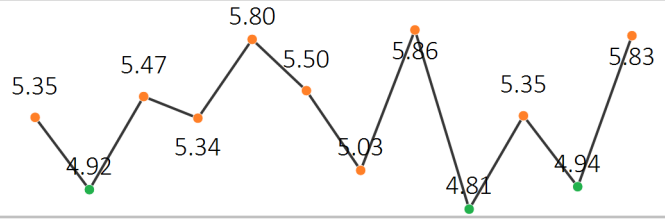
Strategic Theme: Patient Safety

Falls

Jun	Falls (per 1,000 bed days)	5.34 (-75.2%)		Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: Of the 180 patient falls recorded for June (160 in May-16 and 172 in Jun-15), 2 incidents have been graded as moderate harm, but none as severe harm or death. There were 91 falls resulting in no injury and 85 in low harm. The top reporting wards were CDU (WHH), Cambridge L (WHH) and Deal ward (QEH) with 12 falls each; Cambridge M1 (WHH) with 10 falls; Harbledown ward (K&CH) with nine falls; CDU (QEH) with seven falls; Mount/McMaster ward (K&CH), St Augustine's ward (QEH) and St Margaret's ward (QEH) with six falls each; the remaining wards reported five or fewer falls. There were 3 falls resulting in hip fractures of which 1 was unavoidable (Mount/McMaster), 1 was avoidable (Invicta) and 1 is unclear at present (Sandwich bay). RCA's are in progress for the avoidable and unclear fractures. The staffing difficulties within the Falls Team is gradually resolving but we have not yet been able to start the Fallstop project at WHH. This is being planned for September, with support from the Therapy team and Falls Champions. The project forms an essential component of the Trust Falls Action Plan (high level) and national audit action plan.

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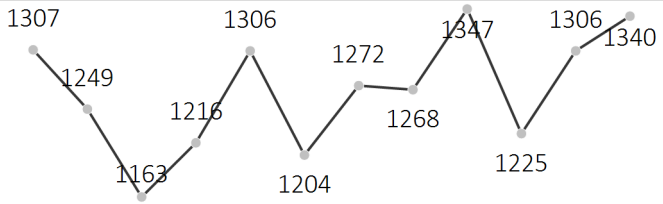
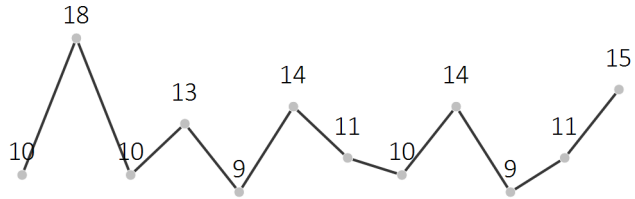
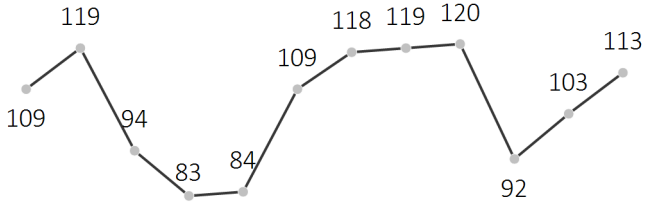
Strategic Theme: Patient Safety

Incidents

Jun	Clinical Incidents: Total (#)	15203 (11.5%)		Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Jun	Blood Transfusion Errors	144 (-14.8%)		The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Jun	Medicines Mgmt. Incidents	1263 (4.0%)		The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

In Jun-16, seven incidents have been graded as death and one as severe harm. In addition, 27 incidents have been escalated as a serious near miss, of which 22 are still under investigation. The number of moderate harm incidents reported during Jun-16 is higher than in previous months [Jun-16: 75 compared with May-16: 67 and Jun-15: 31]. Over the last 12 months incident reporting has increased at QEH and WHH, but remains static at K&CH.

In June, there were 15 blood transfusion errors reported (11 in May-16 and 20 in Jun-15). There were three themes in June: two inappropriate transfusions, two febrile non-haemolytic transfusion reactions and three testing and processing errors. Ten incidents were graded no harm, four as low harm and one moderate harm (inappropriate transfusion currently under investigation). Reporting by site: three at K&CH, eight at QEH and four at WHH.

There were 111 medication incidents reported as occurring in June (103 in May-16 and 106 in Jun-15). Over the last 12 months there has been a gradual increase in reporting of medication incidents at the three main sites.
Of the 111 reported, 91 were graded as no harm (no serious near misses) and 18 as low harm. There were two incidents graded moderate harm: Levemir given twice within same evening resulting in two hypoglycaemic events overnight; patient had to be resuscitated due to a suspected anaphylactic reaction to a pre-operative drug (tranexamic acid). Both of these incidents are under investigation and may be downgraded. Top reporting areas were: Cheerful Sparrows male ward (QEH) with eight incidents; ITU (QEH) with six incidents; Treble ward (K&CH) and ITU (WHH) with five incidents each; Invicta ward (K&CH) and NICU (WHH) with four each; Aseptics (K&CH), Cathedral day unit (K&CH), Kingsgate ward (QEH), Seabathing unit (QEH), CDU (WHH) and Padua ward (WHH) with three incidents each; other areas reported 2 incidents or fewer. Thirty-three incidents occurred at K&CH, 35 at QEH, 42 at WHH and one at BHD.

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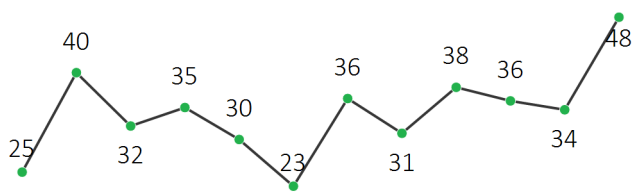
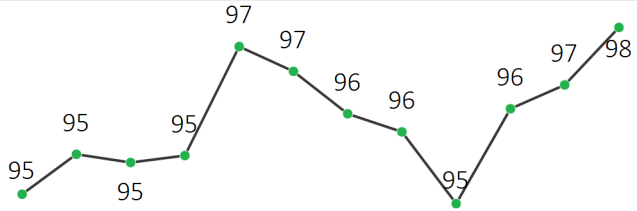
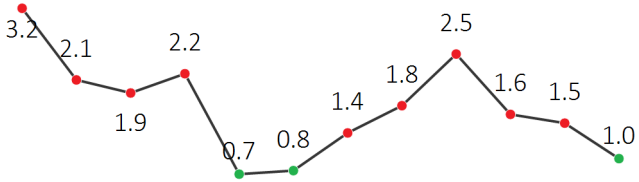
Strategic Theme: Patient Safety

Friends & Family Test

Jun	FFT: Response Rate (%)	34 (-18.5%)		The percentage of patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	FFT: Recommend (%)	96 (1.0%)		Of those patients who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	FFT: Not Recommend (%)	1.7 (-22.0%)		Of those patients who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During June 48% of our eligible patients responded and 98% would recommend us to their friends and family and 1% would not. The total number of inpatients, including paediatrics who would recommend our services was 96% (same as May-16). For A&E it was 79% (same as May-16), maternity 94% (93% in May-16), outpatients 92% (91% in May-16) and day cases 95% (94% in May-16). The Trust star rating in June is 4.58 (4.53 in May-16).

Work to improve response rates has resulted in significant improvement. The response rate for inpatients was 48% (34% in May-16), A&E 17% (12% in May-16), maternity 52% (19% in May-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 day cases was 24% (19% in May-16) but for outpatients was not available due to a national reporting error. 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.

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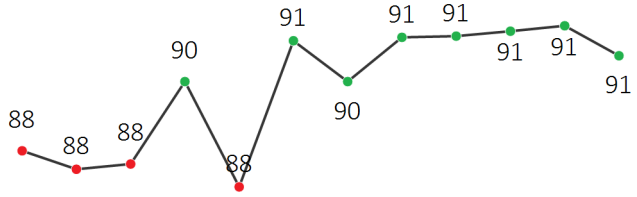
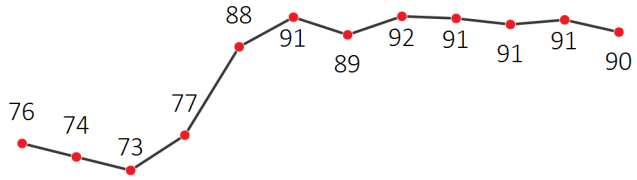
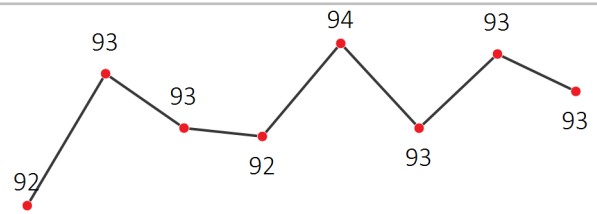
Strategic Theme: Patient Safety

Patient Experience 1

Jun	Overall Patient Experience %	91 (2.5%)		Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	Care Explained? %	88 (17.3%)		Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	Care that matters to you? %	93		Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).

Comments:

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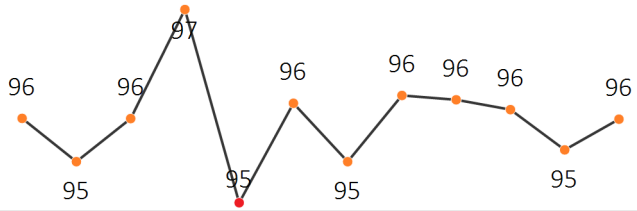
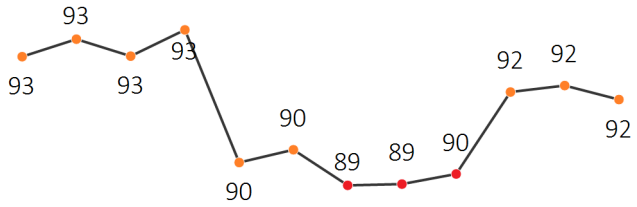
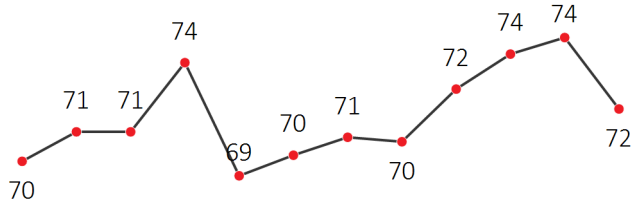
Strategic Theme: Patient Safety

Patient Experience 2

Jun	Respect & Dignity? %	95 (-0.3%)		Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nasing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	Cleanliness? %	91 (-1.0%)		Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Hospital Food? %	71 (1.1%)		Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: These are all areas that could be improved, on the NHS Choices website, despite the overall star rating each of the 3 acute sites site is rated amongst the worst for open and honest reporting and for cleanliness. The one exception is food, which is rated amongst the best in all 3 acute sites.

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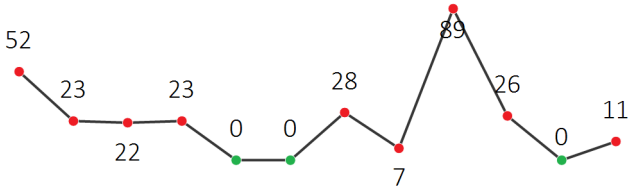
Strategic Theme: Patient Safety

Mixed Sex

Jun	Mixed Sex Breaches	281 (26.6%)		Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During June-16, 3 non-justifiable incidents of mixed sex accommodation breaches occurred at WHH CDU due to capacity issues. This information has been reported to NHS England via the Unify2 system.
There were 12 mixed sex accommodation occurrences in total, affecting 46 patients. This number was the same as last month when there was a total of 12 occurrences affecting 51 patients. The remaining incidents occurred at QEQM on the Fordwich stroke unit (5) and CCU (1), K&C Kingston stroke unit (3), which are justifiable mixes based on clinical need.
During May-16 reporting of mixed sex occurrences has improved at the WHH.

East Kent Hospitals University NHS
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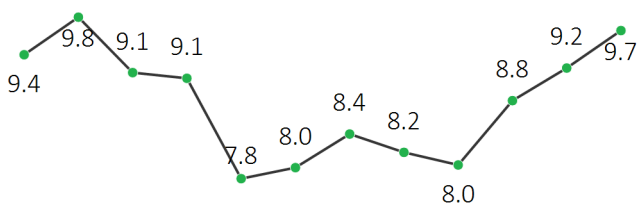
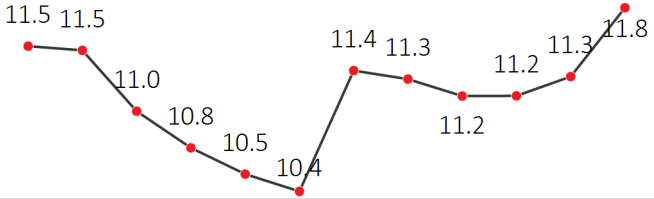
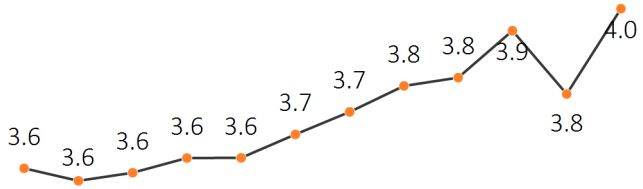
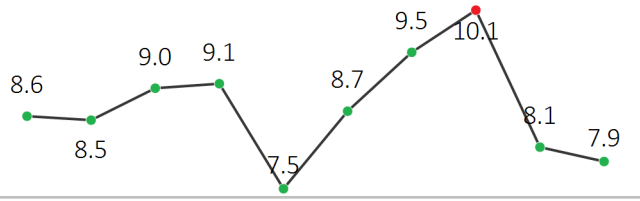
Strategic Theme: Human Resources

Gaps & Overtime

Jun	Vacancy (%)	8.8 (2.9%)		% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Staff Turnover (%)	11.2 (-20.1%)		% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Sickness (%)	3.7 (-1.5%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the
Jun	Overtime %	8.7		% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).

Comments:

Turnover and Vacancies
Turnover in June increased slightly to 11.3 % and the vacancy rate increased from 9.2% in May to 9.7% June..

Absence
The sickness rate for May was 4.0 against a target of 3.5%. Divisions have submitted a monthly trajectory for the reduction of sickness and management actions continue in hotspot areas to reduce rates inline with the trajectories.

Overtime
Overtime use decreased in June to 7.9%.

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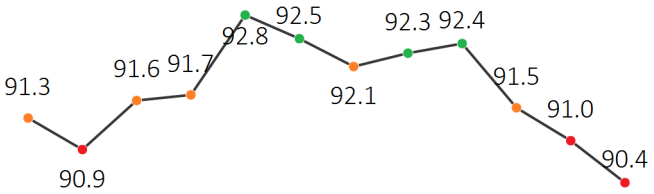
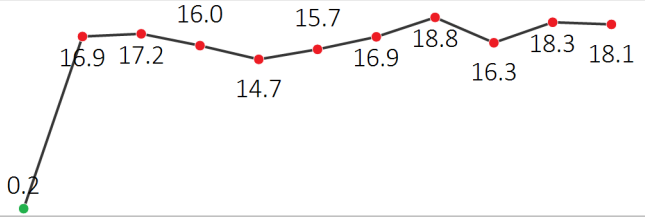
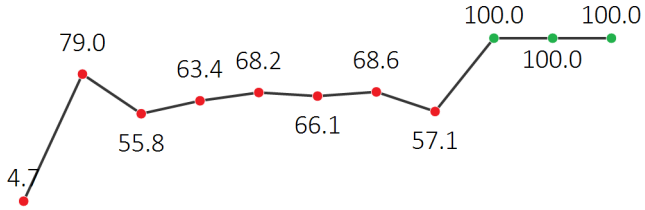
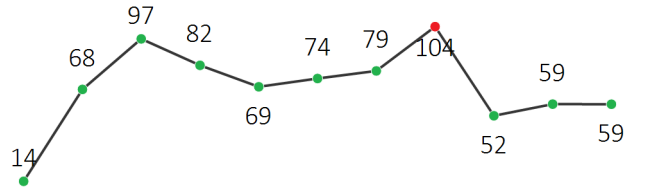
Strategic Theme: Human Resources

Temporary Staff

Jun	Employed vs Temporary Staff (%)	91.7 (-0.4%)		Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Agency %	15.4		% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).
Jun	NHSP Use % of Agency	71.3		% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).
Jun	Agency Orders Placed	69		Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).

Comments: Temporary staff

Agency use is monitored weekly and monthly against trajectory. The percentage of staff employed through agency decreased in June from 18.3% to 18.1%. The Reduction in agency spend group continue to meet fortnightly to explore alternative staffing options to support this continued decrease.

East Kent Hospitals University NHS
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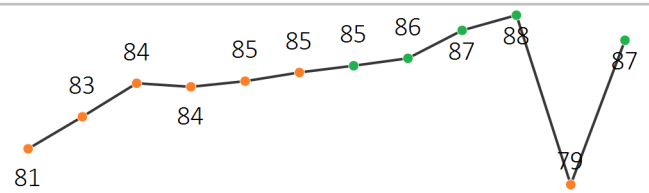
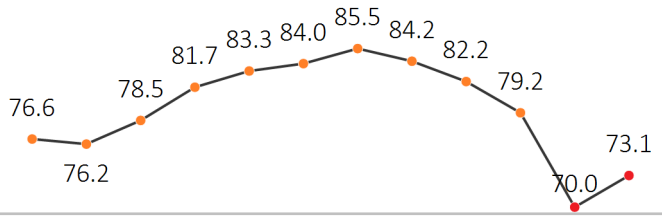
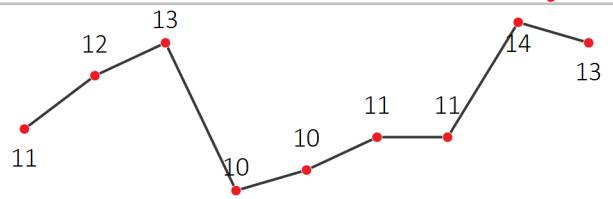
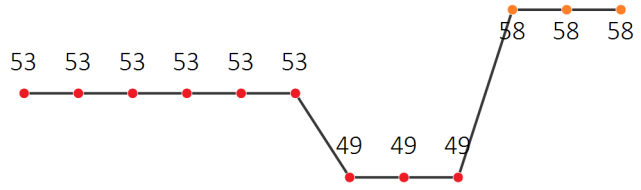
Strategic Theme: Human Resources

Workforce & Culture

Jun	Mandatory Training (%)	85 (6.9%)		The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Appraisal Rate (%)	79.6 (4.3%)		Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Time to Recruit	12 (7.4%)		Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Staff FFT - Work (%)	54 (13.6%)		Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

East Kent Hospitals University NHS
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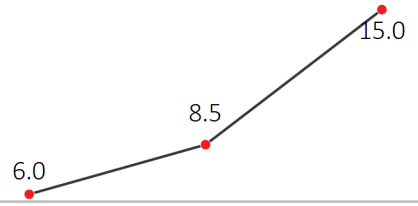
Strategic Theme: Human Resources

Jun

Local Induction Compliance %

9.9



Local Induction Compliance rates (%) for new starters to the Trust.
Number indicates average of last 12 months data (as shown in graph).

Comments:

Statutory training compliance was 87% in June which is above target of 85%. Analyses of the staff who have 'never completed one or more statutory training courses' shows a reduction from 753 in April to 707 in June a 6% reduction. Work continues in the Divisions to understand the reasons for non completion and setting timescales for full completion.

Appraisal rate increased in June to 73.1%, but remains below our target of 90%. Divisions and Corporate areas have been working on reporting throughout July to ensure that all appraisals are completed and recorded. The HR teams are working with divisions to ensure future data integrity and accurate and timely recording of appraisal dates.

The staff friends and family data for Q1 shows an 8% increase in staff recommending the Trust as a place to work. Each division are reviewing their detailed results and ensuring that Great place to work action plans are updated inline with this feedback.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Activity

Activity vs. Internal Business Plan

Key Performance Indicators

Jun

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Green
Referral Primary Care	13,323	12,625	12,611										38,559	<=0%
Referral Non-Primary Care	8,865	8,877	8,909										26,651	<=0%
OP New	15,427	16,090	16,532										48,049	>=0%
OP Follow Up	31,680	31,538	32,770										95,988	>=0%
Elective Daycase	6,719	6,883	7,143										20,745	>=0%
Elective Inpatient	1,202	1,290	1,307										3,799	>=0%
Non-Elective Inpatient	5,953	5,985	6,072										18,010	>=0 & <5%
Urgent Care Assessment	1,208	1,288	1,145										3641	>=0 & <5%
A&E	16,515	18,641	17,856										53,012	>=0 & <5%

The 2016/17 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2015/16 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals, activity required to achieve sustainable elective services is included and further adjustments for patient safety/best practice issues such as reductions or increases in new to follow up rates have been applied. Finally EKHUFT have taken a view on the viability of CCG QIPP schemes achieving a reduction in demand in 2016/17. It should be noted that this does not reflect demand levels agreed within the 2016/17 contract. All trajectories to support attainment of the Sustainability and Transformation Funding have been based on this activity plan.

The capacity levels within the plans should be considered achievable although in many instances will stretch our services beyond their internal substantive capacity, efficiency programmes, workforce recruitments plans and it is anticipated therefore that substantial elements of the plan will continue to be delivered though additional waiting list payments. Within Orthopaedics and Dermatology projected demand exceeded our ability to deliver the operative demand and as such agreements have been made with our local CCGs for services to be directly commissioned with alternative providers.

June 2016

The Primary Care demand over performance that was observed in April has slowed significantly in both May and June, although a year to date over performance of 6% has still been observed. The Trusts Internal Business Plan stretches most services to maximum capacity and as such we have not been able to flex our capacity further to deal with this unplanned demand. As a result of this activity intended to reduce our waiting list sizes is now only serving to deal with current demand placing our recovery trajectories at significant risk. The Trust does not have the operative capacity to deal with the current demand, a key element of our business plan requires Orthopaedic referrals to be directed to the independent sector at point of referral, unfortunately there is no evidence to support the redirection of patient flow and referrals continue to arrive at a rate which far exceeds our ability to treat patients within 18 weeks.

Endoscopy activity continues to drive the biggest underperformance in activity across the Trust. The service has been supported by locum consultants which has not provided consistent and sustainable levels of activity to enable the business plan to be delivered. The service cannot commit to delivering the shortfall from quarter one in quarter two due to the reliance on the temporary workforce, with current capacity is being used to focus on patients on Cancer and Referral to Treatment pathways. The recruitment of a substantive consultant in quarter three will provide additional capacity and stability within the service. In addition, the service will be supported by an Acute Physician with a specialist interest in gastroenterology, which will increase the available capacity. Further recruitment advertisements will be published for Consultant and Middle Grade posts with a view to further bolstering the service as current plans are still insufficient to deliver the full plan for outpatients.

Through our collaboration with the Clinical Productivity Consulting & Service Redesign Company Four Eyes Insight, we have successfully increased the number of theatre cases being delivered per session; however a converse reduction in the number of sessions provided has meant that we are only delivering similar levels of activity to previous years. As the focus now switches to reducing the number of theatre sessions that remain unused this step change in number of cases per list should enable the Trust to realise our full efficiency targets over the coming months. Early indications suggest there has been a significant reduction in dropped lists at WHH and QEQM during August 2016.

Gynaecology elective activity has underperformed in the year to date due to gaps in the middle grade rota, unexpected staff leave, being unable to utilise a list at WHH due to clinician job plan clashes, and being unable to replace a consultant who left late in 2015. The list at WHH has been moved to another day and recommenced from early July, meaning the underperformance against the DC and EL plans will not increase, but the shortfall is unlikely to regained over the course of the year with this alone. The service has approval to recruit two substantive posts, and is investigating the potential of a known locum who could offer capacity whilst the recruitment and notice period of applicants is on-going. Depending on agreement on job plans with the Clinical Lead, the additional activity should recover the business plan and allow for backlog reduction to aid the RTT recovery trajectory.

Dermatology Daycases are under plan due to a combination of lower TUSCC daycase activity in June, and overstating the middle grade capacity during business planning. There is an emerging risk that 3 new specialty doctors will now not start in September as planned, although the service is currently working through plans for additional capacity to minimise the impact. It is anticipated that a small variance will remain if the proposed plans are able to be actioned.

The Orthopaedic team have been unable to provide the Independent Sector Capacity stated in the contract in the year to date, this is in part due to delays with the tender exercises and also due to the inability to obtain enough capacity within the Spencer Wing. To mitigate against this risk the service is working with commissioners to agree

alternative providers for patients waiting for elective and daycase procedures, at this stage no patients have been removed from our admitted waiting lists, and as such our waiting lists have continued to grow. The service has now identified capacity for 300 patients that are due to be treated at the One Healthcare Private Hospitals, Ashford, the process has to transfer the patients to the provider has started immediately. In July 2016, we were unable to deliver the amount of additional high productivity sessions detailed within the plan, the service plans to re-provide the additional capacity in August and September 2016.

The Neurology Service continues to over perform the business plan; the service is front loading outpatient capacity to mitigate against an expected future capacity deficit that is expected due to occur when two consultants leave in July 2016. The over performance is having a positive effect on the services RTT performance with the service 2.3% ahead of their recovery Trajectory with performance now at 94.3%.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	2,184	2,413	-9%	-229
107 - Vascular Surgery	698	589	19%	109
120 - Ear, Nose & Throat	3,074	2,963	4%	111
410 - Rheumatology	904	788	15%	116
101 - Urology	2,006	1,861	8%	145
420 - Paediatrics	1,300	1,111	17%	189
140 - Maxillo Facial	2,066	1,820	14%	246
330 - Dermatology	3,697	3,445	7%	252
502 - Gynaecology	2,704	2,225	22%	479
110 - Trauma & Orthopaedics	2,889	2,389	21%	500
Total	**38,559**	**36,243**	**6%**	**2,316**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
800 - Clinical Oncology	2,653	3,010	-12%	-357
110 - Trauma & Orthopaedics	5,293	5,621	-6%	-328
560 - Midwifery	0	272	-100%	-272
120 - Ear, Nose & Throat	812	958	-15%	-146
140 - Maxillo Facial	451	593	-24%	-142
502 - Gynaecology	1,851	1,968	-6%	-117
340 - Respiratory Medicine	649	533	22%	116
100 - General Surgery	870	754	15%	116
101 - Urology	1,770	1,592	11%	178
130 - Ophthalmology	2,755	2,377	16%	378
Total	**26,651**	**27,348**	**-3%**	**-697**

OP New

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	1,661	2,097	-21%	-436
100 - General Surgery	1,373	1,732	-21%	-359
430 - HCOOP	1,305	1,453	-10%	-148
400 - Neurology	1,466	1,273	15%	193
330 - Dermatology	3,283	3,053	8%	230
300 - General Medicine	597	295	103%	302
420 - Paediatrics	2,241	1,914	17%	327
502 - Gynaecology	3,913	3,485	12%	428
130 - Ophthalmology	6,095	5,500	11%	595
110 - Trauma & Orthopaedics	5,960	5,297	13%	663
Total	**48,049**	**46,500**	**3%**	**1,549**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	2,893	4,501	-36%	-1608
100 - General Surgery	733	1,272	-42%	-539
302 - Endocrinology	1,986	2,431	-18%	-445
430 - HCOOP	1,033	1,437	-28%	-404
410 - Rheumatology	4,006	4,379	-9%	-373
324 - Anticoagulation Service	4,203	4,511	-7%	-308
103 - Breast Surgery	1,637	1,287	27%	350
101 - Urology	5,006	4,651	8%	355
110 - Trauma & Orthopaedics	9,790	8,604	14%	1186
130 - Ophthalmology	15,602	13,510	15%	2092
Total	**95,988**	**96,036**	**0%**	**-48**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	4,401	5,759	-24%	-1358
330 - Dermatology	1,150	1,298	-11%	-148
100 - General Surgery	494	630	-22%	-136
502 - Gynaecology	481	599	-20%	-118
110 - Trauma & Orthopaedics	1,581	1,695	-7%	-114
191 - Pain Management	627	710	-12%	-83
130 - Ophthalmology	3,821	3,746	2%	75
140 - Maxillo Facial	602	505	19%	97
303 - Clinical Haematology	882	730	21%	152
101 - Urology	2,025	1,862	9%	163
Total	**20,745**	**22,410**	**-7%**	**-1,665**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	967	1,135	-15%	-168
502 - Gynaecology	359	482	-25%	-123
100 - General Surgery	295	387	-24%	-92
320 - Cardiology	172	216	-20%	-44
300 - General Medicine	192	233	-18%	-41
430 - HCOOP	15	37	-60%	-22
420 - Paediatrics	87	57	51%	30
503 - Gynaecology Oncology	37	5	671%	32
400 - Neurology	96	60	60%	36
101 - Urology	751	657	14%	94
Total	**3,799**	**4,104**	**-7%**	**-305**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
100 - General Surgery	1,498	1,666	-10%	-168
420 - Paediatrics	1,488	1,651	-10%	-163
501 - Obstetrics	1,150	1,292	-11%	-142
502 - Gynaecology	498	636	-22%	-138
110 - Trauma & Orthopaedics	996	1,104	-10%	-108
320 - Cardiology	494	585	-16%	-91
340 - Respiratory Medicine	56	128	-56%	-72
430 - HCOOP	2,662	2,500	6%	162
180 - Accident & Emergency	1,814	1,361	33%	453
300 - General Medicine	5,274	4,356	21%	918
Total	**18,010**	**17,382**	**4%**	**628**

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

4 Hour Emergency Access Standard

Key Performance Indicators

85.39 %

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
4 Hour Compliance	86.50%	88.46%	87.54%	87.00%	89.37%	87.79%	84.91%	80.01%	79.26%	84.04%	82.68%	85.39%
12 Hour Trolley Waits	1	2	0	0	0	0	1	0	1	1	0	0
Left without being seen	3.88%	3.39%	2.79%	2.87%	3.06%	3.19%	2.87%	3.78%	4.20%	3.46%	4.09%	3.84%
Unplanned Reattenders	9.48%	9.39%	8.98%	8.80%	8.93%	8.71%	8.88%	8.97%	9.31%	9.10%	9.40%	9.17%
Time to initial assessment (15 mins)	94.9%	93.5%	94.9%	91.1%	89.5%	91.7%	93.3%	92.6%	91.1%	86.0%	86.0%	89.0%
% Time to Treatment (60 Mins)	47.9%	53.3%	49.4%	51.0%	49.9%	50.3%	49.5%	43.5%	40.8%	46.3%	43.5%	48.2%

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

-4.78 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
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	84.04%	82.66%	85.39%									

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%.

June performance against the 4 hour target was 85.39%, against a trajectory of 90.17% and a compliance target of 95%. The quarterly performance position was 84.02%, against a quarterly performance trajectory of 88.52%. June's performance shows an improvement compared to the May position, with a higher proportion of patients seen within 4 hours. Analysis of the breach reasons shows a similar split in breach reasons as seen in May, with a large proportion of breaches assigned due to delays to be seen by a first clinician (45% of all breach reasons, compared to 47% in May).

While this breach reason continues to relate to a large proportion of the breaches, performance against the 60 minute time to treatment improved in the month, with an improvement across all sites, (Kent & Canterbury; 51.8% to 59.1%, Queen Elizabeth the Queen Mother; 39.0% to 43.0%, William Harvey Hospital; 34.8% to 38.3%). This improvement in month ties into a key improvement priority for the Emergency Departments (EDs), and improving the proportion of patients seen with in 60minutes is an important outcome measure of success in this area.

Volume of attendances remained high, with approximately 595 attendances per day. This is around 6 per day lower than that seen in May, but continues the trend seen in the year to date of attendances in excess of the planned activity levels (4.6% above plan in month, 4.9% above plan for Q1). Attendance numbers continue to be high, with an individual day in June seeing over 697 attendances, the highest number of patients seen in any day for the last 12 months.

Improvements in Emergency Department performance are being pursued through the urgent care recovery plan. The 4 key high impact areas and actions are as follows;

Priority 1- Improvements in ED

Team Based Working

- Team based working is becoming embedded in the QEQMH Emergency Department (ED) with senior medical, nursing and support staff working in multi-disciplinary clinical teams.
- Implemented in April 2016. The pilot is being run between the hours of 12.00 – 18.00. There continues to be an improvement in performance against the 60 minute standard despite increased attendances in ED.

ED Consultant and ED Specialty Doctor Recruitment

- The two new additional consultants have confirmed start dates to join the Trust in September 2016. Recruitment is on going using UK and overseas advertising.

- The on-going recruitment issues into ED speciality doctor vacancies continue to be a high risk to service provision. The overseas recruitment campaign has been successful with two doctors joining the Trust in June and one doctor planned to arrive in July. There are 9 doctors in the pipeline who have accepted posts and are in the recruitment process. However, there is a national shortage of speciality doctors and a high turnover as the overseas doctors will often transfer into training posts within one year of arrival in the UK.

Senior Nursing pilots:

- Early Senior Review (ESI) - The senior nursing and medical team at WHH are planning to implement the ESI assessment on the 22 August and have been testing ESI to refine and review the process.
- A nursing establishment review has been completed to identify nursing requirements to provide a dedicated Emergency Nurse Practitioner Service and to ensure that there is a Band 7 senior sister on duty at all times. This review will be presented to the Strategic Workforce Committee in July.
- The QEQMH assessment nurse in the waiting room pilot has been implemented to ensure patients who are unwell are identified immediately and patients can also be offered GP appointments as appropriate with their own GP practice.

Priority 2 - Acute Medical Model at QEQM and re-launch at WHH.

- The QEQMH Acute Medical Model continues to become embedded with improved patient waiting times and experience. The model has been presented at an Emergency Care Improvement Programme national conference.
- The increase in medical admissions has continued in June has put increasing pressure on to the hospitals bed base.
- The QEQMH team have launched a Frailty area within the ambulatory floor, providing a dedicated service to ensure that frail elderly patients are assessed and treated in an appropriate environment. It is planned to roll out the frailty service to K&CH in July.
- The WHH project group to review the Acute Medical Model at WHH have identified the accommodation requirements to provide a dedicated ambulatory service, which is co-located to the Acute Medical Unit.
- The redesign of the Emergency Care Centre at K&CH into an Urgent Care Centre is progressing to timescales and will be launched in July with an integrated primary care service within the Minor Injuries area of the Unit. Extensive refurbishment work is underway to expand the waiting area and provide additional consulting rooms and specialist clinical zones for urology and ambulatory care.

Priority 3 - Implementation of SAFER

- SAFER has been launched on two medical wards at WHH with a multi-disciplinary ward or board round every morning on those wards. The wards involved in the programme have reported improved communication between the clinical teams, resulting in early discharge planning, patient treatment plans are progressed and ensuring that patients are fully involved in their management plans.

- The Patient Flow programme was launched at WHH in June, focusing on training junior and senior clinicians in the principles of SAFER, effective ward rounds and clinical leadership.

Priority 4 - Site Management Arrangements

Operational Control Centres (OCC's)

- The expansion and refurbishment to the OCC at QEQMH OCC has been completed and has enabled the room to also become the Operational Control Centre for emergency planning and major incidents.
- The established meeting structure and information systems at QEQMH have been extended to WHH and K&CH, together with a new site sitrep report which focuses on staff, patient and physical space capacity within the emergency departments and across the hospital ward areas. This report includes up with key actions and escalations which are followed up at the following sitrep meeting. The sitrep report is extremely effective in focussing on key information and highlighting potential clinical risks and actions.

Trajectory Confidence

June performance against the 4 hour target was 85.39%, against a trajectory of 90.17%. The increased activity levels seen so far this year remain above plan 4.6% in June, compared to +8.8% above plan in May. The numbers attending the departments have an adverse effect on the ability to meet the 4 hour standard for patients, with difficulties caused by temporary spikes in activity. The performance in month marks the highest compliance position for the 2016-17 year to date, and an improvement from the May position in the initial assessment (15minute) and time to treatment (60 minute) targets.

The increased levels of activity experience in May have continued in June. The QEQMH and WHH have continued to see high numbers of patients attending in the evenings and overnight. The increase in children attending in the evenings has not abated.

There have also been high ambulance attendances presenting with a greater number of majors patients. This is an indication that the patients have had a higher medical acuity and required to be managed within the majors area of the department and have a higher conversion to admission. The ED's and management teams have to work with SECAMB colleagues to reduce the number of handover delays and ensure patients have been safely handed over as quickly as possible.

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 continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.
- 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 and weekends who could be managed by primary care, in particular paediatric attendances.

- Mental health patients who are awaiting assessment overnight by the mental health Crisis Team.
- Mental health patients who require a mental health bed often having to wait several days for a bed, both in ED assessment beds and also in the wider ward bed base.
- Medical staffing vacancies, which medical staffing agencies are unable to fill. QEQMH is a particular risk due to the geographic location of the hospital.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

Cancer Compliance

Key Performance Indicators

76.18 %

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Green
62 day Treatments	64.84%	68.83%	69.76%	70.45%	70.89%	79.11%	71.68%	79.86%	74.53%	71.04%	79.20%	76.18%	>=85%
100 day breaches	85	86	130	87	75	57	64	65	61	42	56	57	<0
Demand: 2ww Refs	3,195	2,535	2,835	2,748	2,785	2,550	2,725	2,839	2,908	3,085	2,963	2,962	2693 - 2976
2ww Compliance	90.32%	89.96%	95.05%	95.62%	94.52%	93.87%	93.28%	94.10%	93.59%	89.25%	88.48%	94.52%	>=93%
Symptomatic Breast	85.45%	80.52%	93.46%	94.12%	93.55%	92.22%	94.06%	88.03%	93.02%	85.00%	83.73%	93.46%	>=93%
31 Day First Treatment	90.64%	94.02%	93.17%	96.43%	97.48%	98.00%	94.82%	97.07%	98.14%	96.11%	96.31%	94.69%	>=96%
31 Day Subsequent Surgery	91.89%	92.86%	92.11%	94.44%	96.97%	94.44%	94.59%	97.50%	96.72%	91.49%	88.24%	86.96%	>=94%
31 Day Subsequent Drug	100.00%	100.00%	100.00%	100.00%	98.53%	98.44%	86.17%	100.00%	100.00%	98.25%	98.95%	100.00%	>=98%
62 Day Screening	96.15%	88.24%	86.27%	84.21%	86.36%	85.00%	93.75%	95.65%	92.59%	92.86%	93.10%	100.00%	>=90%
62 Day Upgrades	25.00%	33.33%	91.67%	66.67%	77.78%	70.00%	50.00%	86.67%	70.37%	100.00%	57.14%	100.00%	>=85%

Sustainability & Transformational Funding Trajectory

-1.42 %

	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	74.10%	76.40%	77.60%	77.40%	82.70%	85.40%	85.00%	85.50%	85.20%	85.10%	85.40%	85.20%	Sept
Performance	71.04%	79.20%	76.18%										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

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 any 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.

The Trust has been non-compliant with the 62-day standard over the past year and an improvement trajectory has been agreed 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 Patient Tracking List review meetings and agreeing timed pathways and operation procedures. Gynae performance was a risk in April/May, following this there is now adequate capacity for ultrasound for first diagnostics at out-patients. Gynae have been experiencing difficulty maintaining capacity for Hysteroscopy, however there is a plan in place to increase hysteroscopy lists. Head and Neck agreed to prioritise opening an extra treatment room for skin cancer patients, this will help prioritise skin cancer referrals in order for skin to reduce breaches and support meeting cancer trajectory. An extraordinary cancer Board was held on 15th June to focus on Colorectal and Head & Neck pathway with a drive to improve performance. This meeting was well attended and had good engagement from Clinical teams. Endoscopy was a priority discussion. The clinicians were supportive in discussing approaches to resolving capacity issues. Following this meeting an action plan for each tumour site was circulated by the Chief Executive with an action to present outcomes for delivery of the trajectory to achieve the 85% compliance in September.

EKHUFT has been selected as a Trust to apply for funding to support diagnostics to diagnose cancer patients sooner. The bid will be submitted in July 2016. The proposal will request support to enable more doctors within the Trust to become JAG accredited (Endoscopy training), consideration of outsourcing Hysteroscopy and support for radiology reporting and earlier access for CT/MRI.

Currently, June performance against this standard is 76.18%, against its improvement trajectory of 77.60%, with 57 patients waiting 100+ days for their first treatment. The Trust delivered a total of 180.5 treatments, and 43 of those patients breached the 62 day timeframe. The Trust aggregate position is 1.42% behind the submitted recovery trajectory. The breaches are generally caused by either capacity shortfalls or delays in agreed pathways e.g. diagnostics and histology turnaround times.

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 will be circulated to Cancer Board Members for ratification at the September 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. Following a review of MDT Coordinators a new management structure has been agreed. The role of MDT co-ordination and Waiting list (PTL) trackers has been separated giving time for greater focus on validation and patient tracking.

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.
A detailed discussion with all tumour sites and in particular Head and Neck and Lower GI is scheduled for the June Cancer Board.

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. The Dashboard is live and operational and clinical teams are encouraged to use this and focus on PTL work. The Dashboard is accessible to all PTL attendees. The PTL meeting is WEBEX and each meeting recorded for auditing purposes.

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.
Two RCA's have been undertaken since January with an outcome of no harm.

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 needed 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

18 Week Referral to Treatment Standard

Key Performance Indicators

86.81 %

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Green
Performance	88.10%	88.14%	90.13%	92.06%	91.51%	88.82%	90.10%	89.17%	89.27%	88.56%	87.89%	86.81%	>=92%
52w+	8	8	15	12	3	5	3	5	4	6	9	17	0
Waiting list Size	44,706	42,508	42,577	40,125	39,842	41,178	42,239	42,791	43,000	44,620	45,663	44,213	<38,938
Backlog Size	5,321	5,042	4,201	3,186	3,384	4,604	4,181	4,633	4,613	5,105	5,531	5,831	<2,178
Demand: PC Referrals	17,105	14,454	15,950	16,435	15,692	14,296	14,979	15,882	16,190	16,141	15,744	15,439	<15,484
Demand: Additions to IP WL	3,412	2,849	3,220	3,474	3,578	3,118	3,358	3,565	3,582	3,437	3,508	3,866	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

Sustainability & Transformational Funding Trajectory

-3.64 %

	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%	87.89%	86.81%										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 June performance against the standard was 86.81% and there were seventeen patients who were waiting for treatment for more than 52 weeks as at the end of the month. Despite evidenced increases in theatre productivity, significant vacancies within isolated services have meant we have been unable to fully deliver the business plan in month three. In addition the Trust has been unable to re-provide theatre sessions in June to recover from previous months of planned annual leave or clinical audit days. In the month of June 2016, we listed over 3,800 patients for elective surgery, this equated to 25% more than we planned. The Services experiencing the biggest demand are General Surgery, Orthopaedics and Ophthalmology, these specialities are now analysing their waiting lists to understand the drivers and impact of this listing rate.

The Trust continues to receive primary care demand over the predicted planned referral rate. If this continues, the trajectory for 18 weeks will be unachievable. The increase in the number of 52 week waiters is predominantly within the ENT specialty. The Trust has a capacity deficit within the Otology sub specialty due to a vacancy, and is currently working in partnership with the Royal National Throat, Nose and Ear Hospital in London and primary care to ensure patients receive treatment.

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. Due to the challenges faced with achieving the RTT recovery plan the trust ran a workshop, in collaboration with Four Eyes Insight, for the operational teams. This was followed by one week of operationalising the agreed action plan from the workshop, which continues to be our focus.

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 programme has now moved into implementation phase with multiple Specialties adopting the system in June 2016, the feedback has been predominantly positive and operational teams have been able to embed the use of the tool within business as usual.

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, colorectal, ENT, urology and General Surgery pathways have all been mapped to compliant pathways. Monitoring will now commence on these pathways.

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, In addition the trust has secured additional capacity on behalf of the CCG and is now commencing the transfer to the independent sectors. The commissioning support unit and our primary care colleagues are continuing to source additional outpatient capacity to divert referrals
- Referrals into the Trust over performed the plan by 6% in Quarter 1, this equates to over 2,300 additional patients referred into the Trust; this level of demand will mean that the recovery plan will be unachievable. This 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 CCG have now confirmed funding, patients have been identified and agreed to transfer their care, patients have been seen and have commenced treatment. The trust is liaising with London for outcomes of these treatments

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 are securing additional capacity for the first two quarters of the year.
- Risk around continued support from nursing staff to accommodate additional capacity remains

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 has commenced.

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

- Endoscopy delays are extending the colorectal pathway, to mitigate this joint clinical colorectal and gastroenterology meetings established in May 2016. Agreed 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.
- Month 3 saw further in- session productivity, with an average case per list increasing to 4.1 across the 6 target specialties.
- Increase in number of sessions run.
- General Surgery and Ophthalmology are the area for focus during August and September

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.
- Profile of unused theatre lists are addressed at weekly theatre site meetings and weekly Trust theatre efficiency meetings.

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.

- Agreed 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 of clinical teams to deliver flexible sessions to achieve cross covering of clinical commitment during leave in outpatient and theatres has commenced
- Identified Ophthalmology sessions to transfer to extended days to release theatre capacity and provide cross cover – commenced

- Independent Sector capacity to transfer patients from the trust admitted waiting list as agreed with the CCG has commenced. This will be delivered during August and September.
- Capacity to be commissioned from alternative provider for Ophthalmology during August and September until recruitment of consultants and technical staff has been successful. 3,000 appointments to be commenced during August and September

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: KPIs

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.86 %

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Green
Performance	99.92%	99.93%	99.73%	99.84%	99.86%	99.90%	99.81%	99.65%	99.65%	99.78%	99.87%	99.86%	>=99%
Waiting list Size	14,271	13,990	14,137	13,962	12,799	13,593	12,496	12,993	13,358	13,449	14,812	13,533	<14,000
Waiting > 6 Week Breaches	12	10	38	23	18	13	24	45	47	29	19	19	<60
Average Wait													<4

Sustainability & Transformational Funding Trajectory

0.71 %

	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%	99.87%	99.86%										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. As well as monitoring the % of patients waiting 6 weeks or less for a diagnostic, the waiting list size and number of breaches over 6 weeks are also monitored, as these are key indicators that result in achievement of the DM01 standard.

19 patients waited over the 6 weeks standards in June 16 – breakdown below

MRI - 7
Non-obstetric ultrasound - 7
Audiology - 1
Colonoscopy – 1
Flexi Sigmoidoscopy- 1
Gastroscopy – 2

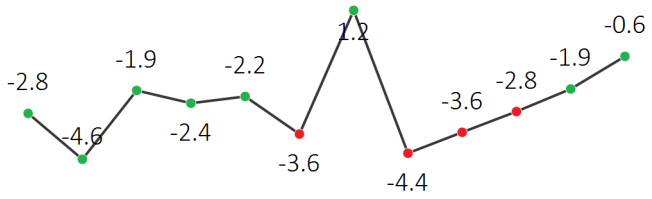
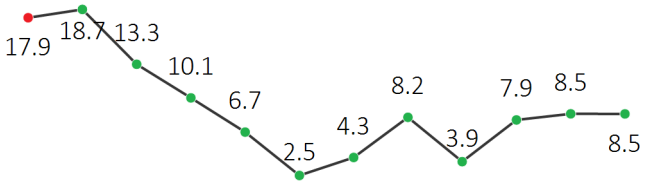
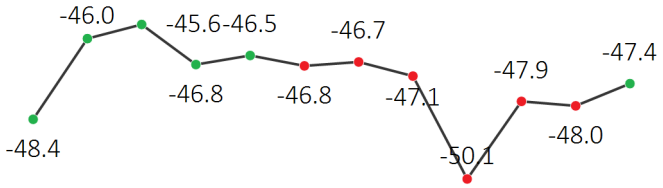
Risks; Issues and action's to mitigate a sustainable performance

- Increasing demand in modalities of CT MRI and Ultrasound with limited capacity to deliver more. All equipment working to maximise opportunity - **Action** continue to vet requests, provide information to Trust Divisional clinical teams; CCG's at Consultant/Practice and GP level to enable a greater level of understanding and assessment of need and challenge as to requesting. Additional lists being undertaken to include both extended days during the week and Saturday lists.
- Recruitment remains a risk to delivery concern across Radiology and Endoscopy Services. **Action** On-going substantive recruitment continues interviews on 26th July, additionally sourcing of locums; paying overtime to internal consultants and outsourcing where practical to do so.
- A further reduction to current workforce and reduction to outsourcing would dramatically reduce the ability to deliver and sustain the DMO1 position –it would further compromise the RTT and cancer standards. **Action** Daily active monitoring of waiting list and backlog position. Prioritise Cancer pathway patients.
- National public drives in screening are driving capacity and demand issues particularly in Endoscopy. The volume of cancer related to endoscopy referrals continue to spike **Action** On-going monitoring of referrals; outsourcing and recruitment to support delivery.
- The Division is dealing with challenging management HR and MHPS issues which may impact further on backlog and performance. **Action** HR and MD involvement
- The Trust ageing equipment continues to be monitored closely and serviced as required. The Division have secured capital funding for the replacement of 2 MRIs at KCH. The New CT is in place and being commissioned at William Harvey. Planning has commenced to deliver MRI solutions in Jan 2017. **Action.** Plan down time for repair sensibly and use of interim mobile solution are in place to mitigate position.
- 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: Finance

Finance

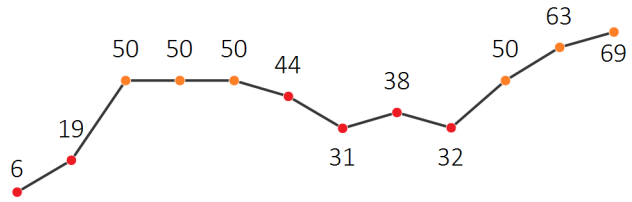
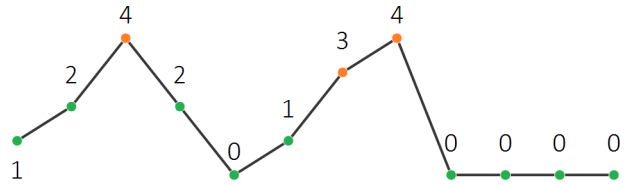
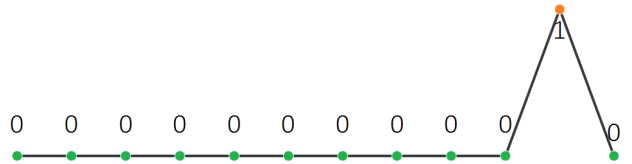
Jun	I&E £m	-5.2 (-68.0%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £5.2m deficit adjusted for "extra" CIPS
Jun	Cash Balance £m	8.5 (-0.1%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Total Cost £m	-47.4 (-1.4%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Forecast I&E £m	-11.0 (0.0%)		This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Normalised Forecast £m	-27.6 (0.0%)		This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: The I&E deficit in June (month 3) was £0.6m driven by higher activity above plan and lower non-pay costs, representing a further improvement over the first two months (£2.8m and £1.9m respectively). This takes the reported deficit at Q1 to £5.2m, consistent with a forecast year end deficit of £10m to £12m. Cash continues to be carefully managed and discussions continue with NHSI to extend the existing £14.6m interim credit facility. The normalised forecast strips out access to Sustainability and Transformation Funds.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

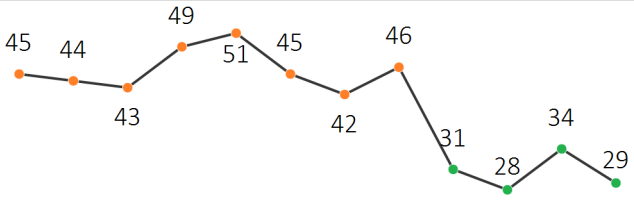
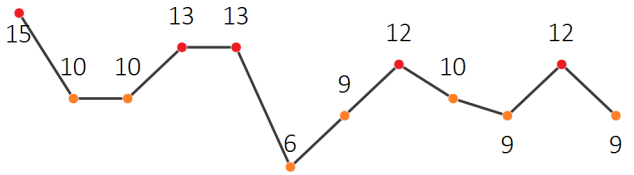
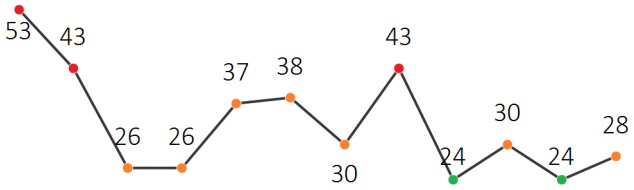
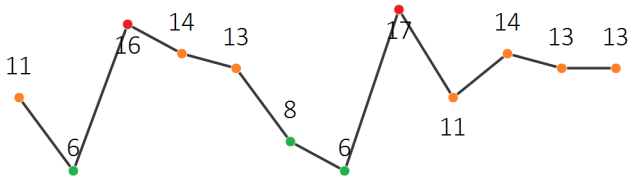
Jun	Representation at H&S	501 (-0.5%)		% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	RIDDOR Reports (Number)	17 (-10.5%)		RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Formal Notices	1		Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).

Comments:

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

Jun	Accidents	487 (-15.2%)		Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Fire Incidents	128 (-5.9%)		Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Violence & Aggression	402 (-4.1%)		Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Sharps	142 (317.6%)		Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: The number of accidents, fire alarm activations and violence & aggression instances are all positive this month. Sharps incidents remain high compared with the preceding 12 months numbers however the last 4 months remain broadly comparable in numbers. It's worth noting that all incidents are dealt with by Occupational Health, including the use of Post Exposure Prophylaxis (PEP), counselling and crucially re-training. The Trust has invested significantly in procedural equipment to support the safe use of needles and therefore training remains the key focus in order to reduce the number of incidents year on year.

H&S training data will formally enter the IPR dashboard next month however now that we are confident in the data quality being capturing for all H&S related training this is Green as per our KPI metric.

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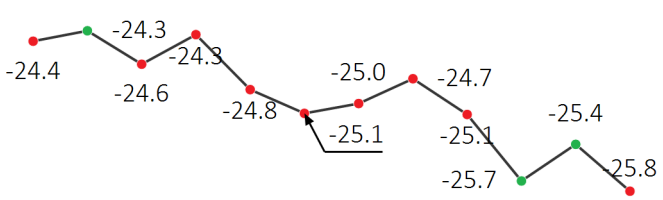
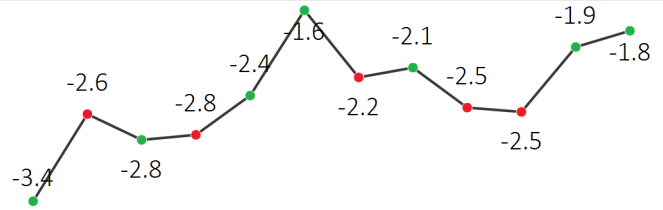
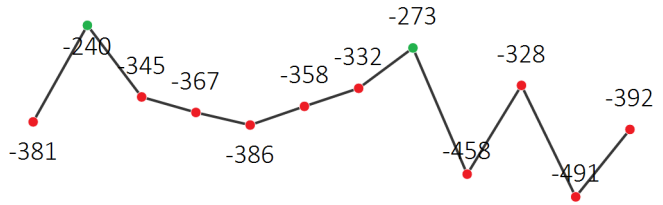
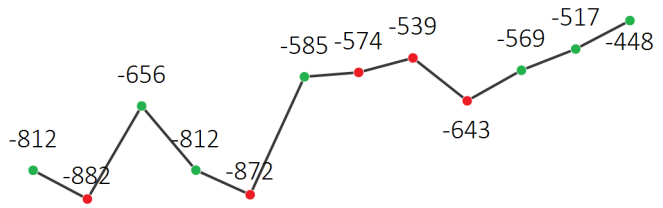
Strategic Theme: Use of Resources

Pay Independent

Jun	Payroll Pay £m	-25.8 (1.8%)		Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Agency Spend £m	-1.8 (-8.3%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Additional sessions £k	-392 (-20.1%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Independent Sector £k	-448 (-13.4%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: Payroll costs increased in June reflecting the payment of two bank holidays from May and pension auto enrolment costs. Agency and locum spend fell marginally with reductions in all staff groups. Additional session payments reduced as did use of IS.

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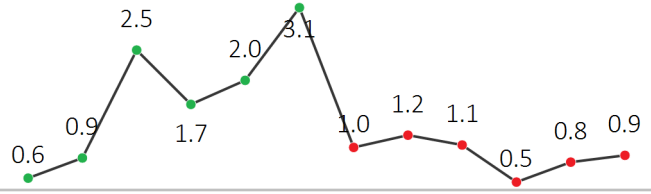
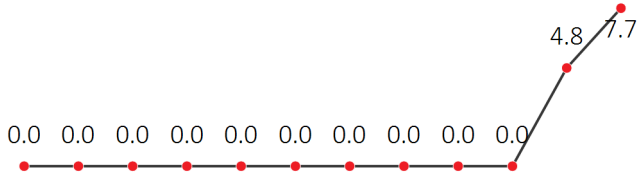
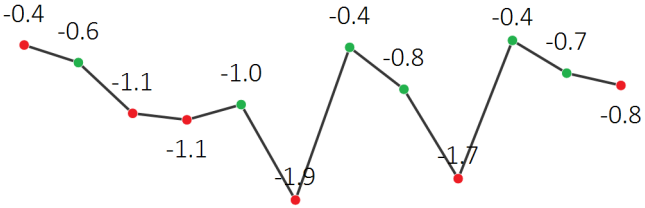
Strategic Theme: Use of Resources

Balance Sheet

Jun	CIPS £m	2.2 (12.3%)		Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.
Jun	Cash borrowings £m			Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Jun	Capital position £m	-1.8 (17.8%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.

Comments:

- CIPS continued to perform marginally below plan in month. Further work is in place to address shortfalls against the £20m target. The ability of the Trust to reduce agency usage is being impacted by the intense demand pressures being felt in urgent care.
- The Trust borrowed a further £2.9m in June bringing the cumulative borrowings to £7.7m.
- capital spend remains consistent with the programme.

East Kent Hospitals University NHS
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Strategic Theme: Use of Resources

Productivity

Jun	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	Clinical Productivity graph: theatre sessions v plan.
Jun	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	Clinical Productivity graph: outpatient sessions v plan

Comments:

Theatres:
The planned savings for Theatres are £3.2m. This is to be achieved by driving significant 'in-session' efficiencies (cases per list), through the same no of lists that the Trust provided this time last year. Implementation started in March as planned with the financial impact from May.
Divisional teams were strengthened with additional delivery support from Four Eyes which has worked well and delivered the results as planned with May YTD delivering significant in-session productivity improvement of 10% or £458k against a plan of £140k. June results are still being validated and have not yet been recorded in Month 3. This is expected to catch-up next month. However, whilst in-session utilisation shows a marked improvement from the work the Trust has been doing with Four Eyes, the activity plan was not met due to the high level of 182 dropped sessions resulting in a loss in capacity of £291k. As a result, the net gain recognised is £167k (reduction in Independent Sector usage).
Recognising that a significant amount of the efficiency gain has been negated by the loss of capacity and the opportunity cost of dropped sessions, the Surgery Division has taken immediate corrective action an have implemented a 10-week recovery plan to make-up for the lost sessions and is confident of full recovery. Consequently, the theatres efficiency CIPs forecast for the year remains at full achievement of £3.2m.

Outpatients:
Identified savings are £1m based on cost reduction. The opportunity could be substantially higher if the increasing demand does not subside and the Trust able to claim additional income under PbR arrangements. For prudence, the £1m cost-out option has been included in the plans.
However, the Divisions are struggling to cope with the high activity being experienced and, as a result, have highlighted a significant risk to achieving the cost-out option. The financial impact is planned to start from July although there is risk of delay to this. If the activity levels remain at current levels the Trust should consider the alternative of including the income option to reflect operational reality.

East Kent Hospitals University NHS
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Strategic Theme: Improvement Journey

		Feb	Mar	Apr	May	Jun
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	80.01	79.26	84.03	82.68	85.38
MD03 - Maternity Capacity	Midwife:Birth Ratio (%)	29	31	29	28	25
MD06 - Pathway Flow	IP - Discharges Before Midday (%)	16	15	15	15	15
	DToCs (Average per Day)	62	71	78	62	62
MD07 - Medicines Management	Pharm: Fridges Locked (%)	83	90	92	94	94
	Pharm: Fridge Temps (%)	86	87	88	85	83
	Pharm: Drug Trolleys Locked (%)	99	100	98	100	100
	Pharm: Resus. Trolley Check (%)	94	91	85	88	88
	Pharm: Drug Cupboards Locked (%)	85	87	87	89	91
MD08 - Staffing Levels	Vacancy (%)	8.2	8.0	8.8	9.2	9.7
	Shifts Filled - Day (%)	90	88	97	101	98
	Shifts Filled - Night (%)	101	97	102	105	103
MD09 - Workforce Culture	Sickness (%)	3.8	3.8	3.9	3.8	4.0
	Appraisal Rate (%)	84.2	82.2	79.2	70.0	73.1
	Staff Turnover (%)	11.3	11.2	11.2	11.3	11.8
	Corporate Induction (%)	100	100	100	100	100
	Staff FFT - Work (%)	49	49	58	58	58
	Staff FFT - Treatment (%)	76	76	78	78	78
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	98	98	98	98
MD13 - Equipment	EME Planned Maintenance (%)	81	83			
MD17 - Incident Reporting	Clinical Incidents: Total (#)	1268	1347	1225	1306	1340
MD18 - Policies & Procedures	Policies in Date (%)	77				
MD19 - Major Incident Planning	Major Incident Training (%)	29	27	28		
MD22 - Agency Staffing	Unplanned Agency Expense	115	111	95	68	68
	Clinical Time Worked (%)	69	67	74	73	73
	Temp Staff (WTE)	218	216	196	205	202
	Employed vs Temporary Staff (%)	92.3	92.4	91.5	91.0	90.4
	Local Induction Compliance %			6.0	8.5	15.0
MD26 - Complaints Process	Complaint Response in Timescales %	68	82	54	84	94
MD30 - Medicines Management	Medicines Mgmt. Incidents	119	120	92	103	113

East Kent Hospitals University NHS
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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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 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 %
	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. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 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. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £5.2m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 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 arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %

Health & Safety	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %
	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	1	15 %
	Representation at H&S	% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 76	20 %
	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 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. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< = 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 & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 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; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 98	20 %

Incidents	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.	< 1	30 %
	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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 0.15	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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		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 %
	C. Diff Infections (Post 72h)	The number of Clostridium difficile cases recorded at greater than 72h post admission. Data source - VitalPAC (James Nash).	< 1	0 %
	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). Position in arrow shows YTD cumulative position and variance against previous month. Graph shows last 12 months, noting that C. Diff is reported as a cumulative YTD position, which explains the drop from 28 (as at March-16) down to 4 (new financial year at April-16).	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	< 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 %

Infection	E. Coli	The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 44	10 %
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	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, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 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	0 %
	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	0 %
	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	0 %
	Diabetes CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	0 %
	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	0 %
Mortality	Crude Mortality EL (per 1,000)	The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data together with variance against previous 12 months.	< 90	35 %

Mortality	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, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	< 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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.95	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? %	Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 98	4 %
	Care that matters to you? %	Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).	>= 98	4 %
	Cleanliness? %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 1	10 %
	FFT: Recommend (%)	Of those patients who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	30 %
	FFT: Response Rate (%)	The percentage of patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 15	1 %
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	Mixed Sex Breaches	Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	1	10 %
	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 %	Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 90	10 %
	Respect & Dignity? %	Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 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 %
	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 %

Productivity	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 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	< 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 Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).	<= 10	0 %
	Agency & Locum Spend	Total agency spend including NHSP spend		0 %
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
	Local Induction Compliance %	Local Induction Compliance rates (%) for new starters to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	0 %
	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 deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).	> 90	0 %
	Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 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 %

Staffing	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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 3.3	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. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 7.4	15 %
	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. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 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). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 10	15 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 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 %

Training	Mandatory Training (%)	The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
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. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	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 Annual Plan is £14.27m.	0	0 %
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	0	0 %
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	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. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	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	C. Diff Infections (Post 72h)	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 (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
KCH - Kent & Canterbury																
ACC - KCH A&E DEPARTMENT		3	3	0	0	2	0									
CATD - CATHEDRAL DAY UNIT		0	0	0	0	4	0									
CDU - CLINICAL DECISION UNIT		0	0	2	0	0	0									
HARV - HARVEY WARD	94.4	0	0	0	0	0	0				86	100	0.0		99	100
KHOM - KCH HOME WARD		0	0	0	0	0	0							0.0		
MFU - MAXILLO FACIAL		0	0	0	0	1	0									
Specialist																
DOLP - DOLPHIN WARD		0	0	0	0	1	0									
KBRA - BRABOURNE (KCH)	100.0	0	2	0	0	0	11				67	100	0.0		91	108
KRU - RENAL UNIT (KCH)		0	1	0	0	0	0									
MARL - MARLOWE WARD	100.0	4	2	1	0	0	50				36	100	0.0	92.3	108	98
Surgical																
CLKE - CLARKE WARD	100.0	2	0	1	0	2	155				41	99	0.7	92.7	82	100
DSSC - DAY SURGERY		0	0	0	0	2	0									
KENT - KENT WARD	85.7	3	2	0	0	0	74	96	96	99	85	99	0.0	100.5	102	96
KITU - KCH ITU	100.0	2	0	0	0	0	0							87.0	89	97
OPTH - OPHTHALMOLOGY SUITE		0	0	0	0	4	0									
Urgent Care																
HARB - HARBLEDOWN WARD	95.0	5	9	0	0	1	0	94	90	95	64	95	0.0	74.2	95	109
INV - INVICTA WARD	100.0	2	3	0	0	0	34	90	69	83	46	100	0.0	94.6	97	104
KCDU - EMERGENCY CARE CENTRE	100.0	0	0	0	0	2	5	92	86	97	19	93	3.2	114.4		
KING - KINGSTON WARD	100.0	0	5	0	0	3	0	91	90	94	42	97	0.0	103.6	95	101
KNRU - EAST KENT NEURO REHAB UNIT		0	1	0	0	0	0							94.7		
MTMC - MOUNT/MCMASTER WARD	95.0	0	6	0	0	1	2	81	74	80	22	100	0.0	87.4	102	127
TAY - TAYLOR WARD	100.0	0	2	2	0	0	0	100	95	100		100	0.0	74.4	69	100
TREB - TREBLE WARD	100.0	0	4	0	0	0	1	97	94	99	74	98	0.0	90.0	89	126
QEH - Queen Elizabeth Queen Mother																

Apdx.

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	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 (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
DL - DISCHARGE LOUNGE QEH		0	0	0	0	1	0									
EPU - EARLY PREGNANCY UNIT		0	0	0	0	1	0									
QHOM - QEH HOME WARD	100.0	0	0	0	0	0	0							0.0		
SBU - SEABATHING UNIT		0	3	0	0	3	0									
Specialist																
BIR - BIRCHINGTON WARD	100.0	1	1	0	0	1	155				49	98	0.0	101.8	115	98
KIN - KINGSGATE WARD	100.0	0	0	0	0	0	53							96.5	80	82
QRU - RENAL UNIT (QEH)		0	1	0	0	0	0									
QSCB - QEH SPECIAL CARE BABY UNIT	100.0	0	0	0	0	0	0							98.1	94	100
RAI - RAINBOW WARD	100.0	0	0	0	0	0	0				27	100	0.0	92.7	89	98
STP - ST PETER'S MLU		0	0	0	0	0	0								94	122
VDM - VIKING DAY UNIT		0	0	0	0	1	0									
Surgical																
BIS - BISHOPSTONE WARD	95.5	1	1	0	0	0	0	95	65	80	91	97	3.3	91.9	93	102
CSF - CHEERFUL SPARROWS FEMALE	96.0	0	5	0	0	2	0	93	94	97	54	97	0.0	61.1	105	139
CSM - CHEERFUL SPARROWS MALE	100.0	2	2	0	0	1	0	91	92	93	33	86	0.0	78.6	120	140
DSU - DAY SURGERY UNIT QEH		0	0	0	0	1	0									
QITU - QEH ITU	100.0	2	0	0	0	0	27							98.8	81	93
QX - QUEX WARD	100.0	0	1	0	0	1	1	97	93	99	112	100	0.0	86.6	89	98
SB - SEA BATHING WARD	100.0	0	0	0	0	0	1	95	94	96	59	98	0.0	90.4		
Urgent Care																
DEAL - DEAL WARD	96.2	1	12	1	1	2	18	100	99	99	46	97	3.2	81.5	94	104
FRD - FORDWICH WARD STROKE UNIT	100.0	0	5	0	0	0	0	100	100	100	48	100	0.0	82.4	103	102
MW - MINSTER WARD	100.0	1	5	1	0	2	0				98	100	0.0	84.0	101	99
QAE - QEH A&E DEPARTMENT		14	0	0	0	11	0									
QCCU - QEH CCU	100.0	0	0	0	0	0	0	100	98	100	70	100	0.0	94.1	83	99
QCDU - QEH CDU	96.6	7	7	0	0	3	64				19	89	10.8	85.1		
QEND - ENDOSCOPY (QEQM)		0	0	0	0	1	0									
SAN - SANDWICH BAY WARD	95.2	1	2	0	0	1	95	100	95	97	73	100	0.0	78.7	127	154
SAU - ST AUGUSTINES, THE REHAB. WARD	95.2	0	11	0	0	1	0	100	100	100	31	100	0.0	62.0		
STM - ST MARGARETS WARD	100.0	1	6	1	1	0	0	80	83	98	41	93	7.1	95.0	108	107

WHH - William Harvey	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	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 (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
SEAU - SURGICAL EMERGENCY ASSESS WHH		0	0	0	0	0	0				186	98	0.6			
WCDU - ***** DO NOT USE *****	100.0	0	0	0	0	0	27									
WHOM - WHH HOME WARD	100.0	0	0	0	0	0	0							225.6		
WWPW - WHH WINTER PRESSURE WARD		0	3	0	0	0	0									
Specialist																
FF - FOLKESTONE	100.0	0	0	0	0	1	3								108	93
KEN - KENNINGTON WARD	100.0	0	0	0	0	0	2				60	97	0.0	91.0	97	67
PAD - PADUA	100.0	0	2	0	0	0	0				37	100	0.0		94	94
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	30								92	102
SING - SINGLETON MLU		0	0	0	0	1	0								101	90
Surgical																
DSC - DAY SURGERY CENTRE		0	0	0	0	2	0									
ITU - WHH ITU	100.0	2	0	0	1	1	6							89.0	121	107
KA2 - KINGS A2	100.0	0	1	0	0	2	76	90	92	94	90	95	1.1	94.8	106	100
KB - KINGS B	100.0	1	3	0	0	0	84	81	82	95	82	100	0.0	95.6	100	140
KC - KINGS C1	100.0	3	1	0	0	4	94	98	93	94	66	95	5.1	88.9	108	102
KC2 - KINGS C2	100.0	0	3	0	0	3	1	93	90	100	93	99	0.5	93.6	95	99
KDF - KINGS D FEMALE	100.0	0	0	0	0	1	1	100	96	97	88	95	0.0	93.3		
KDM - KINGS D MALE	100.0	0	2	0	0	1	158	88	96	99	45	97	0.0		104	103
RW - ROTARY WARD	100.0	0	1	0	0	0	49	97	95	99	55	100	0.0	94.6	110	100
SURA - SURGICAL ADMISSIONS		0	0	0	0	1	0									
Urgent Care																
CCU - CCU	62.5	1	0	0	0	0	30				84	98	2.0	85.9	89	92
CJ2 - CAMBRIDGE J2	100.0	1	4	0	0	1	0	100	100	98	17	93	7.1	84.5	109	108
CK - CAMBRIDGE K	96.3	2	1	0	0	0	0	96	79	98	67	100	0.0	95.7	106	104
CL - CAMBRIDGE L REHABILITATION	100.0	1	12	0	0	1	4	58	69	72	48	100	0.0	89.7	94	132
CM1 - CAMBRIDGE M1 SHORT STAY		0	10	0	0	2	0				37	100	0.0			
CM2 - CAMBRIDGE M2	100.0	1	4	1	0	0	50	96	94	95	81	100	0.0	97.6	104	97
EKCC - EK CARDIAC CATHETER SUITE		0	0	1	0	0	0									

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	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 (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
OXF - OXFORD	100.0	2	3	0	0	0	0				63	100	0.0		100	100
RST1 - RICHARD STEVENS 1 STROKE UNIT	95.7	3	5	0	0	0	6				18	100	0.0	92.3	96	93
WACU - AMBULATORY CARE UNIT		0	1	0	0	1	0									
WAE - WHH A&E DEPARTMENT		32	3	0	0	10	0									
WCDM - WHH CDU MIXED		11	12	0	0	2	0	88	85	96	29	90	7.8			
WEND - ENDOSCOPY (WHH)		0	0	0	0	2	0									

East Kent Hospitals University NHS
NHS Foundation Trust

Human Resources Heatmap

	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term	Kent Pathology Partnership
Agency %	5.5	0.1	5.6	2.1	10.3	2.2	21.1	39.4	
Appraisal Rate (%)	85.5	86.6	68.3	41.0	71.3	51.7	75.5	66.5	
Employed vs Temporary Staff (%)	88.6	87.5	88.1	93.5	93.0	91.5	92.6	87.7	
Mandatory Training (%)	91	92	87	77	83	89	84	88	
NHSP Use % of Agency	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
Sickness (%)	4.0	2.8	2.3	3.6	4.8	3.5	3.9	3.8	
Stability Index (excl JDs) %	86	84	87	86	90	90	90	88	100
Stability Index (incl JDs) %	84	85	87	86	85	89	83	83	100
Staff Turnover (%)	13.3	13.6	16.5	15.2	9.8	9.7	10.1	13.3	0.0
Vacancy (%)	11.4	12.5	14.7	7.8	7.4	8.5	7.6	11.5	

Apdx.