MAY 2017

INTEGRATED PERFORMANCE REPORT

Chief Executive's Summary

I am pleased to report that we have made further improvements in our 'caring' domain, demonstrated by the inpatient latest friends and family test results which reported the percentage of patients not recommending the Trust at the lowest level of dissatisfaction since January 2017. In general, overall inpatient experience improved in May compared to the previous month with 5 out of 6 metrics we measure reporting as 'green'. Our focused work continues in improving patient experience in our Emergency Departments. Challenges remain around our complaints response time and focussed work continues with our Divisions to bring this back in line.

Referral to treatment (18 weeks) has improved by 1%. This is positive particularly as the Trust has seen an increase in referrals and additions to our admitted waiting list in recent months. However, whilst performance has improved, we have seen an increase in the number of 52 week patients within general surgery and gynaecology.

Cancer 2 week wait performance continues to report a compliant position and I am pleased to report that Breast symptomatic is back to a compliant position. Cancer 62 day performance remains a challenge in particular specialties and, as reported last month, we aim to achieve compliance by September 2017.

We have not seen an improvement in our A&E 4 hour performance and the latest position as at May 2017 reported 76.78%. The key driver for this continues to be staffing issues across our emergency departments. Transformation work as part of the Time to Make a Difference programme is underway including changes to the flow within the departments at Ashford and Margate and work in the rest of the hospital on patient flow. Performance continues to be closely monitored, particularly in light of the temporary move of junior doctors from the Kent and Canterbury hospital site in June 2017.

Harm free care (new harms which we can influence) continues to report higher than the national average reporting at 98.4%. This is a positive position showing we continue to perform better than the national average and demonstrates the progress being made by staff across the organisation.

As reported last month, infection control is an area of increased focus as this is a key area of patient safety. Our infection prevention and control team is now to full establishment and site based teams are in place. The focus of the teams will be to implement actions identified in the Trust's Infection Prevention and Control Action Plan to improve the overall Trust performance.

There has been one infection control incident which was more correctly a period of increased incidence of culture of Vancomycin resistant enterococcus (VRE) on our renal ward. Subsequent screening determined that, although 3 further patients were identified as positive, there had been no cross transmission between these patients.

Whilst the rate of falls within the Trust remains lower than the national average, inpatient falls remain a challenge in our hospitals and for the NHS as a whole. As reported last month, the Falls Team continue to work hard to implement the "Fallstop" programme. This audit data will be used to benchmark our wards.

I am disappointed to report that a 'stop before you block' never event occurred within our Trust at the QEQM operating theatre. A full root cause analysis will be undertaken to take forward lessons learned and further information will be reported in our next report.

Performance around Category 2 pressure ulcers compares well with other Trusts but we continue to strive for improved performance. One category 3 pressure ulcer were reported in May 2017.

The Trust's Income and Expenditure (I&E) deficit in May (month 2) was £2.02m (consolidated position excluding Sustainability and Transformation Funds and after technical adjustment) against a plan of £3.03m.

The year to date I&E deficit is £5.51m against a plan of £6.67m (£1.16m ahead of plan). A reconciliation of the various adjustments is presented below.

The reported position is marginally worse than that initially reported owing to EKMS/Spencer Wing reporting a deficit of £86k year to date against a plan of a £28k surplus. This issue is being investigated.

Pay costs in the month of £28.5m saw a continued reduction in agency/locum costs from £1.9m to £1.5m but a £0.3m increase in bank costs. Further work is being undertaken to ensure that the bank pay rates are correct and that NHSP is billing correctly. Waiting list payments continued to be depressed at £0.1m against the average monthly spend of £0.34m in 2016/17. Pay is now £1.3m ahead of plan year to date.

Activity/income was on plan in month with total income £2.1m higher than in April. Income is now £0.7m behind plan year to date.

Against the £32m CIPS target, including income, £1.75m was reported in month (£1.2m recurrent, £0.4m non-recurrent) against a target of £1.46m. Year to date £3.36m is reported against a plan of £2.83m. Of the reported position, £0.5m is non recurrent and steps are being taken to ensure that this is made up recurrently.

The cash balance as at the end of May was £12.9m. No new borrowings were required.

No agreement on the 2016/17 contract value outturn or CQUIN has yet been reached with East Kent CCG commissioners. A proposal has been forwarded and we await a response. Total risks net of opportunities of £8.5m have been identified.

The Trust's Financial Recovery Plan has been received and accepted by NHSI. This is for an £18.9m deficit target (excluding Sustainability and Transformation Funds). The second review meeting took place on 2 June and was a constructive and positive discussion. Our next review meeting is scheduled for early July 2017.

Work continues on improving the workforce metrics in this report and this will continue in June and July to reflect the work undertaken to support the oversight of the cost improvement programmes and delivery of the financial turnaround plan.

The turnover rate has remained relatively steady and is at 12.9% for the year to May 2017. The vacancy rate increased marginally from 11.4% to 11.6%. Continued action is being taken for roles which have been identified as hard to recruit either because of repeated difficulty in recruiting to EKHUFT posts or because of shortages in labour supply nationally, including working with suppliers of the Resident Medical Officer (RMO) model in some specialities.

Sickness absence decreased slightly in April 2017 (the most recent data available) from March's position (2017) to 3.6%. It is predicted to remain at 3.6% for May 2017.

The proportion of temporary staff engaged by the Trust increased in April and May (this despite the fact the wte temporary staff used in month reduced). This has largely resulted from an increased supply of bank staff in the reporting period as well as declining numbers of substantive staff. Wte staff in post has declined from a highest position of 7,000 to 6,913 in May, evidence of the impact of the vacancy control process and cost improvement programmes in place across the organisation. Percentage agency supply showed a marginal increase.

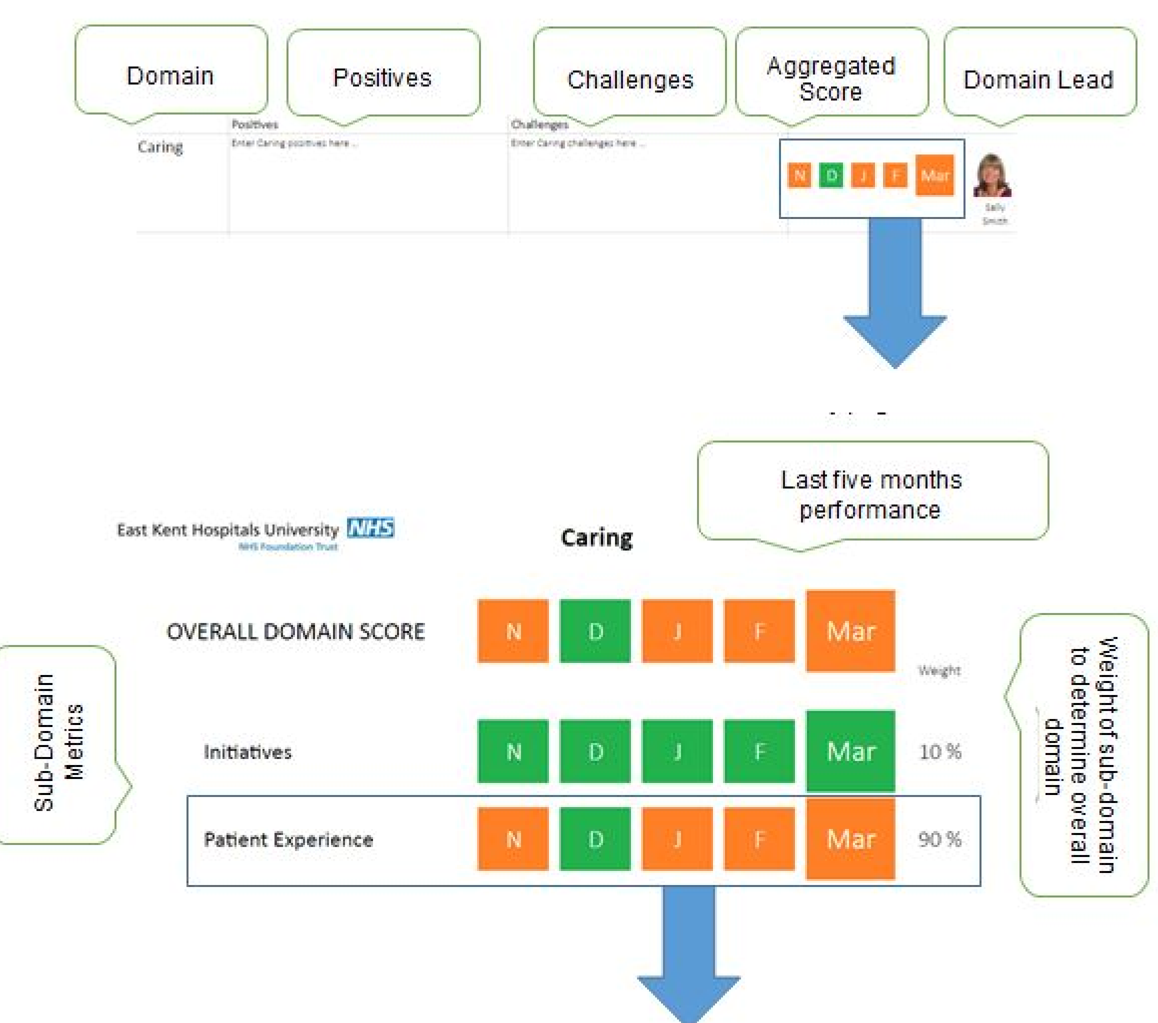
Local induction compliance continues to be an area of concern and focus for the executive team. Statutory training compliance remained steady at 89%. This remains above the target of 85%. The Trust staff appraisal rate decreased to 81.1%, below the 90% target. Divisions are working on plans to complete appraisals due in (traditionally high volumes are due in April/May) to avoid a further drop in appraisal rates.

Time to recruit has decreased in the last two months and it is hoped that this will be further supported by the recruitment process mapping plans in place for implementation by the end of June 2017.

Understanding the IPR

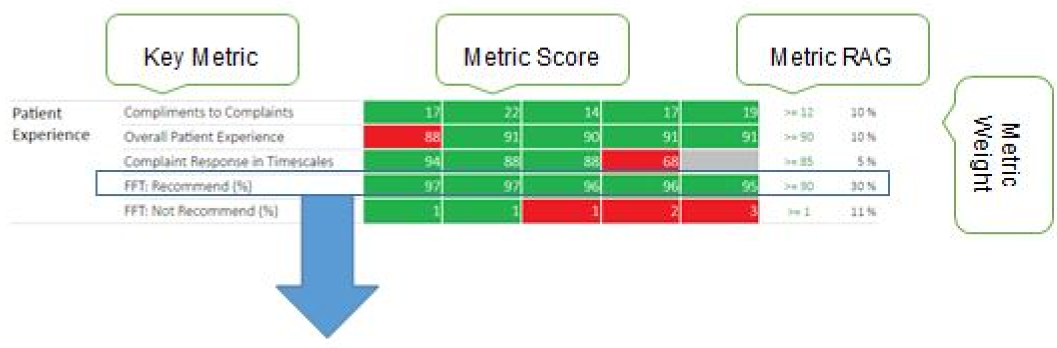
1 **Headlines**: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that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

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

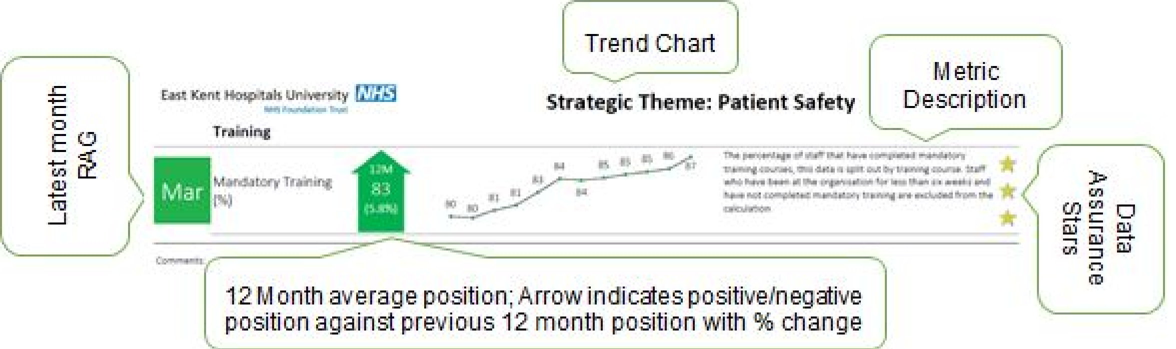


Understanding the IPR

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



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



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

Strategic Priorities

Our vision:
Great healthcare from great people

Our mission:
Together we care: improving health and lives

Our values:
People feel cared for, safe, respected and confident we are making a difference

Our strategic priorities:
Patients, people, provision and partnerships

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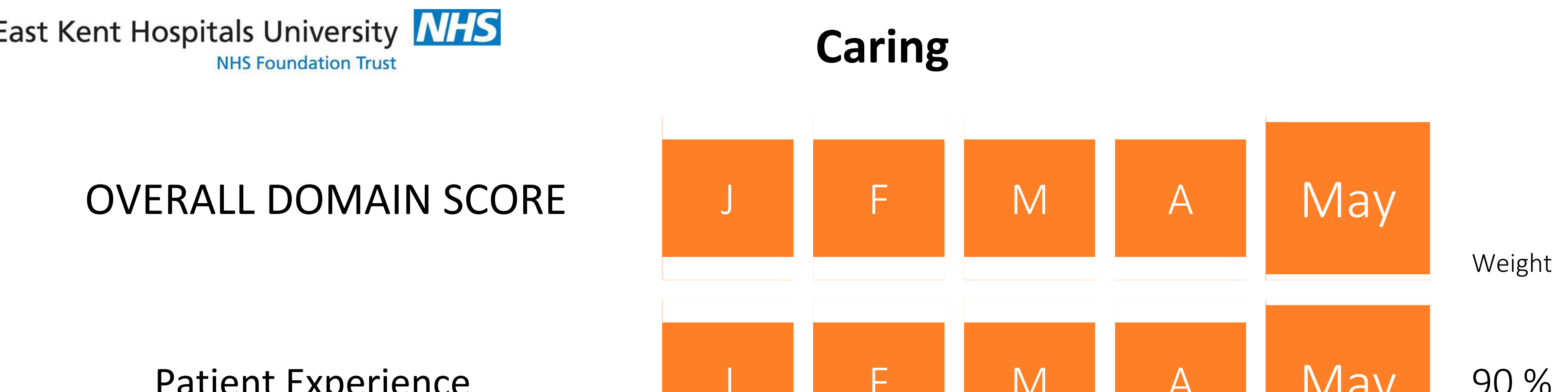
Headlines

	Positives	Challenges	
Caring	Friends and Family Test for inpatients improved in May The percentage of patients not recommending the Trust reduced and is registering the lowest level of dissatisfaction since January 17 Overall patient experience as recorded by the real-time survey improved compared to last month with 5 out of the 6 metrics recorded as green Satisfaction with cleanliness is showing an improvement compared to last month We met our complaints standard during May of responding within the timescale agreed with the client The complaints:compliments ratio is registering green in May We have reported a reduction in mixed sex accommodation occurrences compared to April	We are still reporting mixed sex breaches in our Clinical Decision Units Our complaint responses within 30 working days is still registering red. PALS backlog and vacancy within the teams has been a challenge during May	J F M A May Sally Smith
Effective	Theatre utilisation has improved and the non-clinical cancellations has remained stable.	Bed Occupancy has increased slightly in May due in part to a significant increase in reportable delayed transfers of care which in turn has caused an increase in the average length of stay.	J F M A May Jane Ely
Responsive	Cancer 2 week wait performance has remained compliant and Breast symptomatic is also back to compliance . Diagnostic performance has remained high and complaint. Referral to Treatment (18 weeks) performance has improved by 1% even with an increase in referrals and additions to the admitted waiting list.	A&E 4 hour performance has not improved in May at 76.78%. The main continues to be the challenge to provide sufficient doctors 24 hours a day in our two Emergency departments. Cancer 62 day performance is still a challenge in a number of tumour sites - colorectal, lung, gynaecology and head and neck. Focussed work is on going and improvement will be demonstrated in June. Referral to Treatment (18 weeks) - whilst the performance has improved as predicted, the number of patients treated over 52 weeks has increased largely in general surgery and gynaecology.	J F M A May Jane Ely

Safe	Harm free care (New harms, that we can influence) remains better than the national average. The infection prevention and control team is virtually back to establishment Mortality data remains positive Clinical incident reporting has increased this month compared to last month. We see this as a positive indication of a culture of openness and transparency with regard to safety and quality	VTE risk assessment recording remains sub-standard Although our falls rate compares well with others it is not as good as we require it to be Similarly the pressure ulcer Cat 2 rate compares well but is higher than we are aiming for We reported a Cat 3 deep ulcer during May A stop before you block never event occurred in the QEQMH operating theatre despite work done previously with the anaesthetic teams to prevent this from happening. This will be reported in next month's IPR	J F M A May	Paul Stevens
Well Led	I&E £1.1m ahead of plan at month 2 Reducing agency spend (£1.5m in month, £0.4m below April) Sickness rates stable (3.6%) Cash balance as at 31 March on plan £12.9m) Nursing shifts filled	Vacancies increasing in month (11.6% from 11.4%) Turnover stable (12.9%) Appraisal rate reducing (81.1% from 84.9%) Bank spend £0.3m higher than April High number of medical staff vacancies Local induction low (20.8%)	J F M A May	Matthew Kershaw


East Kent Hospitals University
NHS
NHS Foundation Trust
Caring
OVERALL DOMAIN SCORE
J
F
M
A
May
Weight
Patient Experience
J
F
M
A
May
90 %

Caring

		Jan	Feb	Mar	Apr	May	Green	Weight
Patient Experience	Compliments to Complaints (#/1)	21	38	20	40	31	>= 12	10 %
	Mixed Sex Breaches	57	6	17	10	7	< 1	10 %
	Overall Patient Experience %	91	91	92	92	92	>= 90	10 %
	Complaint Response in Timescales %	94	79	84	86	86	>= 85	5 %
	FFT: Recommend (%)	96	95	95	96	97	>= 90	30 %
	FFT: Not Recommend (%)	2.9	2.7	2.4	1.8	1.4	>= 1	10 %

Effective

						Weight
OVERALL DOMAIN SCORE	J	F	M	A	May	
Beds	J	F	M	A	May	25 %
Clinical Outcomes	J	F	M	A	May	25 %
Productivity	J	F	M	A	May	25 %

Effective

		Jan	Feb	Mar	Apr	May	Green	Weight
Beds	Bed Occupancy (%)	106	104	101	97	99	<= 90	60 %
	IP - Discharges Before Midday (%)	14	15	14	15	15	>= 35	10 %
	DToCs (Average per Day)	59	56	59	49	62	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3.4	3.4	3.4	3.3	3.4	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	16.3	16.2	16.1	16.0	15.9	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	99	99	100	100	100	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	7.4	6.5	6.7	6.7	6.8	< 7	
	DNA Rate: Fup %	7.2	6.1	5.7	6.4	6.2	< 7	
	New:FUp Ratio (1:#)	0.7	0.7	0.7	0.6	0.6		
Productivity	LoS: Elective (Days)	3.1	2.7	2.9	3.3	3.0		
	LoS: Non-Elective (Days)	6.2	6.6	6.2	6.1	6.7		
	Theatres: Session Utilisation (%)	80	81	81	78	82	>= 85	25 %
	Theatres: On Time Start (% 30min)	74	78	80	80	77	>= 90	10 %
	Non-Clinical Cancellations (%)	2.7	1.6	1.7	1.2	1.4	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	7	9	6	0	0	< 5	10 %
	EME PPE Compliance %	75	73	76	76	75	>= 90	20 %

Responsive

						Weight
OVERALL DOMAIN SCORE	J	F	M	A	May	
A&E	J	F	M	A	May	25 %
Cancer	J	F	M	A	May	25 %
Diagnostics	J	F	M	A	May	25 %
RTT	J	F	M	A	May	25 %

Responsive

		Jan	Feb	Mar	Apr	May	Green	Weight
A&E	ED - 4hr Compliance (%)	70.83	76.00	80.17	76.93	76.78	>= 95	100 %
Cancer	Cancer: 2ww (All) %	95.82	96.08	97.41	93.59	96.00	>= 93	10 %
	Cancer: 2ww (Breast) %	97.27	94.81	93.57	90.91	93.57	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	93.63	96.96	97.42	95.68	95.25	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	82.22	94.12	90.24	89.29	91.84	>= 94	5 %
	Cancer: 31d (Drug) %	96.94	95.77	97.50	97.06	97.62	>= 98	5 %
	Cancer: 62d (GP Ref) %	60.61	70.45	77.30	72.40	69.83	>= 85	50 %
	Cancer: 62d (Screening Ref) %	91.67	76.47	89.23	92.00	89.47	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	75.68	92.59	69.77	66.67	74.36	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.65	99.67	99.78	99.06	99.36	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	99.67	100.00	>= 99	
RTT	RTT: Incompletes (%)	83.79	84.35	85.40	84.85	85.82	>= 92	100 %
	RTT: 52 Week Waits (Number)	18	24	28	29	36	< 1	

Safe

						Weight
OVERALL DOMAIN SCORE	J	F	M	A	May	
Incidents	J	F	M	A	May	20 %
Infection	J	F	M	A	May	20 %
Mortality	J	F	M	A	May	50 %
Observations	J	F	M	A	May	10 %

Safe

		Jan	Feb	Mar	Apr	May	Green	Weight
Incidents	Serious Incidents (STEIS)	10	6	9	5	6		
	Harm Free Care: New Harms (%)	99.0	99.1	99.0	99.2	98.5	>= 98	20 %
	Falls (per 1,000 bed days)	5.58	5.51	5.07	5.13	5.29	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.54	0.41	0.30	0.38	0.30	<= 0.15	10 %
	Clinical Incidents: Total (#)	1,538	1,333	1,387	1,251	1,324		
Infection	Cases of C.Diff (Cumulative)	40	45	53	5	8	<= Traj	40 %
	Cases of MRSA (per month)	2	2	2	1	0	< 1	40 %
Mortality	HSMR (Index)	105	83	81			< 90	35 %
	Crude Mortality EL (per 1,000)	0.6	0.5	0.1	0.5	0.3	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	46	34	30	31	35	< 27.1	10 %
	RAMI (Index)	93	91	89			< 87.45	30 %
Observations	Cannula: Daily Check (%)	73.5	75.4	77.2	76.3	77.5	>= 50	10 %
	Catheter: Daily Check (%)	46.6	49.3	49.4	46.9	47.7	>= 50	10 %
	Central Line: Daily Check (%)	68.7	65.4	68.0	67.8	68.5	>= 50	10 %
	VTE: Risk Assessment %	91	91	90	89	89	>= 95	20 %
	Obs. On Time - 8pm-8am (%)	92	92	92	92	92	>= 90	25 %
	Obs. On Time - 8am-8pm (%)	90	90	90	90	90	>= 90	25 %

Well Led

						Weight
OVERALL DOMAIN SCORE	J	F	M	A	May	
Culture	J	F	M	A	May	15 %
Data Quality & Assurance	J	F	M	A	May	10 %
Finance	J	F	M	A	May	25 %
Health & Safety	J	F	M	A	May	10 %
Staffing	J	F	M	A	May	25 %
Training	J	F	M	A	May	15 %

Well Led

		Jan	Feb	Mar	Apr	May	Green	Weight
Culture	Staff FFT - Treatment (%)	76	76	76	76	76	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	0.3	0.6	0.5	1.0	1.5	< 4	25 %
	Valid NHS Number %	100	100	100	100	100	>= 99.5	40 %
	Uncoded Spells %	0.0	0.0	0.0	0.1	0.2	< 0.25	25 %
Finance	I&E £m	-2.9	-3.3	-8.7	-2.8	-1.8	>= Plan	30 %
	Cash Balance £m	9.9	8.2	5.1	8.9	13.0	>= Plan	20 %
	Total Cost £m	-48.7	-46.8	-55.3	-47.3	-48.4	>= Plan	20 %
	Forecast I&E £m	-26.7	-27.7	-31.4	-19.0	-19.0	>= Plan	20 %
	Normalised Forecast £m	-30.7	-31.8	-30.7	-19.0	-19.0	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	3	1	1	0	0	<= 3	20 %
	Formal Notices	0	0	0	0	0	< 1	15 %
Staffing	Sickness (%)	4.1	4.1	4.1	3.6	3.6	< 3.6	10 %
	Staff Turnover (%)	12.5	12.6	12.7	12.9	12.9	<= 10	15 %
	Vacancy (%)	9.6	9.4	9.8	11.4	11.6	<= 7	15 %
	Total Staff In Post (SiP)	6995	6989	6967	6921	6913		1 %
	Temp Staff (WTE)	222	265	260	234	226	< 182	1 %
	Shifts Filled - Day (%)	103	100	100	101	99	>= 80	15 %
	Shifts Filled - Night (%)	117	111	111	110	106	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	11	11	11	10	10		
	Local Induction Compliance %	12.5	15.0	21.8	16.3	20.8	>= 85	
	Agency %	21.5	19.2	21.9	18.5	18.9	<= 10	
Training	Appraisal Rate (%)	82.2	83.6	84.6	84.9	81.1	>= 90	50 %
	Statutory Training (%)	88	88	89	89	89	>= 85	50 %

Mortality

Month	Measure	Value (variance)	Description
May	HSMR (Index)	88 (4.6%)	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.
May	RAMI (Index)	89 (-3.0%)	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.
May	Crude Mortality EL (per 1,000)	0.4 (0.1%)	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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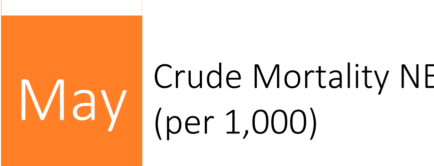
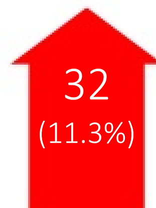
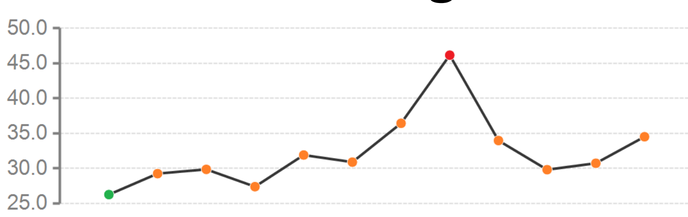
Strategic Theme: Patient Safety



May

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.

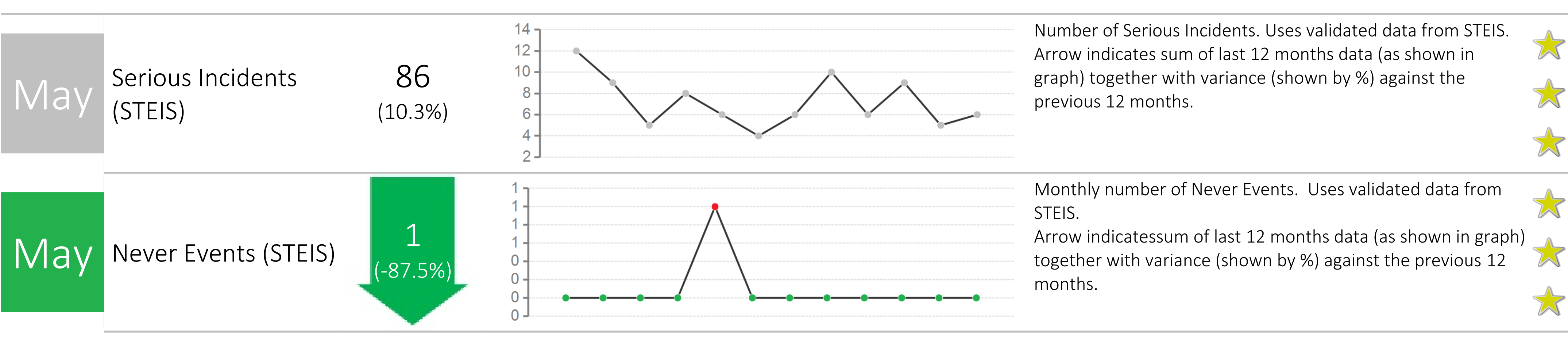
Comments: The top ten diagnostic risk categories derived from SHMI data (remember SHMI considers deaths in hospital and deaths occurring within 30 days of discharge) are:

Septicaemia (except in labour)
Acute myocardial infarction
Cancer of bronchus, lung
Other gastrointestinal disorders
Congestive heart failure; nonhypertensive
Cancer of pancreas
Biliary tract disease
Cancer of stomach
Acute cerebrovascular disease
Hodgkin's disease, Non-Hodgkin's lymphoma

These diagnostic categories will form part of the structured case note review process as it develops in order to establish whether or not there are potentially preventable aspects to deaths in these diagnostic codes and thus whether there is any learning.

Strategic Theme: Patient Safety

Serious Incidents



Comments:

Total open SIs on STEIS May 2017: 69 (including 6 new)
SIs under investigation: 41
Breaches: 19
Non-breaches: 19

SIs awaiting closure: 29
Waiting CCG response: 10
Waiting EKHUFT non-closure response: 19

Supporting Narrative:
The number of breached cases is 19. Breaches are mainly due to the quality of analysis. This is being managed by the Root Cause Analysis Group and at the Executive Performance Reviews each month.

Work continues on clearing the longest breached cases and further progress is predicted. The Clinical Incident Manager and Head of Patient Safety have been working with the divisions to progress these cases and are now attending many of the RCA meetings, and supporting the writing of the investigations.

The six new SIs related to:

- one treatment delay relating to ophthalmology (wet macular degeneration)
- two diagnostic delays relating to an ED patient who had suffered paralysis and a delayed skin cancer diagnosis
- one surgical procedure relating to an amputated tip of finger
- one apparent/actual/suspected self-inflicted harm relating to a patient who was hit by a train following discharge from ED
- one environmental incident relating to a patient who was injured by lockers.

Strategic Theme: Patient Safety

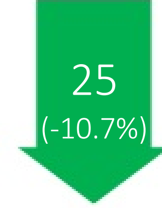
Infection Control

Month	Measure	Value (variance)	Description
May	Cases of MRSA (per month)	9 (200.0%)	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.
May	Cases of C.Diff (Cumulative)	8 (60.0%)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month.
May	E. Coli	94 (22.1%)	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.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

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.

Comments: The infection prevent and control team has now been almost rebuilt and there are once again site based teams who can begin to implement the actions identified in the IPC action plan to improve the overall Trust performance in this key area of patient safety.

Particular problems that were identified in root cause analysis of MRSA bacteraemias include:

1. Hand hygiene audits below acceptable thresholds (66% and 58%)
2. Failure to insert and complete VIP Scores and Catheter Care Records on Vital Pac
3. Access to Vital Pac for Agency staff
4. Blood Culture eLearning not completed by Trust Grade SHO, Locum and Nursing staff as unable to access the on line training.
5. Wider support needed for EU nurses differences in culture, experience and training results in difficulties in implementing IP&C policy.
6. Infection Control Status not added to discharge documentation – District Nurse/EDN

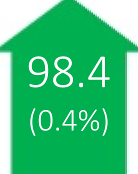
Those relating to C.diff infection include:

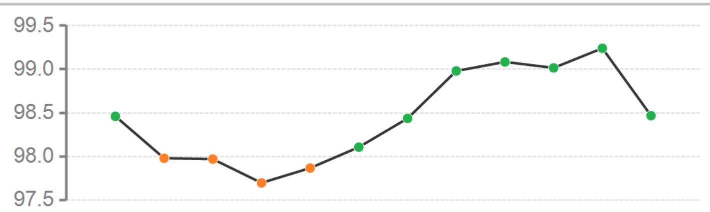
1. Compliance with the Diarrhoea Assessment Tool
2. Compliance around Hand Hygiene
3. Compliance around environmental cleaning
4. Compliance around antibiotics and antimicrobial prescribing
5. Poor communication

There has been one infection control incident which was more correctly a period of increased incidence of culture of Vancomycin resistant enterococcus (VRE) on the renal ward. Patients with severe kidney disease have an increased rate of VRE colonisation and previous VRE colonisation information is used to isolate known VRE patients. In mid-May a new VRE patient was identified by the IPC team who had been an inpatient since late April. Patients identified to have been in contact with this digital patient were screened and 3/14 patient contact screened were positive. 3 other patients were VRE positive but had previous VRE colonisation history. Further analysis of 4 VRE cultures were undertaken to see if these 4 organisms were different strains and comparison by pulsed-field gel electrophoresis has shown them to be 4 distinct strains. This suggests that cross transmission between patients did not occur.

Strategic Theme: Patient Safety

Harm Free Care

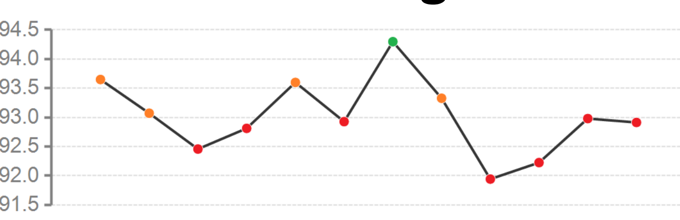




Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.

Strategic Theme: Patient Safety

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.

Comments:

Overall Harm Free Care (HFC) relates to the Harms patients are admitted with as well as those they acquire in our care. HFC in May-17 was 92.91% compared to 92.98% in April and is slightly below both the overall national average of 94.2% and the acute hospitals only national average 94.26%. A wide variation, as expected, is seen across the divisions with specialist achieving 97.32%, surgical 94.18% and UCLTC 90.82%. All harms were 7.09% compared to national average of 5.8% which indicates that our patients are admitted with a higher level of harm than the national average.

However, Harm Free Care experienced in our care (New Harms only) at 98.47% in May is higher than national average which means that our patients are receiving care that causes less harm than is reported nationally.

WHH New Harms Only HFC fell slightly to 99.13% in May compared to 99.78% in April.
QEQM New Harms Only HFC fell slightly to 98.01% in May compared to 98.45% in April.
K&C New Harms Only HFC also fell to 97.84% from 99.53% in April.

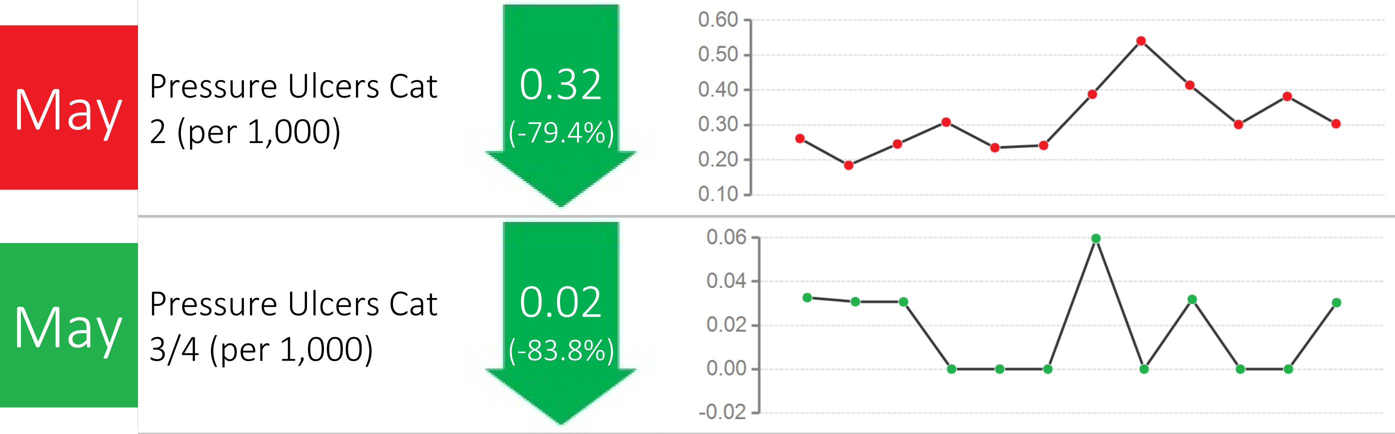
HFC (new harms only) for individual harms are lower than the national average for acute hospitals for 3 out of the 4 harms measured. The Safety Thermometer for May-17 demonstrates:

- Higher levels of catheters & New UTIs (0.57%) compared to the acute hospital average (0.32%)
- Lower levels of New Pressure Ulcers (0.38%) compared to the acute hospitals average (0.74%)
- Slightly lower prevalence of falls with harm (0.29%) than the acute hospital average (0.37%)
- Lower prevalence of new VTEs (0.29%) compared to the acute hospital national average (0.62%)

Rigorous work will continue to ensure validation is carried out correctly and focus work continues to be carried out to reduce the number of falls to ensure patient safety.
Notably, HFC (all harms) shows a higher than national level of patients being admitted who have already started treatment for UTI or a UTI was already present on admission 1.34% compared to the national average of 0.92% for acute hospitals. A review of old harms (patients admitted with) during Q1 will be undertaken to identify any trends and drive improvement work with our partners.

Strategic Theme: Patient Safety

Pressure Damage



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.

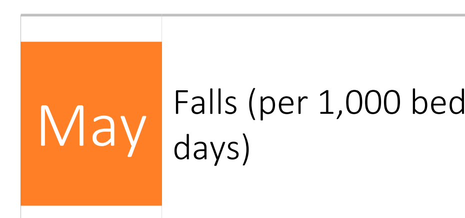
Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days
Data source - Datix.
Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

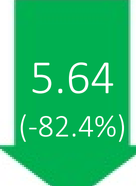
Comments:

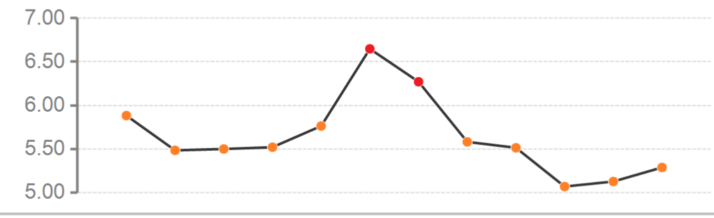
In May 2017 a total of 34 category two pressure ulcers were reported. This is equal to last month. Of these incidents, 10 were confirmed as avoidable, a decrease of 2. All affected the sacrum/buttock area. Four of these were at WHH (ED X2 AND CL X2), learning points include; delay of equipment; and prolonged periods on an ED trolley. The other 6 occurred at QEQM (ED, Fordwich, Seabathing ,Birchington and x 2 Bishopstone), learning points around trolley time in ED, repositioning evidence and skin inspection have been highlighted.
In May 2017, there was 1 confirmed category 3 pressure ulcer (Marlowe ward K&C) deemed avoidable due to lack of evidenced skin inspection under a splint. There were 18 potential deep ulcers, an increase of 12 from last month. Five were confirmed as avoidable, 1 at K&C (Kingston ward) affecting the sacrum due to delay in airwave and lack of SKINS bundles. The remaining 4 were at WHH. Two occurred in Theatres due to an unnecessary prolonged time on a hard surface (sacrum) and a splint (right leg). The remaining 2 incidents affected the heel. (CL) due to lack of heel offloading and (KC1) as the heel protection protocol was not followed. Inappropriate risk assessment was identified for both incidents.
During May 2017, a Trust-wide tissue viability link nurse study was held. The focus was on reducing avoidable category 2 pressure ulcers, including completion of risk assessment paperwork. Work has been carried out with the ED departments and information is planned to be added to the beautiful information board to allow pressure ulcer risk to be identified and actions implemented earlier. The TV team has continued to work with front line teams to identify, address and raise awareness of learning from adverse incidents. Bespoke training is being provided to the trauma floor at QEQM to address repeated themes identified in avoidable pressure ulcers.
In order to improve communication channels with our community colleagues a representative has been invited to attend the next pressure ulcer steering group.

Strategic Theme: Patient Safety

Falls







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

Comments:

While the rate of falls within the Trust remains lower than the national average, inpatient falls remain a great challenge in our hospitals and for the NHS.

The number of falls per 1000 bed days has increased slightly in May compared with April , but this still represents a decrease compared with the end of year 2016 / beginning of the year 2017, overall contributing to a improving picture.

To support continued improvement the Falls Team are working hard to embed the "Fallstop" programme and have had a number of band 4 posts approved that will be recruited into as soon as possible. Aimed at falls prevention, this programme is available to all wards across the Trust sites. With a new focus on self- directed development to promote engagement, the project has now been implemented at the William Harvey Hospital, with further implementation planned across the remaining sites.

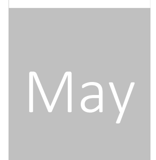
Going forward we will use "Fallstop" audit data to benchmark our wards. The target for the coming year is to improve completion of risk assessments at each site by 10% (based on the national inpatient falls audit result from 2015).

To support this we are encouraging wards to "own" the falls prevention agenda, supporting capability through staff training and awareness raising through the QII hubs and by encouraging our ward leaders to share good practice. Actions and outcomes are overseen by the Falls steering group to support improvement pace.

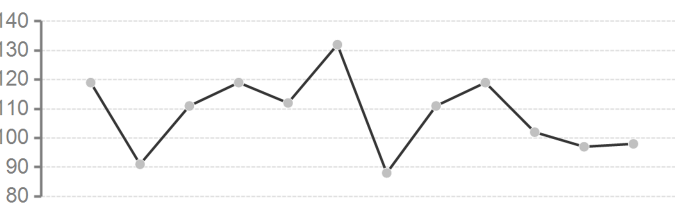
Incidents

Month	Measure	Value		Description
May	Clinical Incidents: Total (#)	16,387 (7.4%)		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.
May	Blood Transfusion Errors	152 (2.7%)		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.

Strategic Theme: Patient Safety



Medicines Mgmt. Incidents 1,299 (2.6%)



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:

A total of 1304 clinical incidents have been logged as occurring in May-17 compared with 1243 recorded for Apr-17 and 1362 in May-16. In May-17, no incidents have been graded as death and two incidents have been graded as severe harm. In addition, 17 incidents have been escalated as a serious near miss, of which 9 are still under investigation. The number of moderate harm incidents reported during May-17 is on a par with previous months [May-17: 18 compared with Apr-17: 19 and May-16: 12].

Six serious incidents were required to be reported on STEIS in May. Seven cases have been closed in May; there remains 69 serious incidents open at the end of May.

Over the last 12 months incident reporting has risen at WHH, has plateaued at QEH and dropped at K&CH.

Blood transfusion

In May, there were 13 blood transfusion errors reported (6 in Apr-17 and 11 in May-16). Themes included two phlebotomy process errors, two allergic reactions to transfusion and two inappropriate procedures. Eight incidents were graded no harm and five low harm. Reporting by site: seven at K&CH, three at QEH and three at WHH.

Medicines management

There were 97 medication incidents reported as occurring in May (97 in Apr-17 and 104 in May-16). On average, over the last 12 months, the numbers of medication incidents reported at QEH have risen and at WHH and K&CH have decreased.

Of the 97 reported, 69 were graded as no harm (including two serious near misses) and 27 as low harm. One incident resulted in moderate harm: penicillin allergic patient discharged from Padua ward (WHH) to be prescribed oral co-amoxiclav, but instead given augmentin, was later seen in A&E (WHH) with a significant reaction. No incidents were graded severe harm or death. Top reporting areas were: Marlowe ward (K&CH) and ITU (WHH) with six incidents each; A&E (WHH) with five incidents; Cheerful Sparrows male / Sandwich Bay / Seabathing Unit (QEH) with four incidents each; UCC (K&CH), CDU / Deal ward / Rainbow ward (QEH) with three incidents each; other areas reported 2 incidents or fewer. Twenty-four incidents occurred at K&CH, 36 at QEH and 37 at WHH.

*Missing Drugs are broken down as follows: nine incidents relating to stock control/documentation errors, two incidents of medication missing between pharmacy and ward, two incidents of broken vials / wastage of medication and one incident where medication was missing on the ward.

Total
Drug error - prescribing 10
Drug error - dispensing 20
Drug error - administering 40
Drug shortage (not available or in stock) 3
Drug missing* (stock discrepancy or lost between wards/pharmacy) 14
Adverse drug reaction 3
Infusion injury - extravasation 5
Infusion problems - medication related 2
Totals: 97

Strategic Theme: Patient Safety

Friends & Family Test

Month	Measure	Value	Description
May	FFT: Response Rate (%)	38 (15.6%)	The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	FFT: Recommend (%)	97 (0.8%)	Of those patients (Inpatients excluding Day Cases) 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.
May	FFT: Not Recommend (%)	1.7 (-5.5%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During May-17 we received 9324 responses in total. Overall 39% eligible patients responded and 97% 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 95.1% (95% Apr-17), for A&E it was 82.8% (83% Apr-17), maternity 98.5% (99% Apr-17), outpatients 89.1% (89% Aprl-17) and day cases 94.8% (95% Apr-17). The Trust star rating in May is 4.49 (4.49 Apr-17).

Response rates for May were slightly lower in day case, inpatients and A&E and significantly lower in maternity. The reason for this is being explored through the senior midwifery team. The response rate for inpatients was 36.8% (37% Apr-17), A&E 21.5% (22% Apr-17), maternity 23.4% (61% Apr-17). (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 29.8% (30% Apr-17) 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.

FFT - Top 5 Positive & Negative Themes
ED
Positive Themes –Staff attitude, Care, Implementation of care, Communication and Competence.
Negative Themes – Care, Waiting times, Staff attitude, Environment, Communication

Inpatients
Positive Themes – Staff, Care, Cleaning, Implementation or care and Competence.

Negative Themes –Care, Environment, Staff attitude, Communication, Competence

Out patients
Positives Themes –Care, Staff attitude, Communication, Implementation of care and Competence.
Negative Themes – Care, Staff attitude, Communication, Waiting time and Environment.

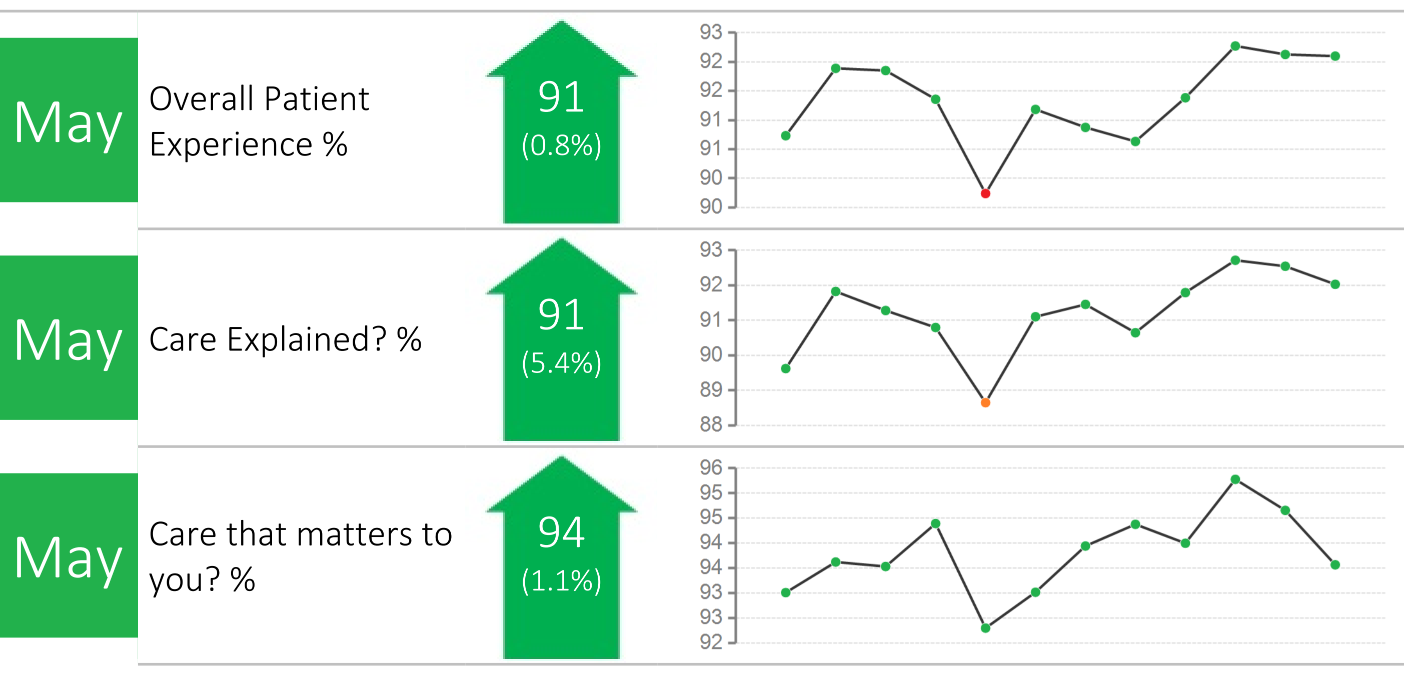
Maternity
Antenatal
Positive Themes – None
Negative Themes – None
Birth
Positive Themes – Staff attitude, Care, Competence, Implementation of care and Communication
Negative Themes – None
Postnatal ward
Positive Themes – Staff Attitude, Care, Competence, Implementation of Care and Commitment.
Negative Themes – None
Postnatal community
Positive Themes – None
Negative Themes - None

Day Case
Positive Themes –Care, Staff attitude, Competence, Implementation of care, Cleaning
Negative Themes – Care, Staff attitude, Communication, Clinical treatment and Environment.
Special Day Case
Positive Themes – Care, Staff attitude, Cleaning, Implementation of Care and Competence.
Negative Themes – Communication.

The trust needs to improve on staff attitude, Care, communication and waiting times. Waiting times have improved within Inpatients. Maternity received no negative themes for April, which is an outstanding achievement.
It should be highlighted that there are considerably more positive themes/comments regarding Staff attitude, care, communication and competence, which staff must be congratulated on.

Strategic Theme: Patient Safety

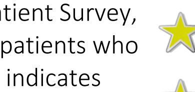
Patient Experience 1



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.

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.

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).

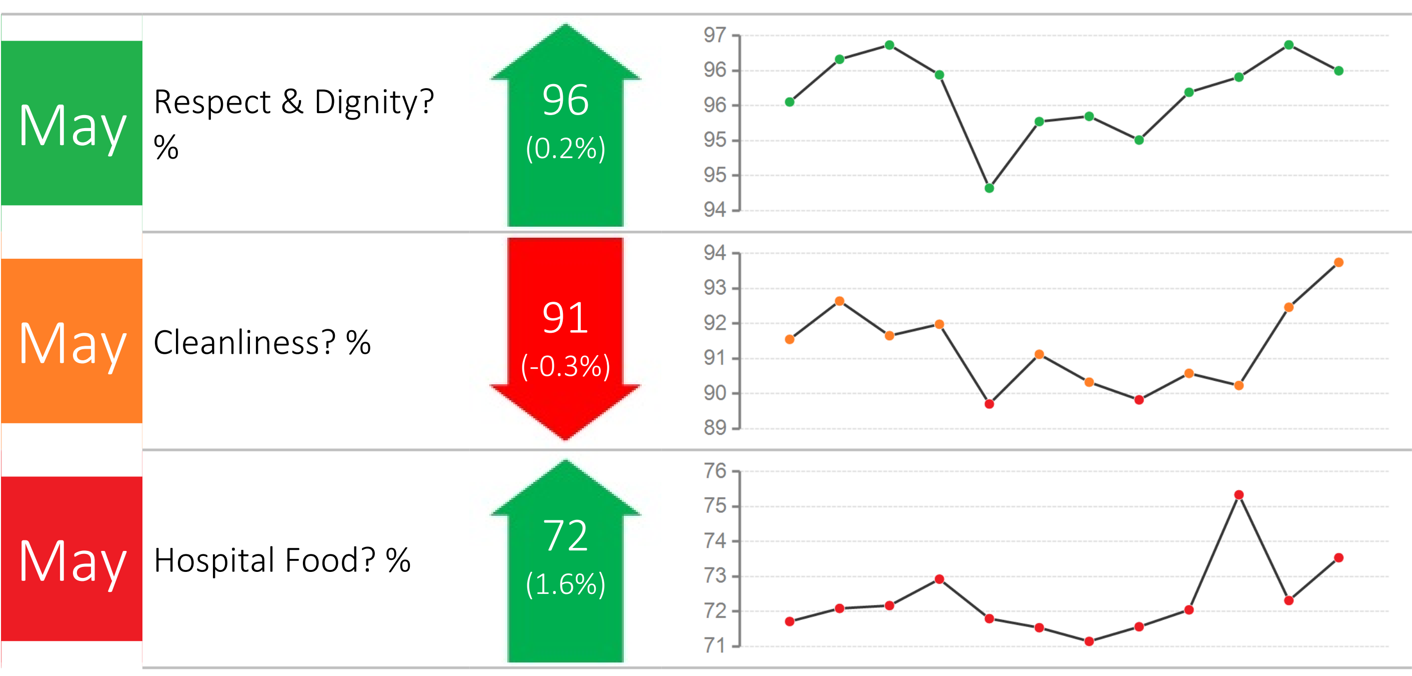


Comments:

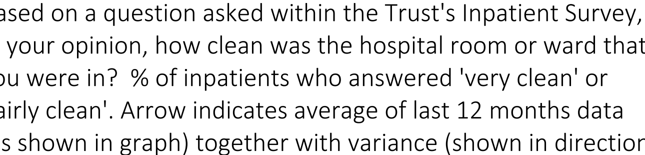
This month patient experience as recorded in real-time by the patients has been sustained with 5 out of the 6 criteria being rated as green.

There has been further improvement in the reporting for the experience of patients in relation to both overall patient experience and overall performance has improved over the last 12 months. Feedback on whether patients received the care that matters to them, the explanation of care or treatment in an understandable way and whether they were treated with respect and dignity have also further improved this month.

Patient Experience 2



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.



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.

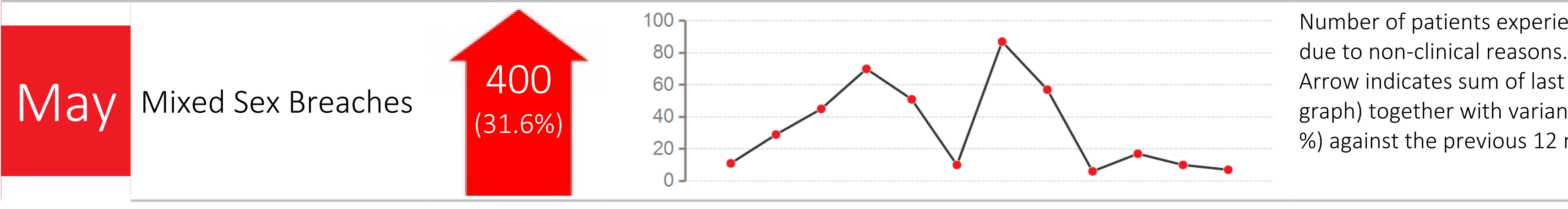
Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: Evaluation of the Patient Safety Heatmap demonstrates that the majority of wards are now compliant with capturing patient experience in May. Escalation to Divisional heads of nursing and matrons has taken place to enable focused local improvements. Patient volunteers are now assisting patients with the completion of the Inpatient Survey at each acute site, thus enabling nursing staff to focus on patient care.

Cleaning rises to 93 this month, however as this is a single increase beyond the normal 91-92 range for cleaning, it is likely to represent a one off result. Ward level auditing remains the more consistent picture at 98.

Hospital Food is down this month, decreasing from a high of 95 last month to the consistent scoring of pervious IPRs. However it continues to fall within normal parameters.

Mixed Sex



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 May-17, 3 non-justifiable incidents of a mixed sex accommodation breach occurred within the QEQM Emergency Department and CDU due to capacity issues. This information has been reported to NHS England via the Unify2 system.

There were 5 mixed sex accommodation occurrences in total, affecting 19 patients. This number is similar to last month when there were a total of 5 occurrences affecting 20 patients. The remaining incidents occurred at QEQM CCU (1) and Fordwich (1) which are justifiable mixes based on clinical need.

May 17 daily reporting of mixed sex occurrences has improved at one acute site demonstrating improvement and a more robust recording of mixed sex occurrences. However, there has been an issue with the recording all the correct data into the daily reporting form for mix sex occurrences at two of the acute sites, which is being addressed.

Strategic Theme: Human Resources

Gaps & Overtime

Month	Metric	Value	Description
May	Vacancy (%)	10.3 (17.1%)	% 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.
May	Staff Turnover (%)	12.5 (12.2%)	% 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.
May	Sickness (%)	4.0 (7.3%)	% 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
May	Overtime %	9.3	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).

Comments:

Gaps and Overtime

The Turnover rate in month is 12.9%. The vacancy rate increased marginally from 11.4% to 11.6%. Continued action is being taken for roles which have been identified as hard to recruit either because of repeated difficulty in recruiting to EKHUFT posts or because of shortages in labour supply nationally, including working with suppliers of the RMO model to support with gaps in junior doctor rotas.

Sickness absence decreased slightly in April 2017 (the most recent data available) from March's position (2017) to 3.6%. It is predicted to remain at 3.6% for May 2017. Work continues on sickness hotspot areas identified in the deep dive completed for January EPR, and ongoing work with Occupational Health to tackle health and wellbeing issues within hotspot areas.

All metrics are reviewed and challenged at a Divisional level in the monthly Executive Performance Reviews.

Strategic Theme: Human Resources

Temporary Staff

Month	Measure	Value	Description
May	Employed vs Temporary Staff (%)	89.9 (-2.1%)	Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Agency %	20.3	% of temporary staff who work via agency Number indicates average of last 12 months data (as shown in graph).
May	Temp Staff (WTE)	226 (7.3%)	WTE Count of Temporary Staff Used
May	Local Induction Compliance %	14.8 (103.6%)	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).

Comments: The proportion of temporary staff engaged by the Trust increased in April and May (this despite the fact the wte temporary staff used in month reduced). This has largely resulted from an increased supply of bank staff in the reporting period. Percentage agency supply showed a marginal increase. Agency costs are controlled by the Agency Taskforce and are a key part of controlling staffing costs. Greater efficiencies are being sought in the use of E-Roster aimed at maximising use of substantive staff, for example, using net hours owed before booking overtime or agency cover. Breaches in pay caps continue to be reported and monitored. Divisions are all now monitoring Agency use on a post by post basis through the agency reduction plans in Aspyre with support from HR and Improvement Delivery Teams. These plans identify detailed and specific actions to eliminate where possible spend on agency.

Local induction compliance continues to be an area of concern and focus for the executive team.

Strategic Theme: Human Resources

Workforce & Culture

Month	Metric	Value	Description
May	Statutory Training (%)	88 (4.6%)	The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Appraisal Rate (%)	81.1 (1.6%)	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.
May	Time to Recruit	12 (2.9%)	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.
May	Total Staff In Post (SiP)	6913 (-0.1%)	Count of total staff in post (WTE)

Comments: Statutory training compliance remained steady at 89%. This remains above the target of 85%. Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements. There remains an on-going issue with the recording of Information Governance, so this is being sent manually in some cases.

The Trust staff appraisal rate decreased to 81.1%, below the 90% target. Divisions are working on plans to complete appraisals due in (traditionally high volumes are due in April/May) to avoid a further drop in appraisal rates.

Time to recruit has decreased in the last two months and it is hoped that this will be further supported by the recruitment process mapping plans in place for implementation by the end of June 2017.

Wte staff in post has declined from a highest position of 7,000 to 6,913 in May, evidence of the impact of the vacancy control process and cost improvement programmes in place across the organisation

Strategic Theme: Activity

Activity vs. Internal Business Plan

Key Performance Indicators

May

	May-17				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	15,238	14,619	619	4%	27,839	28,716	(-877)	-3%	27,839	29,869	(-2,030)	-7%	<=0%
Referral Non-Primary Care	14,502	13,460	1,042	8%	27,150	26,937	213	1%	27,150	28,169	(-1,019)	-4%	<=0%
OP New	19,843	19,140	703	4%	36,778	36,830	(-52)	0%	36,778	40,461	(-3,683)	-9%	>=0%
OP Follow Up	42,916	40,194	2,722	7%	79,023	78,065	958	1%	79,023	81,375	(-2,352)	-3%	>=0%
Elective Daycase	6,333	5,959	374	6%	11,664	11,655	9	0%	11,664	13,603	(-1,939)	-14%	>=0%
Elective Inpatient	1,209	1,233	(-24)	-2%	2,292	2,371	(-79)	-3%	2,292	2,490	(-198)	-8%	>=0%
A&E	18,343	18,265	78	0%	35,551	35,676	(-125)	0%	35,551	35,157	394	1%	>=0 & <5%
Non-Elective Inpatient	7,238	7,255	(-17)	0%	13,903	14,286	(-383)	-3%	13,903	11,865	2,038	17%	>=0 & <5%
Chemotherapy	1,185	1,275	(-90)	-7%	2,313	2,486	(-173)	-7%	2,313	2,514	(-201)	-8%	>=0%
Critical Care	1,764	1,826	(-62)	-3%	3,596	3,627	(-31)	-1%	3,596	3,646	(-50)	-1%	>=0%
Dialysis	6,919	6,906	13	0%	13,502	13,752	(-250)	-2%	13,502	13,978	(-476)	-3%	>=0%
Maternity Pathway	1,112	1,111	1	0%	2,276	2,220	56	3%	2,276	2,342	(-66)	-3%	>=0%
Pre-Op Assessments	2,864	3,116	(-252)	-8%	5,396	6,078	(-682)	-11%	5,396	5,620	(-224)	-4%	>=0%
Diagnostic	448,211	427,467	20,744	5%	835,672	833,626	2,046	0%	835,672	896,723	(-61,051)	-7%	<=0%
Other	4,780	4,840	(-60)	-1%	9,277	9,848	(-571)	-6%	9,277	7,031	2,246	32%	>=0%

The 2017/18 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2016/17 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals. The plan is capped at our total capacity and as such further activity (or demand reduction schemes would be required to achieve sustainable elective services. 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 2017/18. It should be noted that this does not reflect demand levels agreed within the 2017/18 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 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.

May 2017

Elective Care

In May Primary Care referrals were 4% above plan which reduced the YTD variance to -851. We believe the reduction in referrals observed in April was an outlier and we can see no evidence that this will develop into a trend moving forward.

The Trust delivered the New Outpatient plan in May 2017 with a 4% over-performance which has eliminated the variance that was generated in Month 1. Strong performance within Urology, Paediatrics, Ophthalmology and Breast Surgery has helped deliver the in-month position. Despite achievement at Trust level, a number of services have increased YTD variances and we have now instigated our grip and control recovery process intended to ensure delivery of the income targets. Cardiology (-384), Physiotherapy (-207) Orthopaedics (-176), Gynaecology (-128) and Stroke (-128) have all now formally entered this process and have produced recovery plans intended to respond to this underperformance

Whilst the Trust delivered the new Outpatient plan in April & May, this was set at substantive capacity levels with a significant reduction applied for annual leave and as such was not enough to maintain the RTT waiting list size which increased by 2,772 over the first two months of the year. This trend is expected to continue into June until plans to substantively deliver the additional activity are realised.

As with New outpatients The Trust over performed the follow up plan in May and is now over performing the YTD position by 1% (962). There remain a number of large underperformances particularly within Ophthalmology (-782) and Physiotherapy (-904). The Physio service are reporting induction delays, a high vacancy rate maternity leave and unusually levels of maternity leave as the key drivers behind the underperformance.

Despite a sizable and successful recruitment drive in Ophthalmology, not all of the new clinical team or technical support was in place by April 1st. In addition to this the service is no longer using an insourcing provider to deliver activity. It is expected primary care providers will soon start to provide services for existing long term conditions Wet AMD and Glaucoma and as such that this position will improve moving forward. In addition to the services detailed above, Cardiology & Rheumatology have been added to the grip and control recovery process.

In May the Trust over achieved the Daycase plan by 6% eradicating the YTD variance. Despite the improved performance Orthopaedic services remain a huge risk. A number of unavoidable recruitment delays combined with significant unplanned leave is driving an underperformance in activity. In addition to this, the service continues to lose capacity to short notice cancellations for Trauma and DNA’s. Changes to the waiting list initiative has limited the services ability to recover the position with additional sessions in month, as such the service is included within the grip and control recovery process and has produced a recovery plan accordingly.

Non Elective Care

The Trust sees non elective admissions to all of its 3 sites. These are typically some of the patients who attend the Trust Accident & Emergency departments, or are admitted directly through to the wards upon agreement with General Practitioners. These patients have an urgent clinical need that cannot wait for an elective pathway or outpatient appointment to be given, and so are monitored within the hospital site as diagnosis and treatment for their clinical condition is conducted.

Non-elective and A&E Activity came in at expected levels, with sites continuing to see an-uplift in the proportion of majors attending, as seen over the previous year.

In addition to activity counts we balance this with additional monitoring metrics detailed below to determine if patients are able to flow through the hospital without significant delays and bottlenecks.

The Bed occupancy of Trust sites continued to be at challenging levels throughout May which increased from the April position of 96.6% to 98.9% (against funded bed base). This marks an extension of winter pressures into the month, particularly over the early part of the month, where bed occupancy against the sites was in excess of 100%.

Over the end of May the beds occupied started to reduce slightly, predominantly at the K&CH and WHH sites. Part of the reason for this reduction was the reduction of Winter Pressures, which appears to extend into early May this year. Additionally there has been additional discharge capacity & acute management improvements implemented over the second half of May in preparation for a potential emergency business continuity plan involving the K&C site. This will require an alteration in the acute medical take from 3 sites to 2, which will require a reduction in length of stay Trustwide, with transfer of medically optimised patients from acute sites to the Kent & Canterbury site if required.

The Medical Outliers metric shows the daily average number of medical patients which were bedded in non-medical wards. This can happen for a variety of reasons; such as care being recently transferred to a medical specialty consultant, or as a result of the ward in question having free beds available for patients at the time of clinical need. Patients remain under the medical consultant responsible for their care for the purpose of treatment and clinical review. During May the number of medical outliers increased, to a weekly high of 84 for the week ending the 7th. As the bed occupancy has dropped the volumes of medical outliers has also reduced, to a position of ~46 per day Trust wide at the end of the month.

For June, the bed occupancy has continued to fall, and is now in a position close to 92.5%, though it is expected that the bed occupancy at the Margate & Ashford sites should increase over the last fortnight of June as the changes to the admission profile of the trust sites occurs.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	1,405	1,807	-22%	-402
104 - Colorectal Surgery	1,303	1,487	-12%	-184
330 - Dermatology	2,174	2,335	-7%	-161
140 - Maxillo Facial	1,244	1,376	-10%	-132
101 - Urology	1,146	1,264	-9%	-118
107 - Vascular Surgery	365	476	-23%	-111
300 - General Medicine	231	328	-30%	-97
658 - Orthotics	244	150	63%	94
420 - Paediatrics	1,064	963	11%	101
329 - TIA	228	0		228
Total	**27,839**	**28,716**	**-3%**	**-877**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	5,767	6,170	-7%	-403
110 - Trauma & Orthopaedics	3,266	3,407	-4%	-141
328 - Stroke Medicine	183	262	-30%	-79
811 - Interventional Radiology	73	122	-40%	-49
100 - General Surgery	484	531	-9%	-47
800 - Clinical Oncology	2,006	1,950	3%	56
655 - Orthoptics	277	190	46%	87
651 - Occupational Therapy	598	482	24%	116
329 - TIA	148	0		148
130 - Ophthalmology	1,887	1,577	20%	310
Total	**27,150**	**26,937**	**1%**	**213**

OP New

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	3,879	4,263	-9%	-384
650 - Physiotherapy	3,096	3,303	-6%	-207
110 - Trauma & Orthopaedics	3,216	3,392	-5%	-176
104 - Colorectal Surgery	1,012	1,161	-13%	-149
107 - Vascular Surgery	438	576	-24%	-138
103 - Breast Surgery	1,182	1,026	15%	156
301 - Gastroenterology	1,284	1,127	14%	157
101 - Urology	1,818	1,642	11%	176
655 - Orthoptics	548	346	58%	202
420 - Paediatrics	1,341	1,105	21%	236
Total	**36,778**	**36,830**	**0%**	**-52**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
650 - Physiotherapy	10,108	11,012	-8%	-904
130 - Ophthalmology	8,754	9,536	-8%	-782
302 - Endocrinology	354	816	-57%	-462
410 - Rheumatology	2,363	2,747	-14%	-384
140 - Maxillo Facial	1,965	1,641	20%	324
300 - General Medicine	723	395	83%	328
800 - Clinical Oncology	7,133	6,664	7%	469
655 - Orthoptics	1,866	1,276	46%	590
290 - Community Paediatrics	3,547	2,782	28%	765
320 - Cardiology	3,695	2,844	30%	851
Total	**79,023**	**78,065**	**1%**	**958**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	673	827	-19%	-154
303 - Clinical Haematology	489	573	-15%	-84
410 - Rheumatology	231	312	-26%	-81
301 - Gastroenterology	133	173	-23%	-40
320 - Cardiology	502	444	13%	58
101 - Urology	1,358	1,294	5%	64
502 - Gynaecology	377	303	24%	74
800 - Clinical Oncology	681	593	15%	88
130 - Ophthalmology	824	727	13%	97
300 - General Medicine	3,435	3,331	3%	104
Total	**11,664**	**11,655**	**0%**	**9**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	80	112	-29%	-32
400 - Neurology	45	69	-35%	-24
420 - Paediatrics	34	49	-30%	-15
103 - Breast Surgery	70	85	-17%	-15
140 - Maxillo Facial	47	61	-23%	-14
503 - Gynaecology Oncology	6	18	-67%	-12
430 - HCOOP	25	12	110%	13
300 - General Medicine	160	140	15%	20
502 - Gynaecology	287	263	9%	24
104 - Colorectal Surgery	96	64	50%	32
Total	**2,292**	**2,371**	**-3%**	**-79**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
180 - Accident & Emergency	772	1,184	-35%	-412
430 - HCOOP	2,050	2,171	-6%	-121
100 - General Surgery	934	1,013	-8%	-79
101 - Urology	652	685	-5%	-33
422 - Neonatology	91	63	44%	28
320 - Cardiology	361	332	9%	29
410 - Rheumatology	46	10	379%	36
300 - General Medicine	4,329	4,288	1%	41
501 - Obstetrics	806	764	6%	42
110 - Trauma & Orthopaedics	704	648	9%	56
Total	**13,903**	**14,286**	**-3%**	**-383**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	835672	833626	0%	2,046
Pre-Op	5396	6078	-11%	-682
Other	9277	9848	-6%	-571
Dialysis	13502	13752	-2%	-250
Chemotherapy	2313	2486	-7%	-173
A&E	35551	35676	0%	-125
Maternity Pathway	2276	2220	3%	56
Critical Care	3596	3627	-1%	-31
0	0	0	0%	0

Strategic Theme: KPIs

4 Hour Emergency Access Standard

Key Performance Indicators

76.78 %

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
4 Hour Compliance	85.40%	82.85%	82.14%	84.28%	79.44%	76.11%	74.47%	70.83%	76.00%	80.17%	76.93%	76.78%
12 Hour Trolley Waits	0	0	0	0	0	1	1	2	0	0	0	0
Left without being seen	3.84%	4.59%	4.11%	3.31%	3.85%	3.96%	4.35%	4.87%	3.53%	3.08%	3.83%	3.59%
Unplanned Reattenders	9.22%	8.62%	9.01%	8.78%	8.58%	8.68%	8.98%	8.20%	8.62%	9.11%	8.91%	8.99%
Time to initial assessment (15 mins)	91.2%	85.2%	81.0%	86.9%	79.5%	74.4%	78.5%	76.1%	76.4%	77.8%	77.9%	78.5%
% Time to Treatment (60 Mins)	48.3%	46.3%	48.9%	48.5%	40.9%	39.9%	39.9%	39.8%	40.8%	40.7%	39.4%	42.3%

2017/18 Trajectory (NHSI Return 7th June 2017)

1.79 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Trajectory	75.0%	75.0%	80.0%	83.0%	87.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	95.0%
Performance	76.9%	76.8%										

The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard.

Summary Performance

May performance against the 4 hour target was 76.8%, against the NHS Improvement trajectory of 75.0%. There were no 12 Hour Trolley Waits reported in month. The number of patients who have left the department without being seen remains below 4% for a fourth month.

The priority and focus for May has been to continue to maintain safe patient care; improving performance and patient flow across the whole emergency patient pathway. Patient attendances were on plan, however, there continues to be surges in attendances with notable high activity in the evenings and weekends.

Medical staffing vacancies at Speciality Doctor (middle grade level) remain high with on-going recruitment in place via monthly interview panels.

The IR35 challenges have continued, particularly at QEQMH. The agency doctors we had been using to provide ED cover have not returned to work and this continues to leave the rotas seriously depleted. In order to mitigate this risk and ensure that safe patient care is provided daily senior meetings (ED Consultant and General Manager) have been implemented to monitor the clinical risk.

Actions taken include:

- Reviewing the rotas at WHH and QEQMH to assess the depth of cover and skill mix to agree a sharing of staff across both sites.
- GP's were recruited on to the Trust staff bank to provide cover.
- Alternative specialities, i.e. Physicians and Surgical SpR and Consultant level doctors were booked to fill the gaps in the rota.
- Senior core trainee level doctors who had experience of working in ED were booked to fill gaps.
- Agency ENP's were booked to support the minor injuries service.

Ambulance Handover

From 22 May 2017 a turnaround plan was implemented to improve ambulance handover performance. The first week saw an improvement in delays greater than 60 minutes by 80% and saw a 75% improvement in waits over 30 minutes. This was a joint plan from SECAMB and EKHUFT with both organisations signed up to a data set with agreed standards and an escalation plan which included active management of the daily ambulance flow. A small amount of managerial support was provided from both organisations to focus on the project. The early improvements have continued and become embedded.

Risks to delivery of the standard:

- Middle grade medical staffing vacancies and unfilled gaps in rotas due to lack of agency or substantive staff. QEQMH is a particular risk due to the geographic location of the hospital.
- Continued high levels of activity, particularly in the evenings.
- Poor patient flow due to lack of timely bed availability.
- The number of patients waiting for access to short term external capacity in the community continues to be a risk. There have been issues with a lack of external care package capacity across all geographic areas, however this has started to improve towards month end as additional capacity has become available.
- Delays in mental health bed availability for adult and children.

Strategic Theme: KPIs

Cancer Compliance

Key Performance Indicators

69.83 %

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Green
62 day Treatments	75.42%	70.94%	74.58%	71.50%	70.00%	72.77%	75.94%	60.61%	70.45%	77.30%	72.40%	69.83%	>=85%
>104 day breaches	42	56	57	45	53	44	31	40	40	40	38	32	<0
Demand: 2ww Refs	3,282	3,142	3,013	3,171	2,951	3,307	2,636	3,150	2,936	3,580	2,650	3,184	2990 - 3305
2ww Compliance	94.61%	96.44%	94.77%	94.81%	96.62%	97.45%	96.49%	95.82%	96.08%	97.41%	93.59%	96.00%	>=93%
Symptomatic Breast	93.71%	93.10%	93.22%	95.31%	94.59%	96.43%	86.61%	97.27%	94.81%	93.57%	90.91%	93.57%	>=93%
31 Day First Treatment	94.55%	94.31%	93.64%	93.39%	96.10%	94.93%	95.79%	93.63%	96.96%	97.42%	95.68%	95.25%	>=96%
31 Day Subsequent Surgery	86.96%	96.61%	90.38%	92.59%	89.23%	89.09%	89.19%	82.22%	94.12%	90.24%	89.29%	91.84%	>=94%
31 Day Subsequent Drug	100.00%	97.33%	98.88%	100.00%	100.00%	99.12%	98.39%	96.94%	95.77%	97.50%	97.06%	97.62%	>=98%
62 Day Screening	100.00%	83.33%	87.50%	93.94%	89.55%	96.23%	91.89%	91.67%	76.47%	89.23%	92.00%	89.47%	>=90%
62 Day Upgrades	100.00%	82.35%	85.71%	100.00%	80.00%	83.33%	70.73%	75.68%	92.59%	69.77%	66.67%	74.36%	>=85%

2017/2018 Trajectory

3.23 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	71.60%	66.60%	76.80%	80.90%	83.40%	85.90%	85.60%	85.80%	86.00%	86.00%	85.50%	87.00%	Sep
Performance	72.40%	69.83%											Sep

The 62 Day Cancer Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance. A Cancer Recovery Plan is in place with an aim to improve performance and ensure that the cancer standards are sustainably delivered across all tumour sites.

Summary Performance

May performance is currently 69.83% against the improvement trajectory of 66.00%, validation continues until the beginning of June in line with the national time table. The total number of patients on an active cancer pathway is 2,910; this is higher than the previous month and predominately increased in the front part of the pathway (under 40 days). There are currently 32 patients waiting 104 days or more for treatment, 13 of whom have a cancer diagnosis and 10 have a decision to treat.

Risks to delivery of the standard:

- Key areas of concern for the Trust are Endoscopy, Colorectal, Urology, Lung, Radiology (both appointment and reporting capacity) and adequate surgical theatre capacity.

Actions taken to mitigate risk and improve performance:

- PTL meetings have been revamped to clearly identify who is taking actions forward. All incomplete actions are escalated to the weekly performance meeting for resolution.
- All tumour sites and diagnostic elements of the pathway have agreed specific action plans. These are reviewed monthly with each tumour site.
- A summary of the PTL is shared with Divisional Directors each week to support escalation and resolution of pathways of patients on the cancer PTL.
- Monitoring tools for the delivery of waiting times of diagnostic that are timely along the Cancer Pathway have been developed by the Information team (ie. 10 days turnaround time from referral for cancer test to patient having that test).
- The Information team have developed a daily report for radiology which focuses on patients that require diagnostics and their next key event milestone, with the aim for this to decrease.
- A webpage style PTL is currently being developed with the Information team. This will refresh data every 30 minutes from Infloflex providing a real time position and validation for each tumour site. This will also be RAG rated against the gold standard pathway milestones. This is due to be rolled out from July.

Strategic Theme: KPIs

18 Week Referral to Treatment Standard

Key Performance Indicators

85.82 %

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Green
Performance	86.81%	86.65%	85.52%	85.11%	86.03%	85.79%	83.83%	83.79%	84.35%	85.40%	84.85%	85.82%	>=92%
52w+	17	25	20	27	21	13	12	18	24	28	29	36	0
Waiting list Size	44,213	45,487	45,352	45,531	44,822	46,191	46,398	45,682	45,449	46,483	47,649	49,237	<38,938
Backlog Size	5,831	6,072	6,568	6,781	6,262	6,563	7,502	7,407	7,111	6,785	7,218	6,980	<2,178
Demand: PC Referrals	16,253	16,194	15,667	15,532	14,908	16,634	13,619	15,071	14,912	17,854	13,780	16,127	<15,484
Demand: Additions to IP WL	3,489	3,170	3,207	3,211	3,237	3,735	2,920	3,500	3,264	3,852	2,954	3,367	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

2017/2018 Trajectory

2.36 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	84.13%	83.46%	84.20%	84.44%	83.91%	84.45%	84.75%	85.71%	84.95%	85.18%	86.00%	86.93%	87%
Performance	84.85%	85.82%											Sept

The Referral to Treatment Waiting Time Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against this standard. An RTT Recovery Plan has been developed jointly with local CCGs in order to address both short term backlog clearance and longer term increases in recurrent demand. The aim of the plan is to improve performance and ensure that the RTT Standards are sustainably delivered throughout the Trust.

Summary Performance

May performance increased to 85.82%. Whilst performance has improved, the Trust was again unable to provide enough activity to sustain waiting list sizes throughout the month, despite specialities delivering their business plans. Sustainable long terms plans to resolve capacity constraints and deliver RTT 2017/18 trajectory are planned to start and come in to effect from quarter two.

The number of patients waiting over 52 weeks for first treatment increased by 10 to 36 on previous month, General Surgery (15), Gynaecology (15) and ENT (3), Ophthalmology (2) the services most affected.

Risks to delivery of the standard:

- Continued Increase in Orthopaedic & General Surgery waiting list additions.
- Higher than planned demand within business plan resulting in no flexibility within capacity in key specialities such as Orthopaedics, Dermatology, General Surgery, Maxillo Facial and Gynaecology.
- Recruitment constraints in services such as Neurology and Paediatrics leading to long outpatient waits.
- Gastroenterology & Endoscopy capacity.
- Change in payment for waiting list initiatives, has led to a significant reduction in medical staff providing additional capacity outside agreed job plans.
- General Surgery capacity for patients presenting with high BMI for benign disease (single handed surgeon) creating 52 week waits.
- Gynaecology capacity for named sub-specialty conditions resulting in 52 week waits.
- ENT surgical demand remains in excess of capacity in key subspecialties resulting in 52 week waits.
- Changes in RTT administrative guidance with regards to Cornea grafts in Ophthalmology resulting in an increase in waiting times.

Actions taken to mitigate risk and improve performance:

- The new Interactive Patient Tracking Technology has been implemented which allows real time recording of patient pathways and supports the operational teams in delivery.
- Focused management of undated pathways waiting over 30 weeks and risks to 52 weeks, particularly within General Surgery, ENT, Gastroenterology and Gynaecology, daily patient focus meetings and weekly progress reports to COO and CEO.
- Action plans in key specialties to ensure improved performance reviewed weekly.
- Continued sourcing of outpatient internal capacity is being established for Orthopaedics, ENT, General Surgery, Maxillo Facial and Gynaecology.
- Saturday working in new consultants contracts across the trust to improve utilisation of theatre capacity and increase capacity.
- Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste has commenced.
- The Trust is developing long term solutions to sustainably address the imbalance in capacity and demand, through a number of schemes, including; increasing theatre utilisation to 50 weeks per year (commencing July 2017), develop local anaesthetic cataract surgery in Buckland Hospital, Dover releasing 5 theatre sessions per week at acute hospitals William Harvey and Queen Elizabeth the Queen Mother Hospitals (October/November 2017).
- Exploring opportunities to increase theatre base with semi-permanent POD solutions, creating a minimum of 10 additional theatre sessions per week (October/November 2017).

Strategic Theme: KPIs

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.4%

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Green
Performance	99.86%	99.77%	99.56%	99.74%	99.91%	99.88%	99.72%	99.65%	99.67%	99.78%	99.06%	99.36%	>=99%
Waiting list Size	13,533	13,321	10,269	14,728	14,011	15,457	15,023	14,171	14,048	15,580	14,882	14,480	<14,000
Waiting > 6 Week Breaches	19	31	45	39	12	19	42	49	46	35	140	92	<60
Average Wait													<4

2017/18 Trajectory

0.3%

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	Apr
Performance	99.06%	99.36%											Apr

Summary Performance

The standard has been met for May 17 with a compliance of 99.36%. As at the end of the month there were 92 patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 71, 64 in Computed Tomography, 4 of which were in Non-Obstetric ultrasound, 2 in DEXA scanning and 1 in Magnetic Resonance Imaging
- Cardiology: 16
- Gynaecology: 2
- Neurophysiology: 2
- Endoscopy: 1

Risks to delivery of the standard:

- The Radiology Booking team remain under extreme pressure to book additional lists to meet current demand. Additionally sourcing of Locums remains in place to mitigate backlogs and where possible clinicians agreeing to undertake the additional list. The IR35 arrangements and new waiting list payments for Consultants continue to impact- but is an improving picture.
- Reporting in each modality remains a concern for the Division - There is an identified increasing clinical risk of patients waiting too long on a diagnosis. This is on the Division Risk Register and on the Corporate Risk Register.
- Current number of backlog CT = 1,546 and MRI =1,207 Total = 2753 (This is a total in month reduction of 916 broken down by CT 151 and MRI 765)
- CT and MRI Waiting lists remain high. Currently the CT wait is 5 weeks and MRI average waits are 5 weeks and 6 days. If these waiting lists were to increase over the coming weeks/months, the 6 week DM01 standard could be compromised. CT cardiac angiography capacity and ultrasound radiologist capacity are the largest divisional risks being managed.
- Trust average time on the report list is currently 13.3 days but there are 205 reports outstanding over 28 days as of 15th May.
- The calibre of locums is also a risk to the delivery – we are working more closely with procurement and NHSP teams to scrutinise CVs and make more fixed term appointments.
- Cardiology diagnostics has improved in month following a joint meeting with additional list being sourced. We are reviewing internal and external capacity as the demand in this field is growing
- The risk of aging equipment in Nuclear medicine has been monitored more closely as a breakdown in month could have impacted more dramatically. There was a 48 hour break down of the equipment but patients were able to be rebooked within the 6 week window.

Actions taken to mitigate risk and sustain performance:

- The Division are actively recruiting substantive and interim locums to support the demand and address the reporting concerns. Three substantive posts out to national advert with locums in the interim.
- The Division are working with third party companies to support additional reporting in close liaison with procurement.
- All equipment is monitored closely and regularly serviced to ensure we maximise capacity.
- We have extend the opening hours of the CT's and MRI until 8pm and including BH to add extra capacity into the system
- We have opened additional weekend capacity in Ultrasound to support OPD and Inpatients. All of this will have an impact on reporting.
- Replacement of the 2 MRIs is under way at K&CH – The first up and commissioned the 2nd MRI will not fully be commissioned until early 2018 this will mitigate some pressure in the system going forward.
- Additional lists being undertaken by locums to include both extended days during the week and Saturday lists.
- Daily oversight continues.

Strategic Theme: Finance

Finance

Month	Measure	Value	Description
May	I&E £m	-35.8 (-36.0%)	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
May	Cash Balance £m	13.0 (45.1%)	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.
May	Total Cost £m	-48.4 (2.4%)	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.
May	Forecast I&E £m	-19.0 (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.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

May	Normalised Forecast £m	-19.0 (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 Trust's I&E deficit in May (month 2) was £2.02m (consolidated position excluding Sustainability and Transformation Funds and after technical adjustment) against a plan of £3.03m.

The year to date I&E deficit is £5.51m against a plan of £6.67m (£1.16m ahead of plan). A reconciliation of the various adjustments is presented below.

The reported position is marginally worse than that initially reported owing to EKMS/Spencer Wing reporting a deficit of £86k year to date against a plan of a £28k surplus. This issue is being investigated.

Pay costs in the month of £28.5m saw a continued reduction in agency/locum costs from £1.9m to £1.5m but a £0.3m increase in bank costs. Further work is being undertaken to ensure that the bank pay rates are correct and that NHSP is billing correctly. Waiting list payments continued to be depressed at £0.1m against the average monthly spend of £0.34m in 2016/17. Pay is now £1.3m ahead of plan year to date.

Activity/income was on plan in month with total income £2.1m higher than in April. Income is now £0.7m behind plan ytd.

Against the £32m CIPS target, including income, £1.75m was reported in month (£1.2m recurrent, £0.4m non-recurrent) against a target of £1.46m. Year to date £3.36m is reported against a plan of £2.83m. Of the reported position, £0.5m is non recurrent and steps are being taken to ensure that this is made up recurrently.

The cash balance as at the end of May was £12.9m. No new borrowings were required.

No agreement on the 2016/17 contract value outturn or CQUIN has yet been reached with East Kent CCG commissioners. A proposal has been forwarded to them but at the time of writing no response had been received. Total risks net of opportunities of £8.5m have been identified.

The Trust's Financial Recovery Plan has been received and accepted by NHSI. This is for an £18.9m deficit target (excluding Sustainability and Transformation Funds). The second review meeting took place on 2 June and was a constructive and positive discussion.

Strategic Theme: Health & Safety

Health & Safety 1

Month	Measure	Value	Description
May	Representation at H&S	697 (50.4%)	% 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.
May	RIDDOR Reports (Number)	14 (-33.3%)	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.
May	Formal Notices	0 (-100.0%)	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).
May	Health & Safety Training	2215 3855.4%	H&S Training includes all H&S and risk avoidance training including manual handling

Comments: H&S representation at committee's is down again this month. Calendar invites have been refreshed and reviewed to reflect turnover of nominated reps, additionally reminder emails are planned in to ensure attendee's and/or nominee's can prioritise in diaries.

The Trust has received no formal notices or intervention fee's, we have however had a follow up visit from the HSE to review a RIDDOR reported accident that occurred to a member of staff. The HSE were satisfied that the Trust was not at fault and confirmed user error. We took the opportunity to update the inspector on the governance and improvement work undertaken by the Trust. The HSE reported that they felt the Trust is in a different place and were positive about the progress made.

There are No RIDDORs to report this month.

The provision of H&S training remains extremely positive

Strategic Theme: Health & Safety

Health & Safety 2

Month	Measure	Value	Description
May	Accidents	308 (-42.0%)	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.
May	Fire Incidents	134 (3.1%)	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.
May	Violence & Aggression	421 (0.7%)	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.
May	Sharps	183 (31.7%)	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 fell in April, returning to within the normal range, following last months spike.

The number of Fire incidents stayed in Amber during April, whilst the majority of the fire related incidents reported in the IPR are false alarms. It is however worth highlighting to the Board a fire within one of the plant rooms at QEQM on the xxx which caused disruption on site. The fire emanated from a UPS battery which released heavy black smoke into parts of A&E and ambulatory care. The fire was contained by estates staff whilst the services areas affected were evacuated. Staff have been supported with after incident care where appropriate. The UPS pack has been taken off site for inspection by the manufacturer and a visual review of remaining devices has been undertaken.

Violence & Aggression decreased again this month and now stands at the lowest level for 12 months.

Sharps incidents also remain positively low.

Strategic Theme: Use of Resources

Pay Independent

Month	Measure	Latest	Description
May	Payroll Pay £m	-26.9 (3.2%)	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.
May	Agency Spend £m	-1.5 (-19.9%)	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Additional sessions £k	-101 (1.2%)	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.
May	Independent Sector £k	-568 (12.6%)	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: Pay costs in the month of £28.5m saw a continued reduction in agency/locum costs from £1.9m to £1.5m but a £0.3m increase in bank costs. Further work is being undertaken to ensure that the bank pay rates are correct and that NHSP is billing correctly. Waiting list payments continued to be depressed at £0.1m against the average monthly spend of £0.34m in 2016/17. Pay is now £1.3m ahead of plan year to date.

Strategic Theme: Use of Resources

Balance Sheet

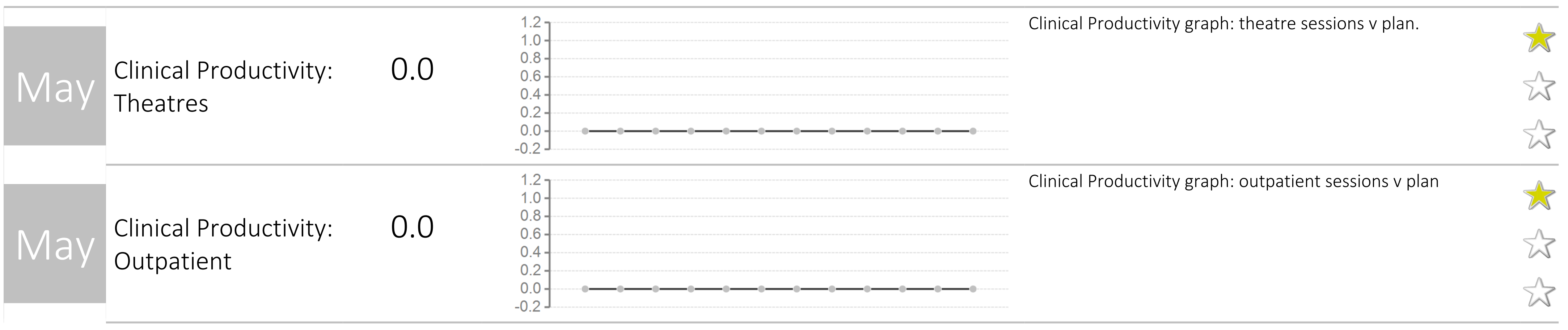
Month	Measure	Year to date	Description
May	CIPS £m	22.2 (8.7%)	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.
May	Cash borrowings £m	37.0 2662.5%	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
May	Capital position £m	-65.2 (61.6%)	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: Against the £32m CIPS target, including income, £1.75m was reported in month (£1.2m recurrent, £0.4m non-recurrent) against a target of £1.46m. Year to date £3.36m is reported against a plan of £2.83m. Of the reported position, £0.5m is non recurrent and steps are being taken to ensure that this is made up recurrently

The cash balance as at the end of May was £12.9m. No new borrowings were required.

Strategic Theme: Use of Resources

Productivity



Comments: A full programme of CIPS valued at £32m for 2017/18 is being rolled out with £16m of pay savings, £8m of non pay savings and £8m of income generation.

Strategic Theme: Improvement Journey

		Jan	Feb	Mar	Apr	May	
MD01 - End Of Life	Lost Days (Fast Track)	14	20	20	19	16	
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	70.83	76.00	80.17	76.93	76.78	>= 95
	ED - 1hr Clinician Seen (%)	40	41	41	39	42	>= 55
MD04 - Flow	IP - Discharges Before Midday (%)	14	15	14	15	15	>= 35
	Medical Outliers	122	88	67	57	61	
	Lost Days (Non-EKHUFT)	86	89	86	70	81	
	DToCs (Average per Day)	59	56	59	49	62	< 28
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	60.61	70.45	77.30	72.40	69.83	>= 85
MD07 - Maternity	Midwife:Birth Ratio (%)	20	26	27	30	28	< 28
	Staff Turnover (Midwifery)	12	12	13	13	13	<= 10
	Vacancy (Midwifery) %	4	3	5	7	7	<= 7
MD08 - Recruitment & Staffing	Staff Turnover (%)	12.5	12.6	12.7	12.9	12.9	<= 10
	Vacancy (%)	9.6	9.4	9.8	11.4	11.6	<= 7
	Staff Turnover (Nursing)	13	13	13	13	13	<= 10
	Vacancy (Nursing) %	17	16	17	12	13	<= 7
	Vacancy (Medical) %	9	9	10	13	13	<= 7
MD09 - Workforce Compliance	Appraisal Rate (%)	82.2	83.6	84.6	84.9	81.1	>= 90
	Mandatory Training (%)	88	88	89	89	89	>= 85
	Local Induction Compliance %	12.5	15.0	21.8	16.3	20.8	>= 85
KF01 - Complaints	Complaint Response in Timescales %	94	79	84	86	86	>= 85
	Complaint Response within 30 days %	28	14	25	13	25	>= 85

KF02 - Workforce & Culture	Staff FFT - Work (%)	54	54	54	54	54	>= 60
	Staff FFT - Treatment (%)	76	76	76	76	76	>= 81.4
KF09 - Medicines Management	Pharm: Fridges Locked (%)	89	89	86	86	86	>=95
	Pharm: Fridge Temps (%)	83	83	80	80	82	>= 100
	Pharm: Drug Trolleys Locked (%)	98	98	98	99	99	>= 90
	Pharm: Resus. Trolley Check (%)	87	88	80	84	85	>= 90
	Pharm: Drug Cupboards Locked (%)	89	89	90	89	89	>= 90

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 1hr Clinician Seen (%)	% of A&E attendances seen within 1 hour by a clinician	>= 55	
	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 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Lost Days (Fast Track)	Beddays lost due to delayed discharge (Fast Track)		
	Lost Days (Non-EKHUFT)	Beddays lost due to delayed discharge (Non-EKHUFT)		
	Medical Outliers	Number of patients recorded as being under a Medical specialty but was discharged from a Surgical Ward (Patients admitted to a ward which is not related to their clinical reason, mainly due to capacity reasons)		
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 %

Clinical Outcomes	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 %
	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 %
	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.	>= 60	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 %

Data Quality & Assurance	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	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
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 %
	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 %

Health & Safety	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	< 1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	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	10 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.	< 1	
	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.		
	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.		
	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.	>= 98	20 %
	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.		

Category	Indicator	Description	Target	Variance
Incidents	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	>= 1	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.		
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	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	
	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). Arrow represents YTD position with the % showing variance against the last month.	<= 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	
	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 %
	E. Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	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	

Category	Metric	Description	Target	Variance
Infection	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	
	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 - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	
Initiatives	Antimicrobial Resistance & Stewardship CQUIN Delivered %	CQUIN made up of two parts – reducing antibiotic consumption in named antibiotics and review of patients on antibiotics after 48/72 hours	>= 100	20 %
	End of Life Pathway CQUIN Delivered %	CQUIN linked to current improvement work and multi-agency policy	>= 100	20 %
	Patient Flow CQUIN Delivered %	CQUIN linked to SAFER project	>= 100	20 %
	Sepsis CQUIN Delivered %	CQUIN including acute wards and with antibiotic review at 72 hours	>= 100	20 %
	Staff Health & Wellbeing CQUIN Delivered %	CQUIN made up of three parts – staff access to healthy activities, health food options on site and flu vaccine uptake	>= 100	20 %
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.	< 90	35 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, 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 HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data.	< 0.95	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-8pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 8pm-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.	>= 89	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).	>= 89	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 %	Complaint Response within agreed Timescales %	>= 85	5 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	FFT: Not Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 1	10 %
	FFT: Recommend (%)	Of those patients (Inpatients excluding Day Cases) 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 %

Patient Experience	FFT: Response Rate (%)	The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 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.	< 1	0 %
	Number of Compliments	The number of compliments recorded overall Data source - Patient Experience Team (Kayleigh McIntyre).	>= 1	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.	>= 89	2 %
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.		
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	< 5	10 %
	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	

Section	Indicator	Description	Target	Variance
RTT	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	
	Agency & Locum Spend	Total agency spend including NHSP spend		
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	
	Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available.		
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
	Local Induction Compliance %	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	
	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 %
	Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	
	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)	>= 80	15 %
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 80	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.	< 3.6	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		
	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		

Category	Metric	Description	Target	Weight
Staffing	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.	<= 10	15 %
	Staff Turnover (Midwifery)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Midwives. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
	Staff Turnover (Nursing)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Nurses. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
	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.	<= 10	
	Total Staff Headcount	Headcount of total staff in post		
	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.	<= 7	15 %
	Vacancy (Medical) %	% Vacant positions against Whole Time Equivalent (WTE) for Medical Staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
	Vacancy (Midwifery) %	% Vacant positions against Whole Time Equivalent (WTE) for Midwives. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
	Vacancy (Nursing) %	% Vacant positions against Whole Time Equivalent (WTE) for Nurses. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
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	

Training	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	
	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	
	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	
	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	
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	< 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	
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		
	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	
	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	

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

Patient Safety Heatmap - MAY 2017

KEY

(grey)	data not yet available
NULL	null return, data not received
N/A	metric is not applicable

	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 (%)	Care Hours Per Patient Day (CHPPD)
KCH - Kent & Canterbury																	
Specialist																	
KBRA - BRABOURNE (KCH)	100.0	0	0	0	0	0	39	100	100	100	75	100	0.0	91.4	81	104	14
MARL - MARLOWE WARD	100.0	3	4	0	0	0	1	87	87	96	52	98	0.0	86.3	94	96	9
Surgical																	
CLKE - CLARKE WARD	100.0	4	7	0	0	2	3	75	72	88	15	100	0.0	80.8	89	90	6
KENT - KENT WARD	100.0	6	3	0	0	0	0	100	100	100	22	100	0.0	94.5	102	93	8
KITU - KCH ITU	100.0	0	0	0	0	0	52	N/A	N/A	N/A	N/A	N/A	N/A	96.9	91	102	29
Urgent Care																	
HARB - HARBLEDOWN WARD	96.0	1	4	0	0	0	1	100	100	100	47	100	0.0	80.1	92	109	6
INV - INVICTA WARD	100.0	0	5	0	0	1	0	NULL	NULL	NULL	26	100	0.0	82.4	92	134	6
KCDU - EMERGENCY CARE CENTRE	100.0	0	0	0	0	0	10	NULL	NULL	NULL	27	89	7.8	87.7	94	92	25
KING - KINGSTON WARD	88.5	1	0	0	0	1	0	NULL	NULL	NULL	7	100	0.0	93.8	92	110	6
KNRU - EAST KENT NEURO REHAB UNIT	100.0	0	3	0	0	0	0	100	91	100	45	100	0.0	80.9	106	142	7
MTMC - MOUNT/MCMASTER WARD	100.0	0	2	0	0	0	7	NULL	NULL	NULL	24	100	0.0	66.0	93	127	5
TAY - TAYLOR WARD	100.0	0	0	0	0	0	0	96	96	97	86	100	0.0	85.1	75	100	7
TREB - TREBLE WARD	94.4	0	1	0	1	1	52	83	83	96	0	NULL	NULL	80.7	80	132	6
QEH - Queen Elizabeth Queen Mother																	
Specialist																	
BIR - BIRCHINGTON WARD	94.4	1	1	0	0	0	137	90	95	91	22	100	0.0	94.3	102	99	6
KIN - KINGSGATE WARD	100.0	0	0	0	0	1	1	N/A	N/A	N/A	N/A	N/A	N/A	96.6	80	80	28
QSCB - QEH SPECIAL CARE BABY UNIT	NULL	0	0	0	0	0	9	N/A	N/A	N/A	N/A	N/A	N/A	103.5	85	100	19
RAI - RAINBOW WARD	100.0	0	1	0	0	3	3	N/A	N/A	N/A	12	100	0.0	93.8	102	114	13
Surgical																	
BIS - BISHOPSTONE WARD	100.0	3	3	0	0	1	0	88	81	95	78	100	0.0	83.4	234	160	1
CSF - CHEERFUL SPARROWS FEMALE	96.3	2	2	0	1	1	0	93	97	96	64	96	2.7	63.8	93	89	6
CSM - CHEERFUL SPARROWS MALE	95.8	4	6	0	0	0	12	90	94	95	35	95	0.0	79.8	91	99	7
QITU - QEH ITU	100.0	0	0	0	0	0	40	N/A	N/A	N/A	N/A	N/A	N/A	87.4	91	113	27

Apdx.

KEY

Key	Meaning
(grey)	data not yet available
NULL	null return, data not received
N/A	metric is not applicable

Ward	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 (%)	Care Hours Per Patient Day (CHPPD)
QX - QUEX WARD	100.0	0	2	0	0	0	91	91	95	96	79	97	1.4	97.4	101	98	5
SB - SEA BATHING WARD	96.2	0	0	0	0	0	0	99	94	99	46	100	0.0	82.4	87	102	10
Urgent Care																	
DEAL - DEAL WARD	100.0	0	8	0	0	0	1	97	95	99	4	100	0.0	82.8	112	136	7
FRD - FORDWICH WARD STROKE UNIT	95.5	1	2	0	0	1	0	100	100	100	31	91	0.0	82.3	114	121	9
MW - MINSTER WARD	100.0	2	1	0	0	0	28	NULL	NULL	NULL	57	100	0.0	83.3	105	112	7
QCCU - QEH CCU	100.0	0	0	0	1	0	0	NULL	NULL	NULL	75	100	0.0	89.7	91	102	8
QCDU - QEH CDU	100.0	0	0	4	0	0	0	100	100	100	19	93	3.6	93.4	118	165	10
SAN - SANDWICH BAY WARD	100.0	2	3	0	0	0	1	95	82	96	36	93	0.0	100.6	161	210	9
SAU - ST AUGUSTINES WARD	100.0	1	6	0	0	1	0	100	100	100	85	93	3.4	101.9	104	111	5
STM - ST MARGARETS WARD	92.0	1	9	0	0	2	1	NULL	NULL	NULL	24	100	0.0	94.3	124	150	7
WHH - William Harvey																	
Specialist																	
FF - FOLKESTONE	100.0	0	1	0	0	1	0	NULL	NULL	NULL	N/A	N/A	N/A	97.6	87	72	25
KEN - KENNINGTON WARD	100.0	1	1	0	0	0	0	84	93	93	22	100	0.0	81.6	87	97	10
PAD - PADUA	100.0	0	1	0	0	1	0	N/A	N/A	N/A	9	100	0.0	92.1	92	96	10
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	9	N/A	N/A	N/A	N/A	N/A	N/A	106.2	103	101	9
Surgical																	
ITU - WHH ITU	100.0	0	0	2	0	0	2	N/A	N/A	N/A	N/A	N/A	N/A	101.9	125	112	33
KA2 - KINGS A2	100.0	1	4	0	0	0	112	94	88	95	53	98	0.0	89.3	97	110	6
KB - KINGS B	100.0	2	1	0	0	0	156	100	100	93	63	98	1.7	90.5	97	118	6
KC - KINGS C1	96.3	1	4	0	0	0	92	98	99	98	52	91	0.0	94.2	112	100	6
KC2 - KINGS C2	95.8	0	1	0	0	0	83	96	96	97	81	100	0.0	85.9	83	94	6
KDF - KINGS D FEMALE	94.4	1	3	0	0	3	2	88	90	92	41	100	0.0	92.7	N/A	N/A	N/A
KDM - KINGS D MALE	100.0	2	7	0	0	2	0	85	83	94	39	97	0.0	N/A	105	122	11
RW - ROTARY WARD	100.0	4	2	0	0	1	0	91	94	98	51	100	0.0	87.7	101	107	9
Urgent Care																	
CCU - CCU	100.0	0	0	0	0	0	0	100	100	100	78	100	0.0	87.9	102	83	14
CJ2 - CAMBRIDGE J2	100.0	0	3	0	0	1	0	100	100	100	39	98	2.3	74.6	120	109	6
CK - CAMBRIDGE K	100.0	1	4	0	0	0	11	97	80	91	66	98	0.0	90.1	104	114	6
CL - CAMBRIDGE L REHABILITATION	100.0	2	10	0	0	1	1	87	66	95	67	100	0.0	98.7	101	129	6

KEY

(grey)	data not yet available
NULL	null return, data not received
N/A	metric is not applicable

Ward	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 (%)	Care Hours Per Patient Day (CHPPD)
CM1 - CAMBRIDGE M1 SHORT STAY	100.0	1	6	0	0	0	0	100	95	98	0	NULL	NULL	61.5	N/A	N/A	N/A
CM2 - CAMBRIDGE M2	100.0	1	5	0	0	0	0	93	90	93	51	100	0.0	94.8	105	113	6
OXF - OXFORD	92.3	1	3	0	0	0	1	86	83	93	43	93	0.0	90.6	113	113	8
RST1 - RICHARD STEVENS 1 STROKE UNIT	100.0	2	12	0	0	0	14	95	88	80	47	98	0.0	81.3	96	88	7
WCDM - WHH CDU MIXED	100.0	0	0	1	0	0	0	95	97	99	17	81	16.1	77.7	99	107	13

Human Resources Heatmap

	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term	Central
Agency %	4.9	3.9	5.2	9.4	10.5	4.9	18.3	44.5	
Appraisal Rate (%)	86.3	85.0	74.8	72.1	84.8	75.3	88.9	67.4	
Employed vs Temporary Staff (%)	86.6	89.4	90.8	85.1	92.6	87.3	91.0	85.7	0.0
Mandatory Training (%)	92	95	90	83	90	94	85	88	
Sickness (%)	2.6	2.2	2.5	3.9	3.7	2.9	4.2	3.9	
Staff Turnover (%)	13.2	9.5	16.6	19.2	13.4	10.8	11.1	14.2	
Total Staff In Post (SiP)	1457	125	198	90	1328	328	1725	1662	0
Vacancy (%)	13.4	10.6	10.1	16.2	7.5	12.7	9.0	14.5	100.0

Corporate
0