East Kent Hospitals University NHS
NHS Foundation Trust

SEPTEMBER 2016

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
NHS Foundation Trust

Chief Executive's Summary

As this report highlights, during September the Trust has continued to provide safe, effective care in what remains a very challenging operational environment. The most recent involvement of our staff in the “NHS Fabulous Change Day” events, through the innovation hubs and through team and individual pledges on how we work together (partnerships), support each other (people), improve experience (patients) and on what we do (provision), is yet another reminder of the dedication and commitment of our staff to great patient care.

It remains expected that a decision on our special measures status will be made in December, but we continue to work on our improvement journey and to refresh the actions in those plans.

For September I am pleased to report that sickness levels have reduced to 3.2%, the lowest level this year, and that both appraisal rates (81.2%) and mandatory training (89%) levels are also improved. However, more worryingly, vacancy rates (10.6%) and staff turnover rates (12.6%) have both worsened, with recruitment and retention continuing to be a challenge.

Operational pressures have continued in September with bed occupancy at its highest level since May, a number of mixed sex breaches, and discharges before midday showing no improvement on previous levels. The number of delayed transfers has averaged 52 over the month, a small improvement. Performance against the national standards remains a challenge with the 4 hour waits standard showing a small improvement in month to 84.19%, but with the Referral to Treatment standard declining to 83.78%. There continue to be detailed, focused and robust discussions with commissioners on both these areas and detailed plans for improvements that continues to be a real priority for the whole team. In month there has been a deterioration in both theatre session utilisation rates and start times to the lowest levels this year, and whilst this may partly be explained by the bed pressures, productivity improvement in this area is a key component of our financial plans.

Performance against diagnostic waiting times continues to be strong whilst cancer waiting times have continued their general improvement although there is more to do for the 62 day treatment standard. At all times high priority is the safety of our patients and we continuously monitor activity, flow, beds and staffing levels to ensure that safety is maintained.

During September there have been a number of constructive discussions with NHSI on the Trust’s financial position. The Trust’s I&E deficit in September was £1.6m with a year to date of £10.99m. this is a small improvement on recent months. The Trust's year end forecast has been revised to a deficit of £19m from £24m against the published NHSI Control Total of a £0.6m surplus. A range of additional actions have been set in place including a peer review process against temporary staff usage, quality impact assessed vacancy management, and a range of both cost avoidance and run rate reduction measures. This includes deferral of a number of programmes, a continued focus on clinical productivity initiatives, and a further review of asset lives. I would also wish to record my thanks to Obi Hasan, Turnaround Director, who finished his assignment at the Trust as the end of September.

There is a new local team at NHSI and we can expect their focus to be on safe and effective care, operational performance and financial improvement. These are the three core elements of our improvement journey which will combine in the development of the clinical strategy to ensure sustainable services in which we can all be proud.

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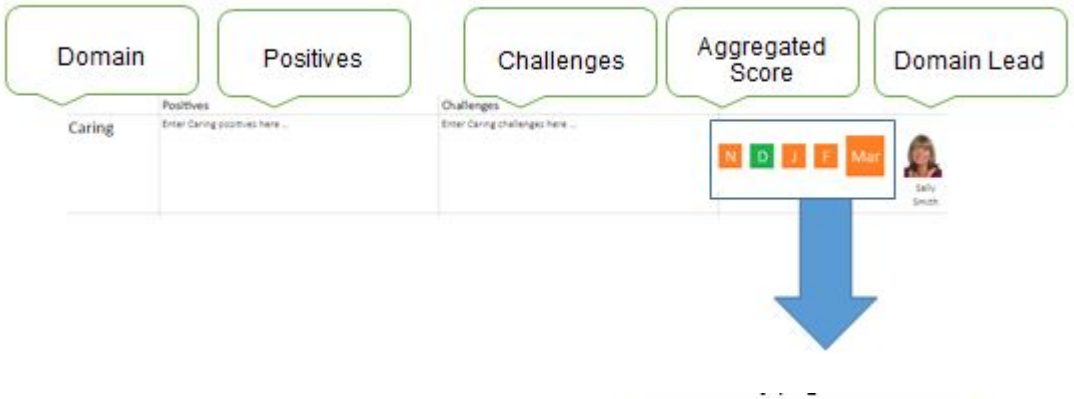
Understanding the IPR

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



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

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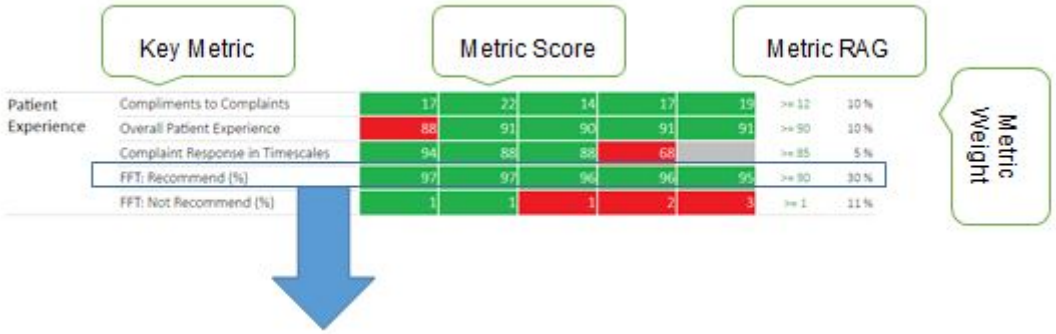
Understanding the IPR

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



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

All RAGs are banded as Green, Amber and Red. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

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Strategic Priorities

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Contents

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Headlines

	Positives	Challenges	
Caring	• Friends and Family Test is higher than national at 97% recommendation; • All wards and departments now have working devices to capture real-time inpatient feedback; • Complaint response times agreed with clients remains above the Trust standard at 92%; • Overall inpatient real-time experience is rated above 90%.	• A sharp increase of reported mixed sex accommodation breaches. These are due to operational pressures during September; • The ED friends and family test recommendations is below national rate with challenges reported by patients around waiting times.	M J J A Sep  Sally Smith
Effective	• There has been a slight reduction in the number of delayed transfers of care from our hospitals	• There has been an increase in the hospital bed occupancy and no change in the percentage of discharges by midday. • There has been a slight decline in theatre on time starts and the audit results for the WHO theatre checklist	M J J A Sep  Jane Ely
Responsive	• Performance for the diagnostic waiting times remains strong at well over 99% completed within 6 weeks • We have again achieved the two week wait cancer standard for referral to being seen by a consultant • Performance against the Emergency four hour standard has improved as a result of all the hard work that our staff deliver everyday	• Our performance against the 18 weeks referrals to treatment standard has deteriorated further due to the higher than expected demand in key specialties and also the reduced validation capacity which has now been addressed. • The 62 day cancer standard performance has not improved this month due to an increased number of cancer treatments in September that were beyond the 62 days.	M J J A Sep  Jane Ely
Safe	• There are signs this month of an improvement in VTE assessment recording. • Mortality rates remain good in comparison to other Trusts and our Summary Hospital Level Mortality Indicator (SHMI - reported 6 months in arrears) is 0.98 representing a sustained improvement over the last 3 reporting periods. A particular positive is that the Trust standardised mortality ratio for deaths in hospital following emergency admission for fractured neck of femur is significantly lower than expected.	• Although hospital acquired infection rates remain on trajectory this continues to be an area of concern and challenge for the organisation, particularly given the over crowding and bed occupancy rates. • Although Harm Free Care experienced in our care remains better than the national average this month has seen a reduction compared to last month and the avoidable Category 2 hospital acquired pressure ulcers per 1,000 bed days shows a similar trend. • The William Harvey site is our hottest site in terms of the emergency care demands and this is reflected in the overall patient safety heat map.	M J J A Sep  Paul Stevens

Well Led	• Sickness levels reduced to 3.2% • Continuing improvement in appraisal rates (81.2%) and mandatory training (89%) • Maintaining positive cash balance • Increase in day shifts filled (93%) • Health and Safety issues	• Increase in vacancy rates (10.6%) and turnover rates (12.6%) • Financial position through to year end • Increase in uncoded spells at month end	M J J A Sep	 Matthew Kershaw

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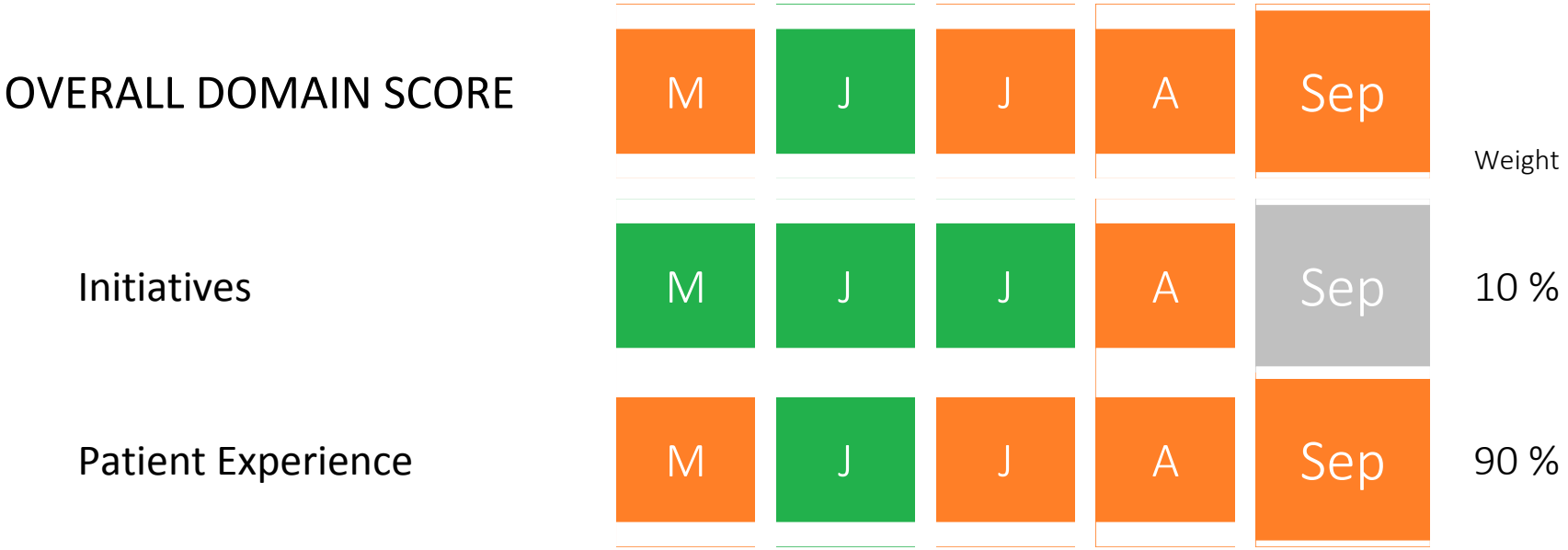
Caring



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Caring

		May	Jun	Jul	Aug	Sep	Green	Weight
Initiatives	Staff Health & Wellbeing CQUIN	100	100	100	100		>= 100	20 %
	Sepsis CQUIN Delivered %	90	90	90	90		>= 100	20 %
	Antimicrobial Resistance &	100	100	100	100		>= 100	20 %
	End of Life Pathway CQUIN Delivered	100	100	100	90		>= 100	20 %
	Patient Flow CQUIN Delivered %	100	100	100	100		>= 100	20 %
Patient Experience	Compliments to Complaints (#/1)	13	12	12	15	19	>= 12	10 %
	Mixed Sex Breaches	0	11	29	45	70	1	10 %
	Overall Patient Experience %	91	91	92	92	91	>= 90	10 %
	Complaint Response in Timescales %	84	94	96	97	92	>= 85	5 %
	FFT: Recommend (%)	97	98	97	97	97	>= 90	30 %
	FFT: Not Recommend (%)	1.5	1.0	1.7	1.1	1.5	>= 1	10 %

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Effective

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Effective

		May	Jun	Jul	Aug	Sep	Green	Weight
Beds	Bed Occupancy (%)	101	98	99	99	101	<= 90	60 %
	IP - Discharges Before Midday (%)	14	14	15	15	15	>= 35	10 %
	DToCs (Average per Day)	62	62	62	58	52	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3	3	3	3	3	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	17	17	16	16	16	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	99	99	98	96	96	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	8.1	8.1	7.9	8.0	7.6	< 7	0 %
	DNA Rate: Fup %	9.0	8.0	7.3	7.1	6.9	< 7	0 %
	New:FUp Ratio (1:#)	0.7	0.7	0.7	0.7	0.7		0 %
Productivity	LoS: Elective (Days)	3.2	2.8	3.0	3.1	3.0		0 %
	LoS: Non-Elective (Days)	5.7	6.3	5.7	6.0	6.2		0 %
	Theatres: Session Utilisation (%)	83	85	82	82	80	>= 85	25 %
	Theatres: On Time Start (% 30min)	79	81	81	78	76	>= 90	10 %
	Non-Clinical Cancellations (%)	0.0	0.0	0.0	0.3	0.0	< 0.8	20 %
	EME PPE Compliance %	85	85	83	83	82	>= 90	20 %

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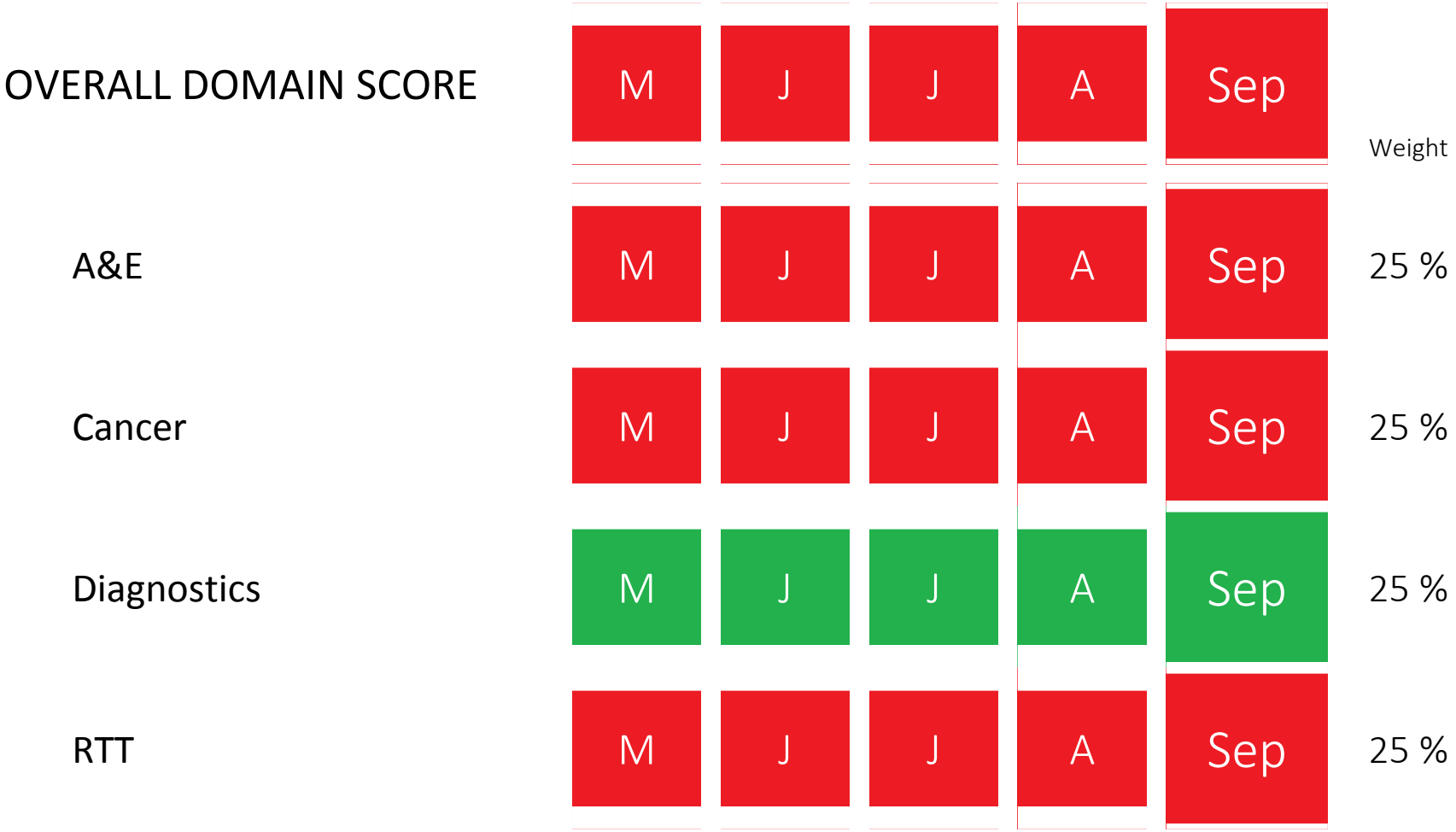
Responsive



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Responsive

		May	Jun	Jul	Aug	Sep	Green	Weight
A&E	ED - 4hr Compliance (%)	82.69	85.40	82.88	82.25	84.19	>= 95	100 %
Cancer	Cancer: 2ww (All) %	88.48	94.61	96.44	94.70	94.64	>= 93	10 %
	Cancer: 2ww (Breast) %	83.73	93.71	93.10	92.44	94.53	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	96.31	94.55	94.31	93.20	93.47	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	88.24	86.96	96.61	90.38	92.31	>= 94	5 %
	Cancer: 31d (Drug) %	98.95	100.00	97.33	98.89	100.00	>= 98	5 %
	Cancer: 62d (GP Ref) %	79.20	75.42	70.94	74.73	70.38	>= 85	50 %
	Cancer: 62d (Screening Ref) %	93.10	100.00	83.33	87.50	93.94	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	57.14	100.00	82.35	85.71	80.00	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.87	99.86	99.77	99.56	99.74	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	100.00	100.00	100.00	99.66	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	0 %
RTT	RTT: Incompletes (%)	87.89	86.81	86.65	85.52	85.11	>= 92	100 %
	RTT: 52 Week Waits (Number)	9	17	25	20	27	< 1	0 %

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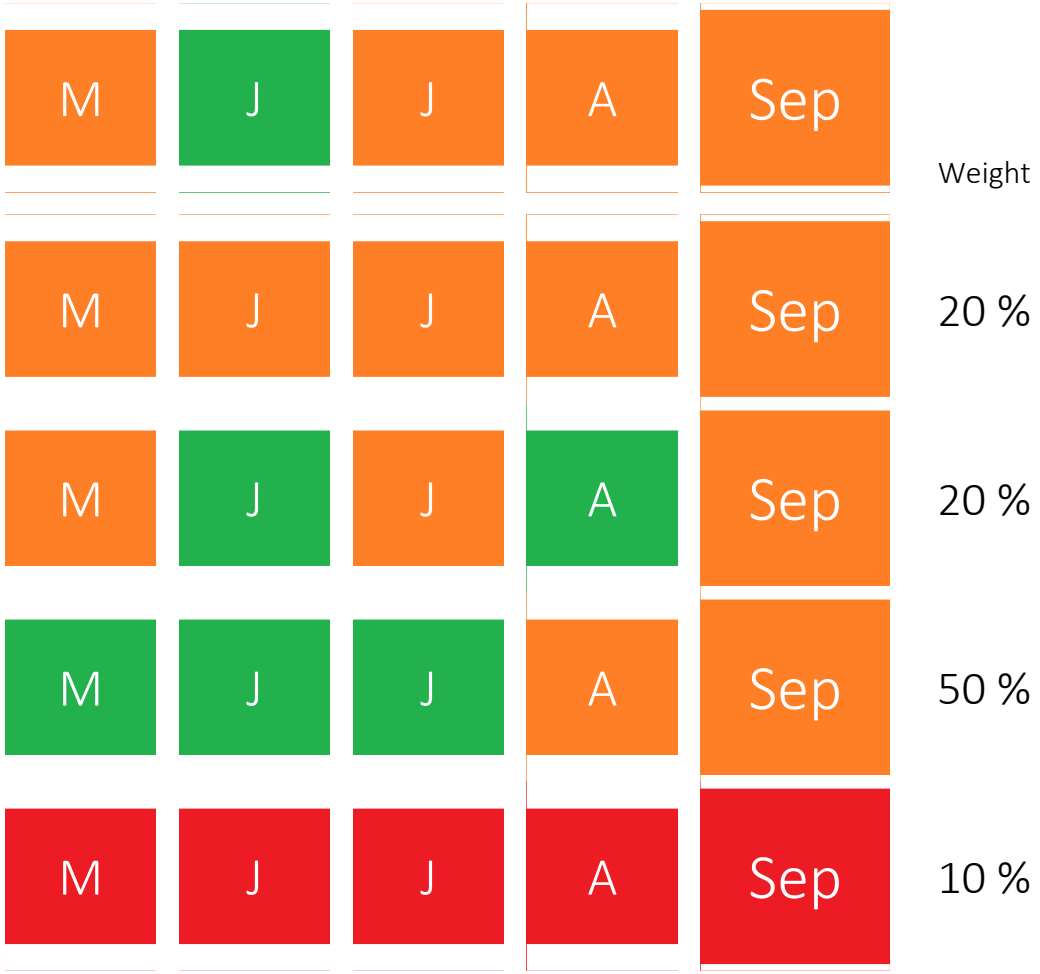
Safe



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Safe

		May	Jun	Jul	Aug	Sep	Green	Weight
Incidents	Serious Incidents (STEIS)	7	12	9	5	8		0 %
	Harm Free Care: New Harms (%)	97.7	98.5	98.0	98.0	97.7	>= 98	20 %
	Falls (per 1,000 bed days)	4.91	5.85	5.46	5.48	5.51	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.37	0.26	0.18	0.24	0.31	<= 0.15	10 %
	Clinical Incidents: Total (#)	1331	1370	1251	1263	1329		0 %
Infection	Cases of C.Diff (Cumulative)	8	11	16	19	21	<= Traj	40 %
	Cases of MRSA (per month)	1	0	0	0	1	< 1	40 %
Mortality	HSMR (Index)	82	81	81			< 90	35 %
	Crude Mortality EL (per 1,000)	0.7	0.5	0.4	0.4	0.3	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	26	26	30	30	27	< 27.1	10 %
	RAMI (Index)	84					< 87.45	30 %
Observations	VTE: Risk Assessment %	87	88	87	88	90	>= 95	20 %

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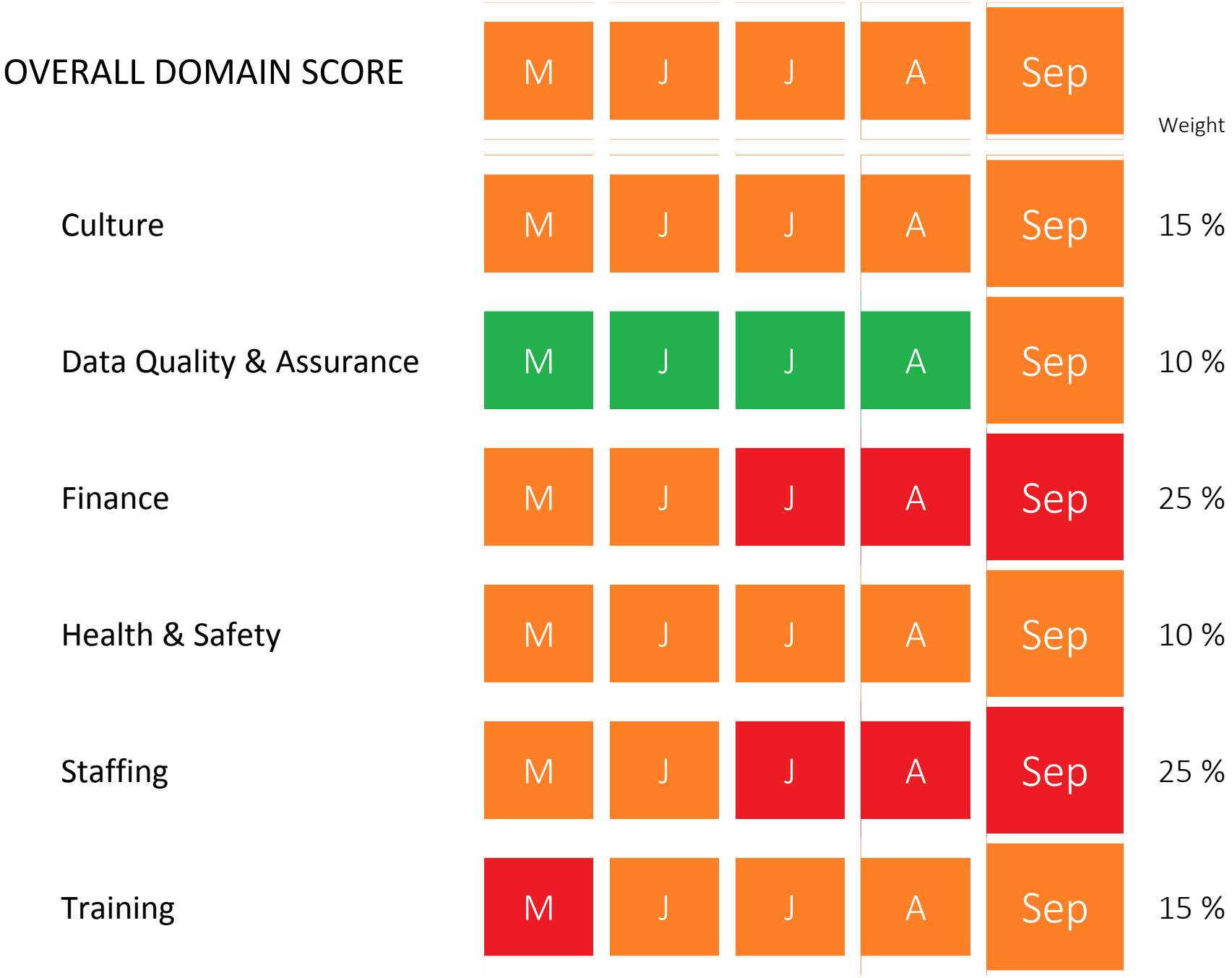
Well Led



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Well Led

		May	Jun	Jul	Aug	Sep	Green	Weight
Culture	Staff FFT - Work (%)	58	58	58	58	58	>= 60	50 %
	Staff FFT - Treatment (%)	78	78	79	79	79	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	1	1	1	1	2	< 4	25 %
	Valid NHS Number %	99	99	99	99	99	>= 99.5	40 %
	Uncoded Spells %	0	0	0	0	2	< 0.25	25 %
Finance	I&E £m	-1.9	-0.6	-0.6	-3.5	-1.6	>= Plan	30 %
	Cash Balance £m	8.5	8.5	14.2	17.5	9.8	>= Plan	20 %
	Total Cost £m	-48.0	-47.4	-47.4	-49.4	-50.1	>= Plan	20 %
	Forecast I&E £m	-11.0	-11.0	-11.0	-24.5	-19.5	>= Plan	20 %
	Normalised Forecast £m	-27.6	-27.6	-27.6	-27.6	-23.6	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	0	0	1	1	1	<= 3	20 %
	Formal Notices	1	0	0	0	0	1	15 %
Staffing	Sickness (%)	3.8	3.8	3.8	3.8	3.2	< 3.6	10 %
	Staff Turnover (%)	11.3	11.8	12.1	12.0	12.6	<= 10	15 %
	Vacancy (%)	9.2	9.7	10.4	10.5	10.6	<= 7	15 %
	Shifts Filled - Day (%)	101	98	91	91	93	>= 97	15 %
	Shifts Filled - Night (%)	105	103	103	102	100	>= 97	15 %
	Agency %	18.3	18.1	20.3	21.7	21.1	<= 10	0 %
	NHSP Use % of Agency	100.0	100.0	100.0	100.0	100.0	> 90	0 %
Training	Appraisal Rate (%)	70.0	73.1	75.4	79.5	81.2	>= 90	50 %
	Mandatory Training (%)	79	87	87	88	89	>= 85	50 %

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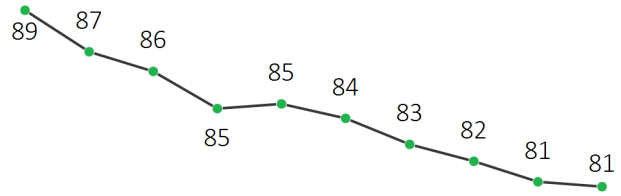
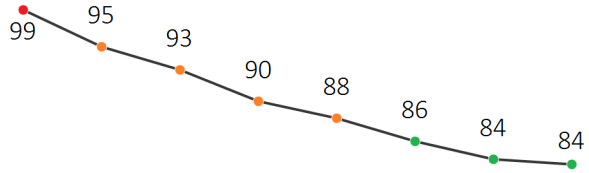
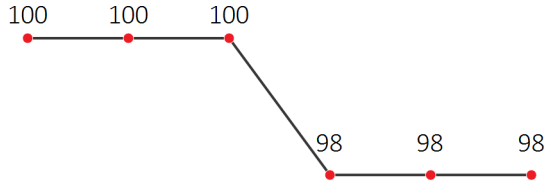
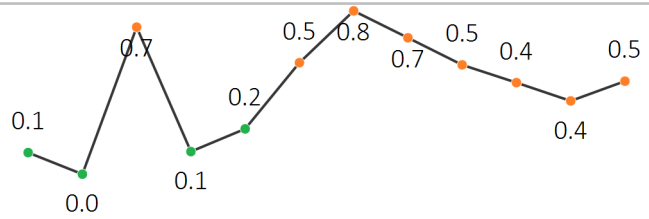
Strategic Theme: Patient Safety

Mortality

Sep	HSMR (Index)	84 (-8.8%)		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.
Sep	RAMI (Index)	90 (-4.5%)		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.
Sep	SHMI	99 (-3.2%)		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.
Sep	Crude Mortality EL (per 1,000)	0.4 (-2.7%)		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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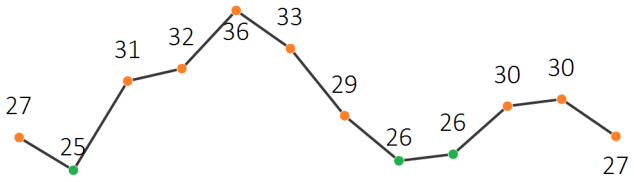
Strategic Theme: Patient Safety

Sep

Crude Mortality NEL (per 1,000)

29
(-4.1%)



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 mortality figures for the month of September continue to be positive in comparison to other Trusts. Our national SHMI is 0.98 for the period April 2015 - March 2016 and this has shown a consistent fall from 1.03 in the period July 2014 - June 2015. There are some areas of concern lying below that overall indicator and these include cardiac related diagnostic groups (acute myocardial infarction, cardiac arrests/ventricular fibrillation, heart failure), carcinoma of the lung and colon, chronic obstructive pulmonary disease and septicaemia.

A higher observed versus expected mortality in the cardiac related diagnostic groups is in part explained by the regional primary percutaneous coronary intervention service at Ashford and there are no worrying trends, however this will be an area that the Mortality Steering Committee concentrates on. Carcinoma of the lung and colon mortality rates are going to be influenced by delays in the cancer pathways and these are being actively addressed. Finally the increase in mortality from sepsis is in part due to more accurate coding (over the period that this has increased mortality from pneumonia and urinary tract infection has significantly fallen). Again this is an area that the Mortality Steering Committee will concentrate on and the sepsis collaborative have also recently introduced inpatient sepsis screening.

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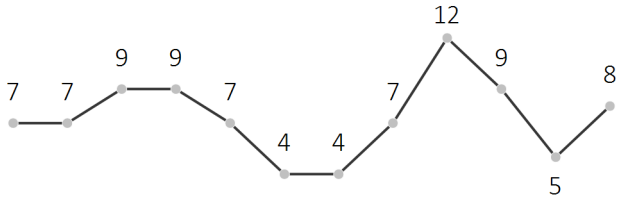
Strategic Theme: Patient Safety

Serious Incidents

Sep	Serious Incidents (STEIS)	88 (7.3%)		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.

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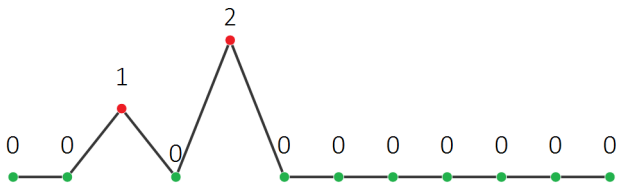
Strategic Theme: Patient Safety

Sep

Never Events (STEIS)

3
(-40.0%)



Monthly number of Never Events. Uses validated data from STEIS.
Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

Total open SIs on STEIS September 2016: 75 (including 8 new)
SIs under investigation: 43
Breaches: 17
Non-breaches: 26

SIs awaiting closure: 32
Waiting CCG response: 16
Waiting EKHUFT non-closure response: 16

Supporting Narrative:
The number of breached cases have risen from 12 to 17. This has been in part due to one division having new governance leads causing breached cases, and in part due to the quality of investigations which require more as the CCGs have evolved. Divisions have continued to investigate mainly by use of health records and not by other forms of evidence. This leads to delays as the Clinical Risk Team (CRT) requires further analysis. There have also been delays while awaiting sign off.

Work continues on clearing the longest breached cases and there has been progress on this and further progress is predicted.

Additional advice has been given to divisions to further enhance the quality of their action plans as the CCGs require robust actions to enable them to be closed.

CRT are reviewing the process for when the draft report comes to the team and this is currently being trialled within the surgical division.

There were eight new SIs relating to:
- three treatment or diagnostic delays (vaginal/vulval cancer, lung cancer and ophthalmology);
- one suboptimal care of the deteriorating patient;
- three maternity incidents affecting the baby only and
- one systems issue (RIS).

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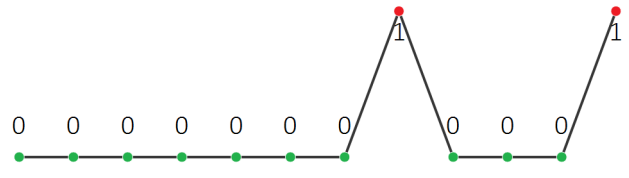
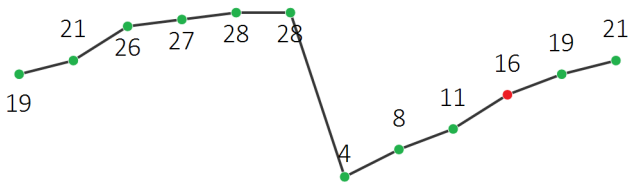
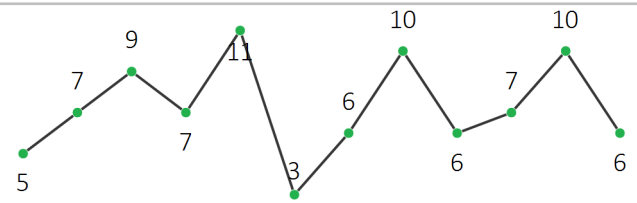
Strategic Theme: Patient Safety

Infection Control

Sep	Cases of MRSA (per month)	2 (0.0%)		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.
Sep	Cases of C.Diff (Cumulative)	21 (10.5%)		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.
Sep	E. Coli	87 (47.5%)		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.

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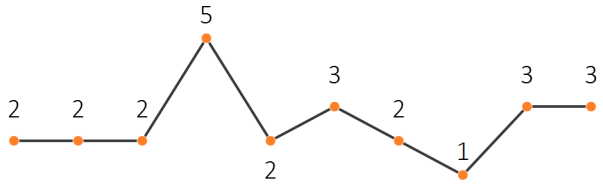
Strategic Theme: Patient Safety

Sep

MSSA

25
(31.6%)



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:

There has been one case of MRSA bacteremia in September 2016 which has been assigned to the Trust at the post infection review meeting. There was a cluster of ward acquired MRSA on St Augustine ward in July-August 2016 and one of these patients developed MRSA bacteremia. A meeting was held to address ward acquired MRSA on St Augustine ward. There haven't been any further ward acquired MRSA cases in September 2016.

MSSA (methicillin sensitive Staphylococcus aureus) is an area of heightened awareness for the infection control team at present, together with E. coli. Bacteraemia data reported for the year 2015/16 shows us to be an outlier for both of these organisms and although the majority of these are attributed to the community (ie are not hospital acquired) we need to be assured that this is the case.

We had 2 cases of C.difficile in September 2016. The total number of C.difficile cases is 21, although this is below the trajectory for this year it is actually a concern and this is a significantly worse position in comparison to last year. The monthly rate per 100,000 occupied bed days is 13.73 compared to Kent average of 11.80 and English average of 13.50. A new diarrhoea assessment tool is currently being piloted on two wards at WHH and QEQM.

Valerie Harmon, new Deputy Director of Infection Prevention and Control has joined the Trust in September 2016.

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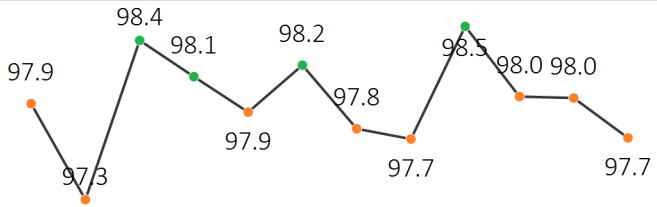
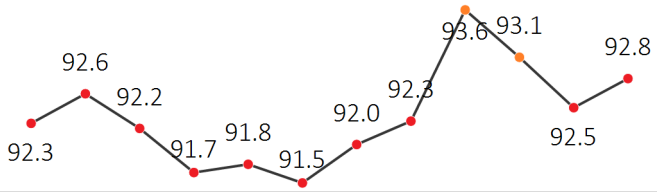
Strategic Theme: Patient Safety

Harm Free Care

Sep	Harm Free Care: New Harms (%)	97.9 (-0.4%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.
Sep	Harm Free Care: All Harms (%)	92.4 (-0.7%)		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:

Harm free care

Overall Harm Free Care (HFC) relates to the Harms patients are admitted with as well as those they acquire in our care. HFC in September improved to 92.53% compared to 92.36 % in August but remains below both the overall national average of 94.07% and the acute hospitals only national average of 93.82%. A wide variation, as expected, is seen across the divisions with specialist achieving 98.83%, surgical 90.63% and UCLTC 91.81%.

However, Harm Free Care experienced in our care (New Harms only) at 97.07% in September is higher than national average which means that our patients are receiving care that causes less harm than is reported nationally. New Harms only were 2.30% compared to 2.28% national average for acute hospitals; this means that our patients acquire slightly higher levels of new harms than the national average for acute hospitals. All harms were 7.19% compared to national average of 5.93%, this means our patients are admitted with a higher level of harm than the national average.

QEH New Harms Only HFC fell slightly to 98.14% in September compared to 98.33% in August.
WHH New Harms Only HFC fell slightly to 97% in September compared to 97.52% in August.
K&C New Harms Only HFC improved to 98.35% in September from 98.17% in August.

HFC (new harms only) for individual harms are higher than the national average for acute hospitals for 3 out of the 4 harms measured. The Safety Thermometer for September demonstrates lower levels of New Pressure Ulcers 0.46% compared to acute hospitals (0.77%). However, our catheters & New UTIs are higher at 0.55% compared to acute hospitals (0.44%), New VTEs are higher at 0.74% compared to acute hospitals (0.62%) and Falls with harm are higher at 0.55% compared to 0.49% for acute hospitals. Rigorous work will continue to ensure validation is carried out correctly and focus work is being carried out to reduce the number of falls to ensure patient safety.

However, HFC (all harms) shows a lower than national level of patients being admitted who have already started treatment for UTI or a UTI was already present on admission - 1.01% compared to the national average of 1.17% for acute hospitals. This has improved by the collaborative work undertaken with community partners.

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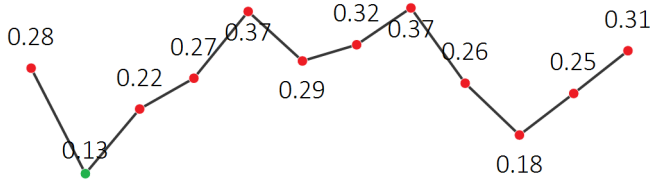
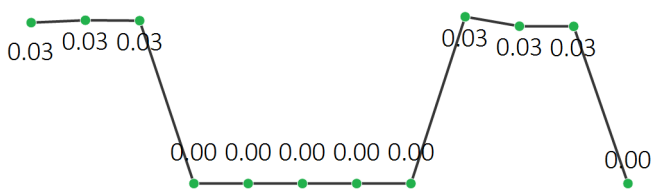
Strategic Theme: Patient Safety

Pressure Damage

Sep	Pressure Ulcers Cat 2 (per 1,000)	0.27 (-25.5%)		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.
Sep	Pressure Ulcers Cat 3/4 (per 1,000)	0.02 (-76.2%)		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 September 2016 a total of 31 category two pressure ulcers were reported and 10 were confirmed as avoidable. This is an increase of 2 avoidable ulcers from last month. Seven affected the sacrum/buttocks occurring on Cambridge K, Kings C1, Sandwich Bay, Harbledown, Seabathing and two on Richard Stevens. Two affected the heels, 1 on RSW and 1 on Cambridge J. All of the heel ulcers were due to lack of evidenced heel offloading.

Lack of pillows is often cited as involved in lack of heel offloading. The pillow trials have now been completed and there is to be a rolling programme of monthly orders to improve the availability. A new offloading device is also being trialled on selected wards.

The sacral pressure ulcers were due again to poor documentation and long periods in the chair as well as delay in the provision of air mattresses. The Tissue Viability support workers continue to work with EME to improve access to equipment. An equipment review was supported at Buckland Hospital Dover which evaluated pressure relieving tilt chairs and also considered innovative prevention equipment aimed at repositioning. Ward based teaching is carried out regularly to help tackle recurrent themes in individual areas.

The other avoidable incident was related to medical devices affecting the ear on Cambridge L (Oxygen tubing) and was due to lack of preventative measures. The SKINS bundle now contains a prompt for these issues and will be uploaded onto PAS once requested amendments are approved.

There was 1 confirmed category three pressure ulcer acquired in September 2016, however this was unavoidable. There were 10 potential deep tissue ulcers and two were avoidable. These occurred on Bishopstone ward (sacrum) with lack of repositioning identified. The other was on Kings C1 and was due to the positioning of the leg brace. Further investigation is planned. During September 16, the Tissue Viability Support team held a QII HUB event on all 3 sites with a further event planned in November to coincide with worldwide 'Stop the Pressure' day.

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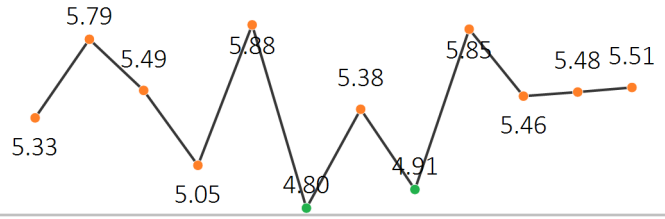
Strategic Theme: Patient Safety

Falls

Sep	Falls (per 1,000 bed days)	5.41 (-49.6%)		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:

In September, 2016 there were 181 in patient falls. 79 were at WHH, 64 at QEQMH and 37 at K&CH. Wards with the most reported falls were Deal, Minster and St Augustine (9) and Cambridge L (13). There were fractures. A fall on CDU at WHH caused a hip fracture but it is not yet clear if this was avoidable or not. An incident on Invicta resulted in hip and wrist fractures and led to the death of a patient. This was an avoidable fall and is being investigated.

The Fallstop project will be commencing in November on Cambridge L at WHH with multi professional support from therapies and pharmacy. Fallstop will run as a TIPS (Teams Improving Patient Safety) project from January 2017 on Invicta ward. Fallstop has now been presented at the Senior Leadership and Quality Forum and to the Falls Link Worker Network. Link workers have been encouraged to use the forthcoming Fallstop audits (outside of the programme) to ensure monitoring and to set weekly targets for improvement. Audit results will be readily available via EKBI. Launch sessions are being planned at each of the QII hubs in November.

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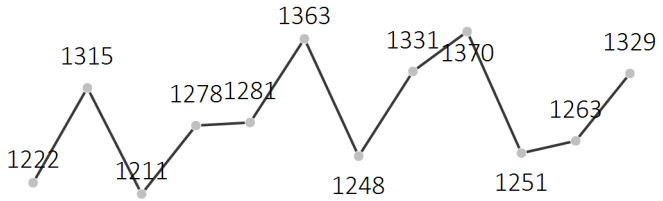
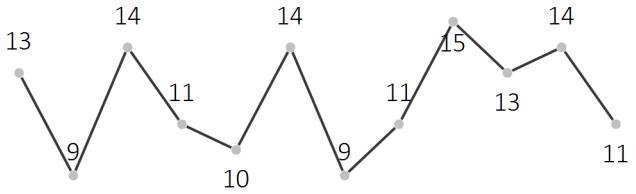
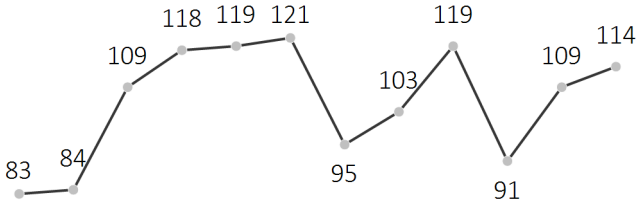
Strategic Theme: Patient Safety

Incidents

Sep	Clinical Incidents: Total (#)	15462 (10.3%)		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.
Sep	Blood Transfusion Errors	144 (-12.2%)		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.
Sep	Medicines Mgmt. Incidents	1265 (3.5%)		The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Strategic Theme: Patient Safety

Comments: A total of 1328 clinical incidents have been logged as occurring in September 16 compared with 1262 recorded for August 16 and 1166 in September 15. In September 16, six incidents have been graded as death and six as severe harm. In addition, 34 incidents have been escalated as a serious near miss, of which 27 are still under investigation. The number of moderate harm incidents reported during September 16 is higher than in previous months (Sep-16: 57 compared with Aug-16: 46 and Sep-15: 45).

Eight serious incidents were required to be reported on StEIS in September. Eight cases have been closed; there remains 75 serious incidents open at the end of September. Over the last 12 months incident reporting has increased at WHH and QEH, and shows a slight decrease at K&CH.

Blood transfusion

In September, there were 11 blood transfusion errors reported (14 in Aug-16 and 10 in Sep-15). There were no themes in September, although, there were two wrong blood in tube incidents and two incidents of blood wastage. Eight incidents were graded no harm and three low harm. Reporting by site: two at K&CH, seven at QEH (of which three occurred in A&E), one at WHH and one in the Community.

Medicines management

There were 114 medication incidents reported as occurring in September (109 in Aug-16 and 94 in Sep-15). On average, over the last 12 months, the numbers of medication incidents reported at WHH and K&CH have risen and at QEH have declined.
Of the 114 reported, 91 were graded as no harm (including three serious near misses) and 23 as low harm. There were no incidents graded moderate harm, severe harm or death.
Top reporting areas were: Cathedral day unit (K&CH) with eight incidents; Cheerful Sparrows female ward (QEH) and CDU (WHH) with five incidents each; Clarke ward (K&CH), Kent ward (K&CH), Marlowe ward (K&CH), Pharmacy (K&CH) and Rainbow ward (QEH) with four incidents each; CDU (QEH), NICU (QEH), Seabathing unit (QEH), A&E (WHH), Kings A2 ward (WHH), Kings C1 ward (WHH), Kings D Female ward (WHH) and Rotary ward (WHH) with three incidents each; other areas reported 2 incidents or fewer. Forty incidents occurred at K&CH, 38 at QEH and 36 at WHH.
*Missing Drugs are broken down as follows: eight incidents relating to stock control/documentation errors, four incidents where medication went missing in transit / was not delivered to the ward, one incident where there was no record of medication being delivered to pharmacy therefore unable to dispense and one incident where drugs were delivered to the wrong ward.

Total
Drug error - prescribing 21
Drug error - dispensing 13
Drug error - administering 49
Drug shortage (not available or in stock) 7
Drug missing* (stock discrepancy or lost between wards/pharmacy) 14
Adverse drug reaction 2
Infusion injury - extravasation 5
Infusion problems - medication related 3
Totals: 114

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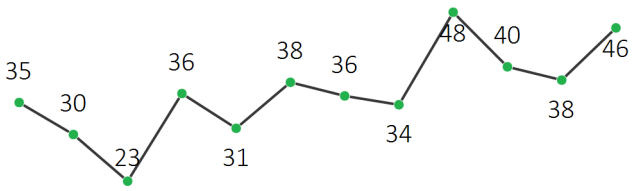
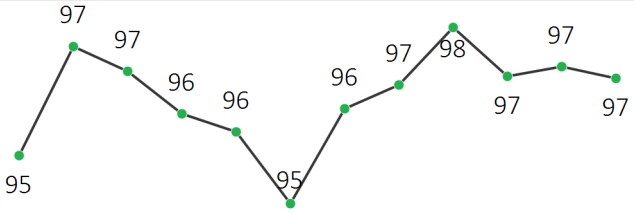
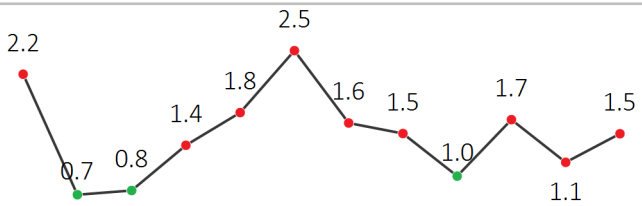
Strategic Theme: Patient Safety

Friends & Family Test

Sep	FFT: Response Rate (%)	36 (-2.3%)		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 together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	FFT: Recommend (%)	96 (1.4%)		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.
Sep	FFT: Not Recommend (%)	1.5 (-33.8%)		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:

FFT

During September we received 11,248 responses in total. Overall 46% 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 97% (same as August-16). For the Emergency Departments (ED) it was 82% (78% August -16), maternity 98% (same as August-16), outpatients 92% (same as August -16) and day cases 95% (same as August-16). The Trust star rating in August is 4.55 (4.51 in August-16).

Work to improve response rates has resulted in significant improvement. The response rate for inpatients was 46% (38% in August -16), EDs 20% (same as August -16), maternity 38% (28% in August -16). (Please note as per DH guidelines only the Birth experience is given a response rate, FFT questions at other stages in the patient's pathway are not calculated or required nationally). The response rate for day cases was 30% (33% in August -16) but for outpatients was not available due to a national reporting error. All areas receive their individual reports to display each month, containing the feedback left by our patients which will assist staff in identifying areas for further improvement. This is monitored and actioned by the Divisional Governance teams.

FFT patient comments demonstrate similar positive and negative themes across many departments/wards. All comments received from patients are recorded and entered into the ward service reports; these are displayed and available on the wards for patients and staff to view.

ED
1,284 positive comments; Positive Themes – Excellent care, kind, friendly, gentle, compassionate, professional
251 negative comments; Negative Themes – Waiting times, treatment, staff rude

Strategic Theme: Patient Safety

Inpatients
1,200 positive comments; Positive Themes – Friendly staff, good care, professional, helpful, caring , kind
24 negative comments; Negative Themes - Long discharge, poor communication, staff shortage, noisy environment

Out patients
2,299 positive comment; Positives Themes - Great care, staff attitude, communication good, kind
153 negative comments; Negative Themes – Staff attitude, rude, communication, waiting time

Maternity
Birth – 181 positive comments; Positive Themes – Supportive, Great care/staff, kind, caring, friendly,
5 negative comments; Negative themes – Waiting time for Dr, Toilets

Postnatal ward – 185 positive comments; Positive Themes – Friendly, kind, helpful, reassuring, great teamwork, good care
5 negative comments; Negative Themes- waiting for discharge, no information, staff - no time

Postnatal community – 25 positive comments; Positive Themes – Excellent care, friendly, caring, kind, professional.
There were no negative comments

Day Case
966 positive comments; Positive Themes – Staff attitude, good service, great care, kind, helpful
46 negative comments; Negative Themes – Staff attitude, No food/drink, pain, waiting

The trust needs to improve on staff attitude/shortages and the waiting times for patients within the ED, Outpatients and Day Case care. Inpatient and Outpatient feedback indicates that we should look to improve our discharge/waiting times and staff attitude. Maternity needs to improve on discharge/waiting time and staff time. It should be highlighted that there are considerably more positive comments regarding Staff attitude and the excellent care/service that is given by all departments, which staff must be congratulated on.

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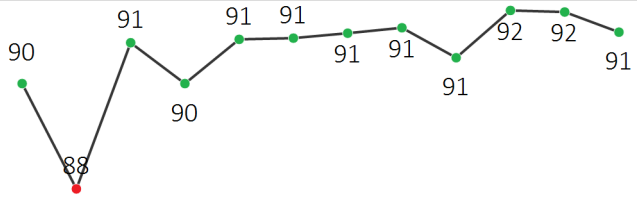
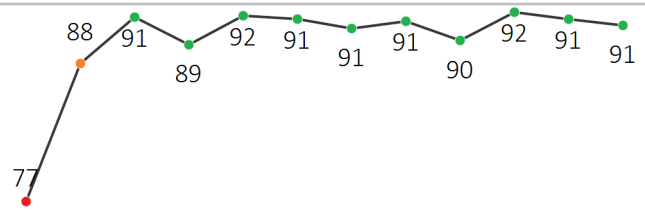
Strategic Theme: Patient Safety

Patient Experience 1

Sep	Overall Patient Experience %	91 (2.8%)		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.
Sep	Care Explained? %	90 (21.0%)		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.

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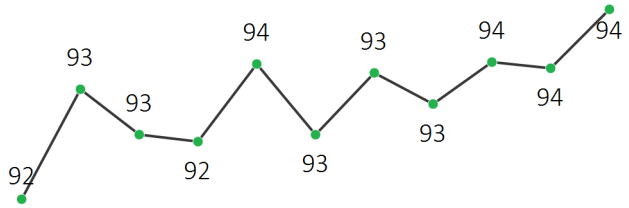
Strategic Theme: Patient Safety

Sep

Care that matters to you? %

93



Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).

Comments:

This month patient experience as recorded in real-time by the patients is similar to last month with only cleanliness being rated as amber by the patients. This is being monitored on a daily basis by SERCO with daily audits undertaken in conjunction with the Matron or Ward Manager. Corrective action is taken immediately when any deficits occur.

As demonstrated within the Patient Safety Heatmap summary - patient experience was not always captured and many wards appear not to be completing many of the inpatient surveys. All wards that had not completed the inpatient survey were visited, in order to discuss the reason for non-compliance.

Ward walks were completed at each acute site to focus on those wards that had not been completing Inpatient Survey on the ward I pads. 16 wards were visited over 3 days at each acute site – 7 QEQM, 6 WHH and 3 at K&C.

QEQM (7) and WHH (2) wards will now commence in completion of the Inpatient Survey with their patients using the ward I pad. The main reason for noncompliance was staff time to assist the patients complete the inpatient survey (One ward at QEQM has Inpatients with dementia/confusion, therefore have not been completing the Inpatient Survey, but they will try with the support of the patients family/friends/carers).
WHH (4) and K&C (3) ward had I pads that were not functioning and WIFI issues which now has been rectified by the IT department.

Summary of actions

- All ipads now fixed and in full working order, confirmed by IT department.
- Wards walk over the next 2 weeks to each ward to check that inpatient survey is now being completed and I pads are working correctly.
- Evaluate the October Heatmap to ensure that Inpatients survey is being completed by these wards.
- E mail to all ward managers outlining the ward visits, to ensure that the team are updated regarding the inpatient survey that it is reported monthly to the Integrated Performance Report and the importance of completing the Inpatient Survey daily using the ward I pad.
- To invite volunteers on each EKHUFT acute site to help patients complete Inpatient Survey.

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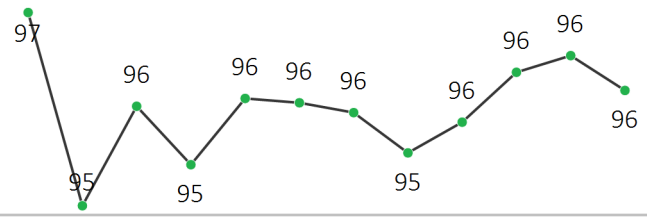
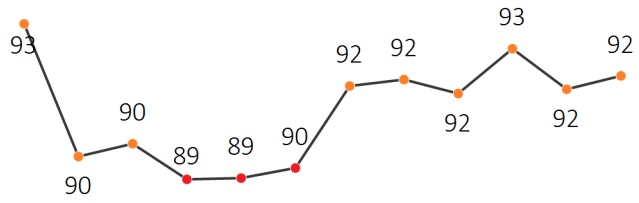
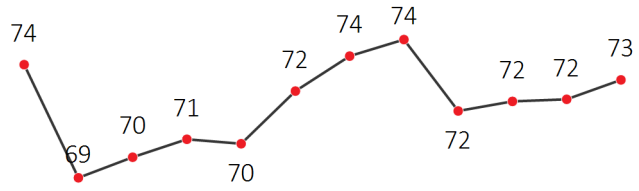
Strategic Theme: Patient Safety

Patient Experience 2

Sep	Respect & Dignity? %	96 (-0.2%)		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 nasrsing 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.
Sep	Cleanliness? %	91 (-1.6%)		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.
Sep	Hospital Food? %	72 (1.6%)		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:

Cleanliness remains in the low 90% this month. This has remained consistent for the last quarter. The Trust continues to manage cleaning on a daily basis through its weekly auditing process. The Audits continue to show a positive stable picture of cleanliness.

Hospital Food remains in the low 70% range this month. We continue to monitor performance of the catering contract and any new initiatives through the Food Steering group.

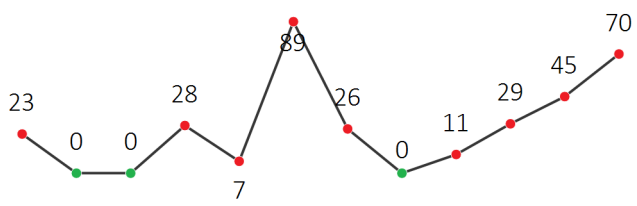
Strategic Theme: Patient Safety

Mixed Sex

Sep

Mixed Sex Breaches

328
(2.8%)



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:

Mixed Sex Accomodation

During September-16, 10 non-justifiable incidents of mixed sex accommodation breaches occurred at WHH CDU due to capacity issues. This information has been reported to NHS England via the Unify2 system.

There were 28 mixed sex accommodation occurrences in total, affecting 134 patients. This number has increased since last month when there were a total of 15 occurrences affecting 71 patients. The remaining incidents occurred at QEQM on the Fordwich stroke unit (6), QEQM CCU (4), K&C Kingston stroke unit (8), which are justifiable mixes based on clinical need.

During September-16 daily reporting of mixed sex occurrences has improved at the three acute sites. WHH CDU had a significant increased number of mixed sex breaches during September and to minimise the risk of mix sex occurrences the nursing team are:

- Nursing staff move patients continuously to stop mixed sex breaches
- Discharge patients home as soon as possible
- Use the discharge lounge, whilst patients await transport etc.
- Observation bay is used for patients when possible to stop any mixed sex breaches
- Each side of CDU is separated one side for males and the other for females
- Side rooms are used (if mixing has to occur on the male/female side)
- Failsafe put into place for ward clerk to document mixed sex breaches onto excel spreadsheet, to assist in validation

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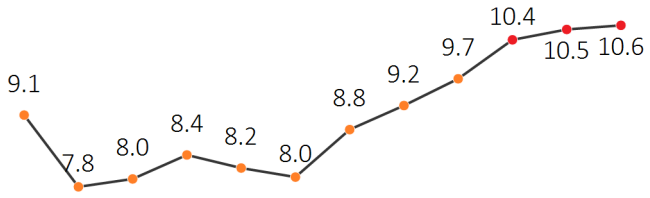
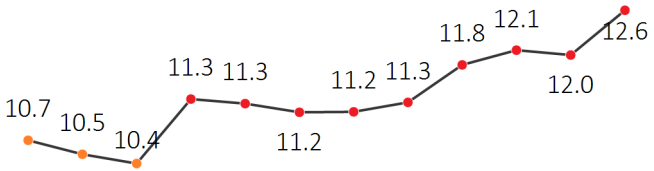
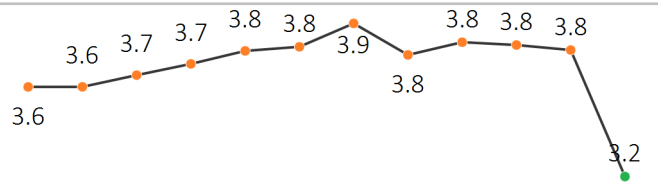
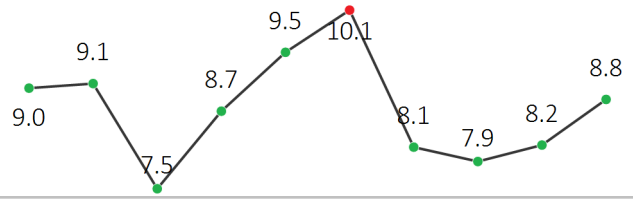
Strategic Theme: Human Resources

Gaps & Overtime

Sep	Vacancy (%)	9.1 (3.0%)		% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Staff Turnover (%)	11.4 (-16.4%)		% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Sickness (%)	3.7 (-1.5%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the
Sep	Overtime %	8.7		% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).

Comments:

Gaps and Overtime

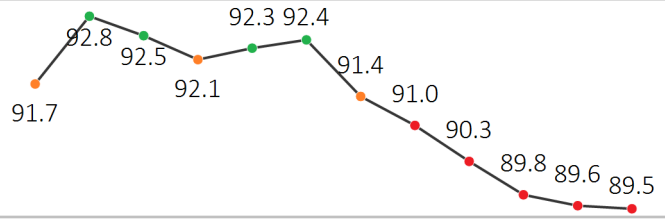
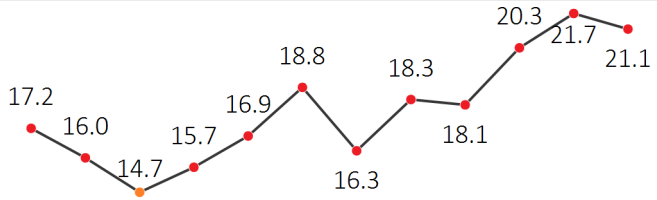
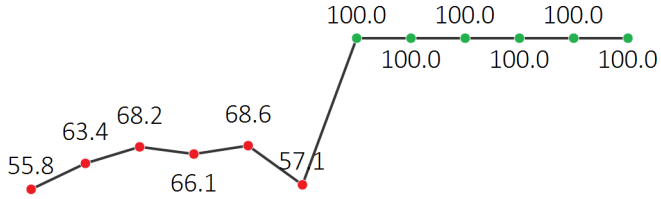
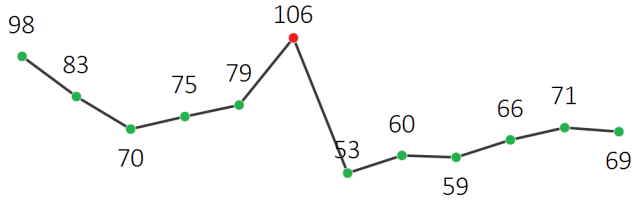
The Turnover rate rose to 12.6% and the vacancy rate increased marginally from 10.5% to 10.6%. The average Turnover rate for the past 12 months remains marginally higher than the previous 12 months at 11.4%. The vacancy and turnover rates by Division are examined in detail at Executive Performance Reviews (EPR), and Divisions have actions in place to address their recruitment and retention challenges.

Sickness absence decreased to 3.2% in September from 3.8% in August which is now below the Trust target of 3.3%. Divisions have submitted a monthly trajectory for sickness absence, which are examined at EPRs and monthly Agency Pay Control meetings. Although Divisions are running behind their trajectories, the 12 month average continues to reduce month on month.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Temporary Staff

Sep	Employed vs Temporary Staff (%)	91.3 (-0.6%)		Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Agency %	17.9		% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).
Sep	NHSP Use % of Agency	78.4		% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).
Sep	Agency Orders Placed	74		Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).

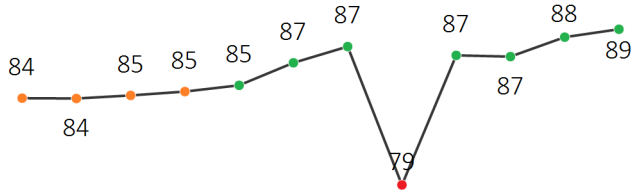
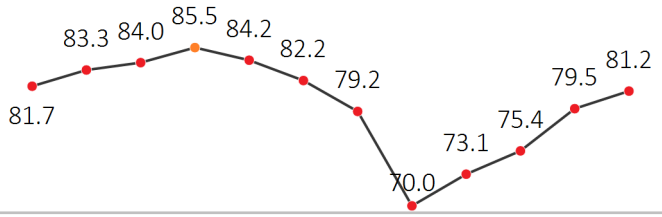
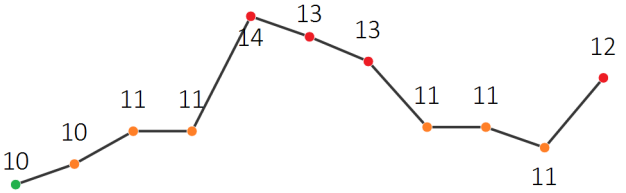
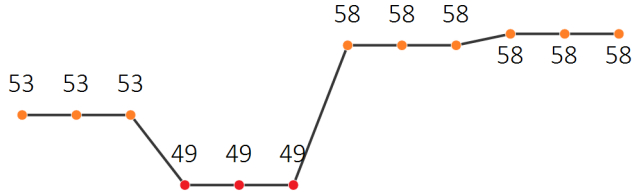
Comments: Reduction in agency spend is a key component of our cost improvement programme and continues to be an area of focus. There is an Agency Pay Control programme, led by the Head of Human Resources and supported by the Improvement Delivery Team and Programme Management Office. The Trust monitors and reports on a weekly basis, all agency shifts that breach the agency framework and NHSI pay caps by occupational group and division. The percentage of employees deployed through an agency that are NHSP remains at 100%. The percentage of staffing which is agency has reduced from 21.7% to 21.1% despite a slight 0.1% increase in the vacancy percentage this month, although interestingly the sickness rates have also reduced by 0.6% this month.

Divisions are held to account for their Agency CIPs at EPR meetings, and against Divisional Agency Spend Trajectories, that are updated monthly by Divisional Finance Leads and HR Business Partners.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Sep	Mandatory Training (%)	86 (4.3%)		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.
Sep	Appraisal Rate (%)	80.0 (4.0%)		Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Time to Recruit	11 (5.0%)		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.
Sep	Staff FFT - Work (%)	55 (11.3%)		Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

East Kent Hospitals University NHS
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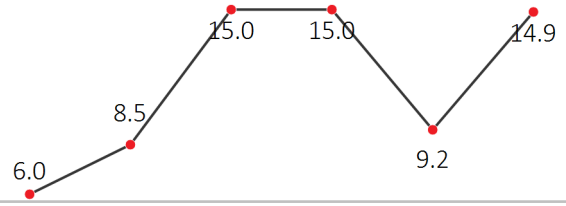
Strategic Theme: Human Resources

Sep

Local Induction Compliance %

11.5



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

Comments:

Statutory training was at 89% for September, up marginally from 88% in August. This remains above the target of 85%. There remains a significant risk in regard to statutory training compliance, particularly with staff who have been identified as not completing one or more of the statutory training courses required; 610 staff fall in this category in September which is a reduction from 642 (5% reduction) in the previous month. The Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements.

The Trust staff appraisal rate has continued to increase in September to 81.2%, but remains below the 90% target. Divisions have been focussed on improving appraisal compliance, and most have not implemented a more consistent and robust way of reporting Appraisal dates to the HR Systems team. Work continues to implement less manual ways of reporting the information.
Weekly Recruitment Updates are sent out by the Resourcing Team to Divisions to provide information on workload within the team, and plans to reduce time the time taken to recruit.
The Staff Survey launched on 3rd October. This will provide a more detailed annual review into staff satisfaction within the Trust.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Activity

Activity vs. Internal Business Plan

Key Performance Indicators

Sep

	Sep-16				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	14,023	14,626	(-603)	-4%	87,615	87,098	517	1%	87,615	86,178	1,437	2%	<=0%
Referral Non-Primary Care	13,759	14,476	(-717)	-5%	83,721	88,632	(-4,911)	-6%	83,721	88,361	(-4,640)	-5%	<=0%
OP New	20,333	20,693	(-360)	-2%	122,705	122,001	704	1%	122,705	122,683	22	0%	>=0%
OP Follow Up	40,842	42,396	(-1,554)	-4%	246,774	248,955	(-2,181)	-1%	246,774	252,420	(-5,646)	-2%	>=0%
Elective Daycase	6,486	7,454	(-968)	-13%	40,176	44,774	(-4,598)	-10%	40,176	41,062	(-886)	-2%	>=0%
Elective Inpatient	1,456	1,299	157	12%	7,902	8,099	(-197)	-2%	7,902	7,807	95	1%	>=0%
A&E	17,914	16,368	1,546	9%	107,461	101,594	5,867	6%	107,461	102,413	5,048	5%	>=0 & <5%
Urgent Care Assessment	933	1,146	(-213)	-19%	6,487	6,852	(-365)	-5%	6,487	6,746	(-259)	-4%	>=0 & <5%
Non-Elective Inpatient	5,739	5,781	(-42)	-1%	35,264	34,785	479	1%	35,264	34,553	711	2%	>=0 & <5%
Chemotherapy	1,265	1,072	193	18%	7,791	6,298	1,493	24%	7,791	6,659	1,132	17%	>=0%
Critical Care	1,839	1,740	99	6%	10,737	10,663	74	1%	10,737	10,764	(-27)	0%	>=0%
Dialysis	6,578	7,079	(-501)	-7%	41,311	42,869	(-1,558)	-4%	41,311	42,869	(-1,558)	-4%	>=0%
Maternity Pathway	1,165	1,242	(-77)	-6%	6,953	7,199	(-246)	-3%	6,953	7,134	(-181)	-3%	>=0%
Pre-Op Assessments	2,772	2,820	(-48)	-2%	17,037	17,187	(-150)	-1%	17,037	17,241	(-204)	-1%	>=0%
Diagnostic	432,520	474,300	(-41,780)	-9%	2,645,833	2,759,443	(-113,610)	-4%	2,645,833	2,588,571	57,262	2%	<=0%
Other	4,536	4,261	275	6%	27,921	23,591	4,330	18%	27,921	22,739	5,182	23%	>=0%

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

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

September 2016

The Primary Care demand received by the Trust was under planned levels this month which has reduced the Trust level over performance to within 1% of the contract. Encouragingly the Trust has not observed the historic exponential growth that has occurred in both Gastroenterology and Breast Referrals, although referrals into key specialties Orthopaedics, Maxillo Facial, Gynaecology, and Paediatrics have significantly exceeded planned levels. The Trusts Internal Business Plan stretches most services to maximum capacity and as such we have not been able to flex our capacity further to deal with this unplanned demand. The Trust does not have the operative capacity to deal with the current demand, a key element of our business plan requires Orthopaedic referrals to be directed to the independent sector at point of referral, encouragingly referrals in September reduced to within 1% of the agreed plan.

Rapid Access referrals into the Dermatology service over performed the plan by 31% (+157) in September 2016, this was in part bought about by a change in referral profile, with the annual spike of rapid access referrals arriving August and continuing into September. The service in conjunction with insourcing company DMC and delivered 355 new outpatient appointments above plan, this ensured they were able to achieve the two week wait cancer target and reduce waiting times despite this unprecedented level of demand.

Gastroenterology activity continues to drive the biggest underperformance in activity across the Trust. The service has been supported by locum consultants, a model which has not provided consistent and sustainable levels of activity to enable the business plan to be delivered. The service cannot commit to delivering the shortfall from quarter one and two in quarter three due to the reliance on the temporary workforce, with current capacity being used to focus on patients on Cancer and Referral to Treatment pathways. With the introduction of two Consultants the service is also able to release a further 16 new outpatient appointments per week.

Additional endoscopy capacity is to be put in through October & November, with plans to provide an additional 108 units weekly from mid-October, and up to an additional 240 units of activity, with diagnostics taking between 1 & 3 units depending on the type of activity. It is envisaged that this capacity will allow the service to hit the planned day case activity levels and hit demand for most of Q3 and all of Q4.

Health Care of Older People Clinics cover a wide range of patients and conditions. Activity within HCOOP outpatients is significantly below the YTD plan for new and follow up Outpatient appointments, this has been driven by a shortfall in nurse-led outpatient capacity due to vacancies in these roles. Recruitment has taken place; but training requirements over Q1 has meant that the capacity has been reduced over the early part of 2016-17. The nurse-led capacity is now in place to deliver the planned activity on a monthly. Further to this there has been 2 recent retirements of substantive HCOOP consultants, which will impact on consultant led capacity in the short term. Attempts are being made to recruit and there is currently partial covering of the capacity and attempts to source available locum staff.

The Neurology Service, significantly over subscribed outpatient activity throughout the first 4 months of the year, this over performance delivered locum doctors enable the service to significantly reduce waiting times from referral to treatment. The service is now performing well against the national standard and has now reduced the additional capacity accordingly.

Gynaecology elective activity has underperformed in the year to date due to gaps in the middle grade rota, unexpected staff leave, inability to utilise a list at WHH due to clinician job plan clashes, and being unable to replace a consultant who left late in 2015. As a result of securing a locum clinician who started in September, the service has overperformed the elective plan by 15% (+42) and has a similar level of activity planned into October. Furthermore, another locum clinician is planned to start in early November to increase capacity in all elective areas. Work continues on identifying additional elective capacity to reduce the wait times to sustainable levels.

The Orthopaedic team have been unable to provide the Independent Sector Capacity stated in the contract so far this year, this is in part due to delays with the tender exercises and also due to the inability to obtain enough capacity within the Spencer Wing. To mitigate against this risk the service is working with commissioners to agree alternative providers for patients waiting for elective and daycase procedures, the Trust has secured additional capacity on behalf of the CCG and has commenced the transfer to the independent sectors for Orthopaedics, 428 patients have been transferred to date with a 178 patients being treated to date. The commissioning support unit and our primary care colleagues are continuing to source additional outpatient capacity to divert referrals this is reviewed at the primary care Contract Performance Notice meetings (CPN)

The Ophthalmology service implemented a contractually mandated cost neutral change in activity recording within the AMD Injection service. The service is now recording and reporting approximately 600-800 injections per month as outpatient procedures as opposed to Elective admitted daycase activity. The change is reflective of the PbR tariff the trust receives for this activity. As a result of the change we are now expecting Daycase activity to underperform the plan for the remainder of the year.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	4,320	4,882	-12%	-562
103 - Breast Surgery	3,472	3,780	-8%	-308
101 - Urology	3,952	3,787	4%	165
107 - Vascular Surgery	1,370	1,184	16%	186
410 - Rheumatology	1,770	1,581	12%	189
140 - Maxillo Facial	4,017	3,660	10%	357
420 - Paediatrics	2,623	2,083	26%	540
330 - Dermatology	7,662	7,077	8%	585
110 - Trauma & Orthopaedics	5,414	4,805	13%	609
502 - Gynaecology	5,270	4,583	15%	687
Total	**76,125**	**73,250**	**4%**	**2,875**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
560 - Midwifery	0	543	-100%	-543
110 - Trauma & Orthopaedics	10,722	11,164	-4%	-442
800 - Clinical Oncology	5,531	5,883	-6%	-352
502 - Gynaecology	3,656	3,943	-7%	-287
140 - Maxillo Facial	917	1,193	-23%	-276
430 - HCOOP	2,132	2,363	-10%	-231
340 - Respiratory Medicine	1,278	1,014	26%	264
BLANK	308	5	5565%	303
101 - Urology	3,596	3,177	13%	419
130 - Ophthalmology	5,305	4,780	11%	525
Total	**54,018**	**54,356**	**-1%**	**-338**

OP New

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	3,205	4,249	-25%	-1044
100 - General Surgery	2,650	3,426	-23%	-776
430 - HCOOP	2,456	2,836	-13%	-380
303 - Clinical Haematology	733	1,032	-29%	-299
420 - Paediatrics	4,052	3,697	10%	355
300 - General Medicine	1,071	614	75%	457
130 - Ophthalmology	11,657	11,059	5%	598
502 - Gynaecology	7,924	7,312	8%	612
110 - Trauma & Orthopaedics	11,549	10,695	8%	854
330 - Dermatology	7,651	6,262	22%	1389
Total	**94,981**	**93,828**	**1%**	**1,153**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	5,724	8,972	-36%	-3248
100 - General Surgery	1,488	2,574	-42%	-1086
324 - Anticoagulation Service	7,745	8,738	-11%	-993
430 - HCOOP	2,000	2,831	-29%	-831
302 - Endocrinology	3,938	4,764	-17%	-826
330 - Dermatology	12,388	11,719	6%	669
103 - Breast Surgery	3,300	2,587	28%	713
800 - Clinical Oncology	20,507	19,560	5%	947
110 - Trauma & Orthopaedics	19,183	17,155	12%	2028
130 - Ophthalmology	32,175	28,742	12%	3433
Total	**191,686**	**192,192**	**0%**	**-506**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	8,747	11,525	-24%	-2778
130 - Ophthalmology	6,295	7,514	-16%	-1219
110 - Trauma & Orthopaedics	3,067	3,387	-9%	-320
330 - Dermatology	2,353	2,622	-10%	-269
100 - General Surgery	1,093	1,269	-14%	-176
410 - Rheumatology	790	937	-16%	-147
320 - Cardiology	1,380	1,258	10%	122
101 - Urology	3,971	3,801	4%	170
140 - Maxillo Facial	1,215	1,014	20%	201
303 - Clinical Haematology	1,748	1,511	16%	237
Total	**40,176**	**44,774**	**-10%**	**-4,598**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
502 - Gynaecology	768	959	-20%	-191
100 - General Surgery	642	790	-19%	-148
320 - Cardiology	358	475	-25%	-117
110 - Trauma & Orthopaedics	1,963	2,036	-4%	-73
430 - HCOOP	34	75	-55%	-41
503 - Gynaecology Oncology	53	14	292%	39
120 - Ear, Nose & Throat	372	332	12%	40
400 - Neurology	181	128	41%	53
103 - Breast Surgery	265	208	27%	57
101 - Urology	1,499	1,324	13%	175
Total	**7,902**	**8,099**	**-2%**	**-197**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
502 - Gynaecology	876	1,333	-34%	-457
420 - Paediatrics	2,771	3,182	-13%	-411
100 - General Surgery	3,088	3,396	-9%	-308
501 - Obstetrics	2,325	2,578	-10%	-253
110 - Trauma & Orthopaedics	2,044	2,195	-7%	-151
320 - Cardiology	984	1,133	-13%	-149
560 - Midwifery	1,360	1,239	10%	121
430 - HCOOP	5,210	4,865	7%	345
180 - Accident & Emergency	3,214	2,698	19%	516
300 - General Medicine	10,345	8,965	15%	1380
Total	**35,264**	**34,785**	**1%**	**479**

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

4 Hour Emergency Access Standard

Key Performance Indicators

84.19 %

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
4 Hour Compliance	87.01%	89.37%	87.78%	84.91%	80.01%	79.25%	84.06%	82.69%	85.40%	82.88%	82.25%	84.19%
12 Hour Trolley Waits	0	0	0	1	0	1	1	0	0	0	0	0
Left without being seen	2.87%	3.06%	3.19%	2.87%	3.78%	4.20%	3.46%	4.09%	3.84%	4.59%	4.11%	3.31%
Unplanned Reattenders	8.80%	8.93%	8.71%	8.88%	8.97%	9.31%	9.10%	9.40%	9.22%	8.62%	8.68%	7.93%
Time to initial assessment (15 mins)	94.6%	93.4%	94.7%	95.4%	94.6%	92.9%	88.4%	88.7%	91.2%	85.2%	81.0%	86.6%
% Time to Treatment (60 Mins)	51.0%	49.9%	50.3%	49.5%	43.5%	40.8%	46.3%	43.5%	48.3%	46.3%	48.9%	51.6%

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

-6.61 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Trajectory	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%
Performance	84.06%	82.69%	85.40%	82.88%	82.25%	84.19%						

Summary Performance

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

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. An Emergency Care Recovery Plan (ECRP) has been developed, which reviews all aspect of the emergency patient pathways from attendance in the Emergency Department to discharge from an inpatient ward. The aim of the plan is to improve performance and ensure that the ECRP delivers sustainability across emergency care pathways. It has been

mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

September performance against the 4 hour target was 84.19%, against a trajectory of 90.80% and a compliance target of 95%. September's performance shows an improvement compared to the August position, with a higher proportion of patients seen within 4 hours.

Analysis of the breach reasons shows a change in the split in breach reasons compared to previous months, with the largest proportion of breaches assigned as due to delays to be seen by a first clinician (reduced to 30% of all breaches, compared to 44% of all breaches in August and 47% in July). The next biggest breach reason was around delays to Treatment Decision, which increased to 22% of all breaches from 18% in August. Breaches due to Bed Management reasons also increased from 13% of all breaches to 17% of all breaches (399->484).

While the delay in Treatment Decision breach reason continues to relate to a large proportion of the breaches, the improved performance against the 60 minute time to treatment continued to improve in September, and this has shown an impact on the distribution of breach reasons referenced previously, with a shift in the breach reasons due to delays to be seen, and a rise in the proportion of Treatment Decision and Bed Management breaches.

Volumes of attendances remain above expected levels, with September activity maintaining raised activity numbers. This continues the trend of year to date attendance volumes being in excess of the planned activity levels (5.8% above plan YTD, +9.4% in Month). Volumes of attendances to Trust A&E departments continue to be higher than the previous year (+4.9% YTD), with raised volumes in particular noted at the Dover Buckland Hospital Minor Injuries Unit.

Improvements in Emergency Department performance are being pursued through the ECRP. The programme now has a dedicated programme manager who has supported a full review of the governance arrangements and a detailed review of the ERCP, including updating the evidence portfolio for all closed actions. The programme uses a BRAG rating to monitor progress against the plan and any new actions relating to improving emergency care pathways are discussed / agreed at the Urgent Care Board to ensure that there is an audit and governance trail. During September the ERCP has been fully reviewed to ensure that the plan reflects all local initiatives which the clinical teams in the ED's, Acute Medical Unit, Operational Control Centres and SAFER programme have identified.

Good progress is being made across all the workstreams with the following notable highlights in September:

Improving ED Clinical Leadership:

- WHH launched the ESI (Early Senior Intervention) model on the 22 August with immediate improvement in the 60 minute first clinician metric. The model ensures that there is an assessment nurse in the waiting room who will allocate the patient a card which is presented to the receptionist. Patients who are very unwell will be streamed direct to majors, patients who have a minor injury will be streamed to the minors area and those patients who do not fit into either category will be allocated to the 'purple zone'. The purple zone is a consulting room which is managed by an ED senior doctor and nurse; patient will receive an early senior review and be stream to the appropriate clinical area and may also be 'seen and treated' by the ED senior doctor.

The impact of ESI has been very positive with excellent feedback from patients and staff alike. The WHH has managed to maintain the ESI service across the full 24/7 period due to the high commitment of staff in the Department to the service. It is planned that the model will be shared with QEQMH following early evaluation.

- At QEQMH ED the Majors Assessment Pilot (MAP) being tested as and when staffing resources are available to support it. This pilot involves an ED Consultant or senior doctor, Consultant Acute Physician, Emergency Surgeon and senior ED nurse to either see and treat or directly stream patients to a speciality. The pilot has also been successfully managed by and ED Consultant and Acute Physician, if a surgical colleague has not been available. The MAP pilot requires the whole of the minor's area to be available to stream patients; however the clinical team are actively reviewing the pilot to assess whether it can be provided within current space constraints or alternative options can be accommodated.

  Consideration will be given as to how the MAP pilot may compliment ESI. Initial feedback from clinicians is that the process reduces delays and handoffs in the emergency pathway and on the days that the MAP has been piloted there has been improved performance against the 4 hour access standard.

- The new paediatric area at WHH has successfully opened and is being fully utilised by staff. The area provides a dedicated waiting area with assessment and treatment cubicles. This area is an excellent addition to the department and initial feedback from parents and children has been very positive.

- A full nursing review is almost completed to establish the staffing requirements to provide a dedicated Emergency Nurse Practitioner service across a minimum of 12 hours per day. This would reduce the requirement for medical staff to support the minor injuries service and develop a sustainable service for the future.

Acute Medical Model

- The Acute Medical Model project group at WHH is now established with actions being progressed at pace. Shared learning is underway via the Acute Medicine clinical lead to ensure that best practice from the QEQMH model is being implemented at WHH. The Acute Medicine Consultant job description and advertisement is under review with the Trust being represented at the BMA jobs fair in the Autumn. Active networking and recruitment is underway in the meantime with shared posts across Divisions being actively considered to ensure that all opportunities to engage substantive consultants are being progressed.

- At QEQMH the Acute Medical Model continues to become embedded with a second Nurse Consultant now started in post. This post will enable further nurse led services to be developed and expanding the opportunity for MDT working and challenge on ward and board rounds.

Implementation of SAFER & Patient Flow Programme

Phase 1 of the Improving Patient Flow (enhancing SAFER) Programme has been completed and the Closure Report was presented on 19th August; this signified the end of the intensive support from Four Eyes Insight. The four wards participating in phase 1 were Cambridge L, Cambridge J1 and J2 and Cambridge M2. Success has been monitored through weekly production of the SAFER Dashboard (see Picture 1) in line with five KPI's:

- Reduced Medical outliers on surgical wards
- 33% of ward discharges before 12.00
- Weekly review and reduction of patients with a LOS >7 days
- 90% of EDD's set and recorded on PAS within 24hrs of admission to the ward
- 10% reduction in LOS within the target wards.

Clinical engagement within the Programme has been essential to success and this was the main area of involvement for Four Eyes insight, although the entire multidisciplinary team have been actively engaged across all four wards. This has been supported by the Improvement Delivery Business Partners , who have worked in partnership with ward and MDT teams to develop Standard Operating Procedures for Board Rounds and Setting of EDD's, as well as agreeing Roles and Responsibilities for key staff groups involved with patient flow. A Training and Communication cascade process has been specifically tailored for each ward, to reflect issues identified during the preparatory 'deep dive' analysis. An overarching Patient Flow Toolkit is in its final stages of development and will form part of the 'central repository', soon to be available within a dedicated webpage on the Trust's Internet Staff Zone.

Provision of Senior Review and an EDD (the 'SA' of SAFER) has been well embedded within the target wards, but it is acknowledged that additional input is required to fully implement better flow of patients, earlier discharge and weekly review of patients with a >7 day LOS (the 'FER' o SAFER). This will be the IDBP's priority until 31st August, before commencing the phase 2 rollout.

Priorities for August have been:

- Sustain achievement of progress to date and embed the remaining elements of SA**FER** on the initial target wards, until 31st August.
- Commence phase 2 rollout and undertake baseline assessments, deep dives, training, engagement and communication.
- Celebrate the success of phase 1 wards and agree a quarterly baseline review process with Matrons, to ensure sustainability.
- Develop and provide discharge competency training across the WHH site, in association with Matrons and the Integrated Discharge Team; especially in relation to CHOICE.
- Finalise the Patient Flow Toolkit and break it down into 'learning units' for ease.
- Finalise and establish the Improving Patient Flow webpage (Staff Zone)
- Patients EDD to be written on white boards above the bed to and all staff are to be encouraged to discuss EDD with patients &/or family.
- Finalise and implement the Inpatient PTL tool to enable visibility of the patients pathway and any associated delays.

Operational Control Centres:

- The staff consultation to review the current site management teams and support the implementation of a 24/7 clinical site management team is in the process of being implemented through an active recruitment plan.
- The Operational Control Centres (OCC's) standardised approach to recording site SITREP information with a RAG rates report being sent out following the site SITREP meetings at 08:00, 13:00 and 16:00 continues to become embedded.
- Escalation action cards are being actively used in the OCC environment and are being shared with ward staff and consultants to normalise their use.
- The escalation plan is being rewritten to include a more proactive and pre-emptive approach by all specialities to managing the risk of overcrowding in ED.

Notable risks

- The Emergency Departments (ED's) continue to have a high level of specialty doctor vacancies. This is an ongoing national issue and is a key workforce risk within the ECRP. UK and international recruitment continues along with a nursing review to enable an Emergency Nurse Practitioner Service which will reduce the departments dependency on medical staff.

  During August there has continued to be gaps in the specialty doctor rota, particularly on evening and night shifts. Mitigating actions have continued to ensure that a safe service is provided, however, despite these actions there continues to be a serious risk in identifying sustainable cover for the rota and this does result in increased breaches in the evenings and overnight.

- There has been an increase in the number of patients presenting to QEQMH and WHH with mental health conditions. This has been a significant risk at QEQMH with an occasion in which there was 8 patients with a mental health condition in the ED overnight. To mitigate the risk a 24/7 agency mental health nurse is booked to support the nursing staff and mitigate the risk to patients and staff. Once assessed there have been significant delays for those patients requiring a mental health bed. There has been a significant risk of an high risk patient absconding and ongoing monitoring of such patients creates additional pressure on the ED nursing staff. Although there is a mental health team allocated to each site between 08.00 and 20.00, in reality any patient attending after 6pm is likely to have to wait for the Crisis Team to assess overnight and this may be delayed if there are high risk patients in the community. Once assessed there may be a delay of several days before a mental health bed is identified.

Trajectory Confidence

September performance against the 4 hour target was 84.19%, against a trajectory of 90.80%. The increased activity levels seen so far this year remain above plan 9.4% in month, compared to +5.5% above plan in August. The numbers attending the departments, particularly in the evenings and overnight continue to have an adverse effect on the Trusts ability to meet the 4 hour standard for patients, with difficulties caused by spikes in activity and also the gaps in the specialty doctor rota. It is not unusual for 35 – 40 patients to attend over two hours and such high numbers of attendances are creating additional pressure in already busy departments.

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

There has been a movement in activity with QEQMH in particular seeing higher numbers of ambulances from the Canterbury catchment area since the new Urgent Care Centre criteria has been implemented. ED clinicians continue to work closely with SECAMB colleagues to reduce handover delays. Patients are being clinically assessed on arrival and safely streamed to areas such as the waiting room or minors. The conversion to admission is an indication that the patients have had a higher medical acuity with patients also being streamed to ambulatory care where possible.

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

- A high % of breaches of the 4 hour emergency access standard relate to patient flow and bed availability.
- High numbers of patients attending ED in the evenings and weekends who could be managed by primary care, in particular paediatric attendances.
- Impact on the efficiency of the ED when trying to safely manage patients with a mental health condition who are awaiting assessment overnight by the Crisis Team.
- Mental health patients who require a mental health bed often having to wait several days for a bed, both in ED assessment beds and also in the wider ward bed base.
- Medical staffing vacancies, which medical staffing agencies are unable to fill. QEQMH is a particular risk due to the geographic location of the hospital.
- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

18 Week Referral to Treatment Standard

Key Performance Indicators

85.11 %

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Green
Performance	92.06%	91.51%	88.82%	90.10%	89.17%	89.27%	88.56%	87.89%	86.81%	86.65%	85.52%	85.11%	>=92%
52w+	12	3	5	3	5	5	6	9	17	25	20	27	0
Waiting list Size	40,125	39,842	41,178	42,239	42,791	43,000	44,620	45,663	44,213	45,487	45,352	45,531	<38,938
Backlog Size	3,186	3,384	4,604	4,181	4,634	4,614	5,105	5,531	5,831	6,072	6,568	6,781	<2,178
Demand: PC Referrals	16,446	15,713	14,306	15,048	15,897	16,419	16,737	16,063	16,042	15,949	15,449	15,165	<15,484
Demand: Additions to IP WL	3,439	3,517	3,026	3,213	3,364	3,352	3,206	3,314	3,705	3,471	3,552	3,639	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

Sustainability & Transformational Funding Trajectory

-6.99 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%	Sept
Performance	88.56%	87.89%	86.81%	86.65%	85.52%	85.11%							Sept

Summary Performance

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

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

In August performance against the standard was 85.11%. There were twenty seven patients who were waiting for treatment for more than 52 weeks as at the end of the month. There are number of issues that are driving the reduction in performance against the trajectory; higher than planned primary care referrals and an inability to deliver the additional capacity identified within business plans in key specialities such as Orthopaedics, General Surgery, Gastroenterology, and Gynaecology across all points in the patients pathway (first appointment, follow up and patients listed for surgery intervention). In other specialities such as ENT there are administrative delays leading to an unreliable reported waiting list position.

The Trust continues to receive primary care demand over the predicted planned referral rate, in the year to date the trust has received over 1,600 more referrals than planned. They key areas are Orthopaedics, Maxillo Facial, Gynaecology and Paediatrics. The current rate of referrals means that the trajectory for referral to treatment for patients is unachievable unless the trust and the CCG agree a process to either; invest to create more internal capacity across the patient pathway which will involve additional pay and non-pay resource, outsourcing to the independent sector; or contract with alternative providers to utilise our facilities with an alternative workforce to the trusts. The decision making process to this will be taken jointly with the CCG and the trust within the existing meeting structures

There has been a significant decrease in the number of 52 week waiters is predominantly within the ENT specialty. The Trust has a capacity deficit within the Otology sub specialty due to vacancies, and is currently working in partnership with the Royal National Throat, Nose and Ear Hospital in London and primary care to ensure patients receive treatment.

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

Priority 1 - Improve Pathway Management

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

- The system will be fully operational from 22nd August
- Over 6000 patient records were validated in August
- The Trust has developed innovative methods to identify data quality metrics which enables us to direct training to the most challenged areas.

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

- All clinical pathways have now been mapped and agreed with the clinical staff, implementation of these pathways is now required to commence. This will begin in September.

Priority 2 - Achieve the Outpatient Milestones

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

- The CCGs are continuing to identify alternative providers to deliver Orthopaedic pathways in 2016/17.
- The CCG's are implementing choice navigators into referral management centres for Orthopaedics and are exploring other avenues to aid other specialities, such as gastroenterology and Gynaecology.
- The CCG are in the process of awarding the contracts for outpatient procedure management of wet macular oedema (Ophthalmology). This will mean patients will receive treatment closer to home in a primary care setting and will no longer have to attend hospital. As of the end of August the tender is yet to be awarded.
- The trust is working with the CCG to explore the development of in-house sleep studies in ENT to enable a one stop service to avoid transfer to the community for diagnostic testing.

The Trust is addressing current shortfalls in capacity with increased demand by;

- Additional outpatient internal capacity is being established for Orthopaedics, ENT, General Surgery, Maxillo Facial and gynaecology
- A tender process is underway to secure additional capacity in Ophthalmology using a company who will utilise our facilities in order to treat our patients.
- Two new consultants commencing in gastroenterology in September to stabilise the service
- Two new consultants commencing in Otology in November
- One new consultant commencing in October in Maxillo Facial
- Seven new consultant posts in recruitment process for Ophthalmology, interviews in November
- Validation process in ENT being reviewed with individual consultants with training being provided on the RTT pathway
- The Trust has identified an alternative provider who will accept tertiary referrals for complex adult ear procedures. The trust is liaising with London for outcomes of these treatments
- Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste has commenced.

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

Priority 3 - Deliver the Efficiency Programme

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

- The Trust has developed key monitoring documentation and enhanced the booking procedures required to achieve the required Theatre efficiency target.
- Increase in number of sessions run.
- General Surgery, Gynaecology and Ophthalmology continue to be the areas for focus during August and September

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

- The Trust has developed future focused reports and established meetings to review underutilised and empty theatre sessions.
- Profile of unused theatre lists are addressed at weekly theatre site meetings and weekly Trust theatre efficiency meetings.

Priority 4 – Deliver recurrent demand substantively

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

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

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

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

- Job planning of clinical teams to deliver flexible sessions to achieve cross covering of clinical commitment during leave in outpatient and theatres is now operational
- Identified Ophthalmology sessions to transfer to extended days to release theatre capacity and provide cross cover – commenced
- Capacity to be commissioned from alternative provider for Ophthalmology during August and September until recruitment of consultants and technical staff has been successful. 3,000 appointments to be commenced during August and September – commenced
- The trust has secured additional capacity on behalf of the CCG and has commenced the transfer to the independent sectors for Orthopaedics, 279 patients have been transferred to date with a further 150 being validated. The commissioning support unit and our primary care colleagues are

continuing to source additional outpatient capacity to divert referrals this is reviewed at the primary care Contract and Performance Notice meetings (CPN)

- The trust has also secured additional capacity (130) on behalf of the CCG with the independent sector for General Surgery and has commenced transfer of patients for treatment.

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

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

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

Cancer Compliance

Key Performance Indicators

70.38 %

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Green
62 day Treatments	70.45%	70.89%	79.11%	71.68%	79.86%	73.57%	71.04%	79.20%	75.42%	70.94%	74.73%	70.38%	>=85%
>104 day breaches	130	87	75	57	64	65	61	42	56	57	45	53	<0 m
Demand: 2ww Refs	2,748	2,785	2,550	2,725	2,838	2,913	3,087	2,968	3,007	2,899	2,825	2,948	2628 - 2905
2ww Compliance	95.62%	94.52%	93.87%	93.28%	94.10%	93.58%	89.25%	88.48%	94.61%	96.44%	94.70%	94.64%	>=93%
Symptomatic Breast	94.12%	93.55%	92.22%	94.06%	88.03%	92.98%	85.00%	83.73%	93.71%	93.10%	92.44%	94.53%	>=93%
31 Day First Treatment	96.43%	97.48%	98.00%	94.82%	97.07%	98.10%	96.11%	96.31%	94.55%	94.31%	93.20%	93.47%	>=96%
31 Day Subsequent Surgery	94.44%	96.97%	94.44%	94.59%	97.50%	96.72%	91.49%	88.24%	86.96%	96.61%	90.38%	92.31%	>=94%
31 Day Subsequent Drug	100.00%	98.53%	98.44%	86.17%	100.00%	100.00%	98.25%	98.95%	100.00%	97.33%	98.89%	100.00%	>=98%
62 Day Screening	84.21%	86.36%	85.00%	93.75%	95.65%	92.31%	92.86%	93.10%	100.00%	83.33%	87.50%	93.94%	>=90%
62 Day Upgrades	66.67%	77.78%	70.00%	50.00%	86.67%	70.37%	100.00%	57.14%	100.00%	82.35%	85.71%	80.00%	>=85%

Sustainability & Transformational Funding Trajectory

-15.02

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	74.10%	76.40%	77.60%	77.40%	82.70%	85.40%	85.00%	85.50%	85.20%	85.10%	85.40%	85.20%	Sept
Performance	71.04%	79.20%	75.42%	70.94%	74.73%	70.38%							Sept

Summary Performance

The Trust has been non-compliant against the 62 day standard since December 2014. A trajectory to recover this target was agreed in April 2016, which predicted compliance by September 2016. Performance in Urology has dipped significantly over the summer period lack of capacity and the MRI failure on the Canterbury site has impacted on performance. Radiology and Urology teams are meeting to align the MRI appointments and reporting with the TRUS biopsy to prevent delays in the pathway. A review of the capacity plan for the service is being undertaken.

September performance is currently 70.38% against the improvement trajectory of 85.40%;

- The total number of patients currently on an active Cancer Pathway is 2,948
- Number of patients over the 62 day standard is 211 (7.4% of total PTL) of which;
    - 50 have a diagnosis
    - 43 of these have a decision to treat
- The total number of patients waiting 104 days is 54 (1.8% of Total PTL) of which;
    - 20 have a diagnosis
    - 15 have a decision to treat

The number of 2 week wait referrals continues to grow around 10% year on year with 19,678 referrals received in 2011 compared to 36,453 in 2015 and 34,133 in 2014. 2016 is on track for a 10% increase. This is reflected in the number of patients being tracked against the 62 day pathway we saw 1800 patients on the PTL in 2011 and in in 2016 it hovers just below 3000.

PTL

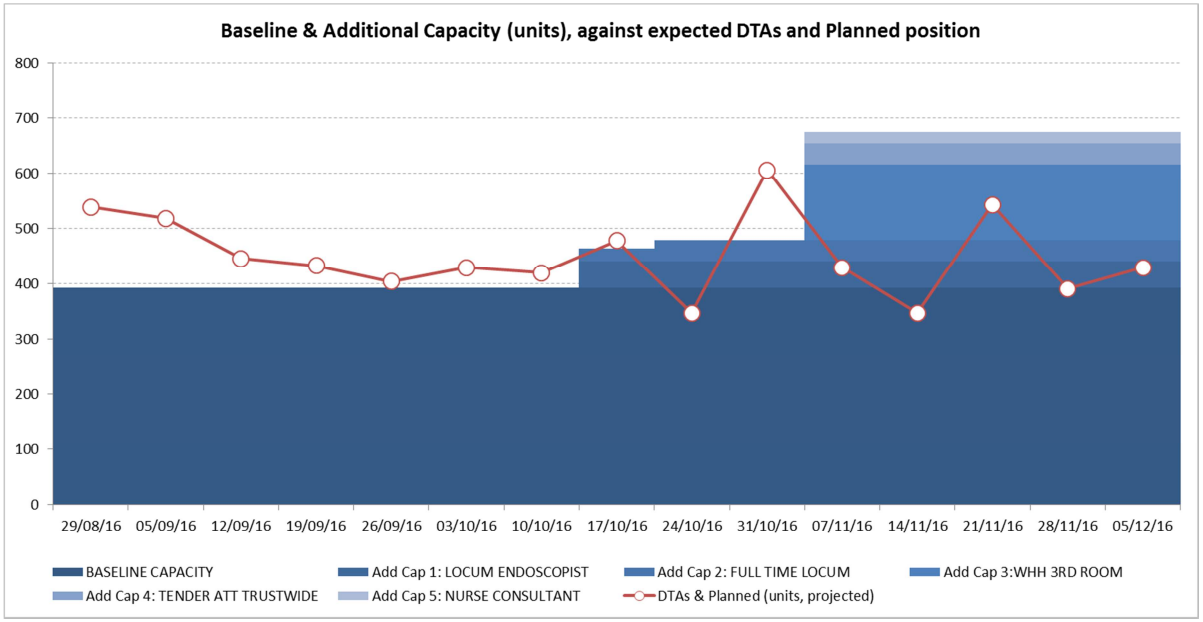
To highlight the current waiting times on the Patient Target List (PTL) a snapshot is produced each Monday and sent to Divisional Directors, included in the spread sheet are further tables to indicate specific key events (eg. Endoscopy and Radiology). The spread sheet is interactive and by clicking on the numbers it takes you to the patient detail. Divisional Directors have been requested to focus on patients waiting 40 plus days to help the compliance team move actions forward. A copy of the PTL table is shown below.

Count of NHS No	Tumour																
Period	Brain & CNS	Breast	Childrens	Gynaecological	Haematological	Head & Neck	Lower GI	Lung	Other	Sarcoma	Skin	Sympt. Breast	Testicular	Thyroid	Upper GI	Urological	Grand Total
> 104 days		2		5		5	18	2		1	1	1		3	3	17	58
> 100 days				2		1	4								2		9
90 to 99		2		1		2	7				1				1	4	18
80 to 89				8		5	17	1	2		2			1	4	9	49
70 to 79		1		6		6	14	6			2			2	4	12	53
63 to 69	1	2		13		8	10	4			4			1	2	17	62
55 to 62		10		22	2	2	12	4			3		1		8	22	86
45 to 54		17		34		10	50	7			10			1	9	51	189
35 to 44	1	6	2	14	2	9	33	2	4	1	14	2		1	14	40	145
25 to 34	1	25		57	1	25	78	15	6		29	9		6	42	75	369
15 to 25		50	1	90	2	31	95	28	7		53	29		1	70	59	516
0 to 14	6	174	1	111	2	105	175	37	3		255	47		1	139	124	1180
Grand Total	9	289	4	363	9	209	513	106	22	2	374	88	1	17	298	430	2734

The Cancer Compliance Team are meeting each morning with the MDM co-ordinators and agreeing actions for the day. The Cancer Compliance managers are taking the escalated actions forward and going out and meeting with operational teams or clinicians to take action and move the patient's event on. This may mean pulling an operation date, outpatient date or diagnostic test forward, getting a report on CT or MRI etc. The team are able to offer on the spot training. Issues are escalated daily to Divisional Directors to unblock.

The key areas of concern for the Trust are Endoscopy, Colorectal, Urology, Gynae-oncology and Radiology (both appointment and reporting capacity). The most significant risk is Colorectal and Endoscopy. A joint meeting of Colorectal and Gastroenterology Ops Team and Clinicians has taken place, chaired by Paul Stevens below is an overview of the key actions:

- Increase capacity once tender awarded – the graph below shows when additional activity is planned to come on line and how much this will increase capacity by. An assessment of this against the business plan indicates that there will be sufficient capacity to meet demand. (table 2)
- Recruited two consultants which has created additional gastro and endoscopy capacity.(table 2)
- Recruit to Consultant vacancy on the William Harvey site.
- Nurse Consultant will be completing his endoscopy training at the end of the month and will have substantive endoscopy lists independently from November (table2).
- Business plan underway to expand IBD nursing team which includes funding faecal calprotectin test (FC)- this will reduce demand in endoscopy as the FC test will be used instead of scoping. Currently South Kent Coast is the only CCG to have this test funded in the community. We are in discussion with the remaining 3 CCG's to introduce this test. Further work is being done to agree a standard pathway for the management of IBD
- November – advertising for Endoscopy Lead (Gastro and Surgical Consultant) to jointly manage endoscopy services. This will support a more collaborative approach to KPI's, service development and workforce development. This will compliment Dr Muller role who will continue to manage gastro and screening services
- Validation and audit of referrals for gastro and surgical endoscopy referral - this will inform a revised locally agreed criteria to support appropriate endoscopy referrals.
- Governance meetings have been establishes to review the KPI's of Endoscopists, clinical incidents, RCA/AAR which are all supported by risk and change registers
- Continue work operationally to ensure our surgical colleagues are delivering 42 weeks of activity and leave process in as per trust policy
- Build on the joint meetings and establish a regular gastro/surgical business meeting.
- Through the additional capacity waiting times will be reduced and this will enable a successful application for JAG accreditation. The aim is to apply in December 16 at the William Harvey. This will enable Public Health England to approve EKHUFT to roll out bowel scope.
- Daily PTL management of the cancer pathway in place
- The revised cancer PTL showing diagnostics is assisting a new weekly demand and capacity model that the Information Business Partner ids developing– this will help us with the on-going management of the LGI pathway and enable us to share learning and constraints re booking Lower GI Endoscopy referrals



104 day patients

The number of patients waiting past 104 days has reduced and is hovering around 55, which is around 1.8% of the PTL, it had been 2.15% of the PTL for the past year. DATIX reporting and clinical investigation continues for these patients, if harm to a patient is considered an RCA will be completed.

The escalation processes that have been introduced will ensure that patients with long waits are moved more quickly through their pathway. There will always be clinical exceptions, but these will be small in numbers.

A report of patients waiting over 104 days is presented to Patient Safety Board and discussed at Cancer Board.

A meeting with the CCG has reviewed the process for monitoring patients over 104 days and reported serious incidents where there has been a delay in diagnosis or missed cancer. This will continue to be an agenda item through the CCH Performance and Quality Meeting.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

18 Week Referral to Treatment Standard

Key Performance Indicators

83.76 %

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Green
Performance	92.06%	91.51%	88.82%	90.10%	89.17%	89.27%	88.56%	87.89%	86.81%	86.65%	85.52%	83.76%	>=92%
52w+	12	3	5	2	4	4	6	9	17	25	20	26	0
Waiting list Size	40,125	39,842	41,178	42,239	42,791	43,000	44,620	45,663	44,213	45,487	45,352	47,923	<38,938
Backlog Size	3,186	3,384	4,604	4,181	4,634	4,614	5,105	5,531	5,831	6,072	6,568	7,781	<2,178
Demand: PC Referrals	16,444	15,713	14,306	15,042	15,890	16,414	16,728	16,001	16,029	15,953	15,436	14,957	<15,484
Demand: Additions to IP WL	3,440	3,518	3,026	3,216	3,370	3,359	3,215	3,329	3,729	3,504	3,556	3,582	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

Sustainability & Transformational Funding Trajectory

-8.33 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%	Sept
Performance	88.56%	87.89%	86.81%	86.65%	85.52%	83.76%							Sept

Summary Performance

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

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

In September performance against the standard was 83.76%. There were twenty six patients who were waiting for treatment for more than 52 weeks as at the end of the month. There are number of issues that are driving the reduction in performance against the trajectory; higher than planned primary care referrals and an inability to deliver the additional capacity identified within business plans in key specialities such as Orthopaedics, General Surgery, Gastroenterology, and Gynaecology across all points in the patients pathway (first appointment, follow up and patients listed for surgery intervention). In other specialities such as ENT there are administrative delays leading to an unreliable reported waiting list position.

Whilst at Trust level primary care demand is in line with the predicted planned referral rate. Key areas are Orthopaedics, Maxillo Facial, Gynaecology, Dermatology and Paediatrics are significantly above plan. The current rate of referrals in these specialties has meant that the trajectory for referral to treatment for patients is unachievable unless the trust and the CCG agree a process to either; invest to create more internal capacity across the patient pathway which will involve additional pay and non-pay resource, outsourcing to the independent sector; or contract with alternative providers to utilise our facilities with an alternative workforce to the trusts. The decision making process to this will be taken jointly with the CCG and the trust within the existing meeting structures.

There has been a significant increase in the number of 52 week waiters is predominantly within the ENT & General Surgery specialties. The Trust has a capacity deficit within the Otology sub specialty due to vacancies, and is currently working in partnership with the Royal National Throat, Nose and Ear Hospital in London and primary care to ensure patients receive treatment. There has been an increase in 52 week breaches in General Surgery due to the number of bariatric patients requiring surgical procedures that can only be done by one consultant at WHH. The surgical division has been working with the CCGs to reduce referrals for elective surgical procedures for bariatric patients.

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

Priority 1 - Improve Pathway Management

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

- The system was fully operational on 22nd August 2016

- Over 9,200 patient records were validated in September
- The Trust has developed innovative methods to identify data quality metrics which enables us to direct training to the most challenged areas.
- The surgical division commenced more intensive time protected validation form Monday 4th October. This will be reviewed weekly to ensure continues to have an impact on the RTT position

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

- All clinical pathways have now been mapped and agreed with the clinical staff, implementation of these pathways is now required to commence. This will begin in September.

Priority 2 - Achieve the Outpatient Milestones

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

- The CCGs are continuing to identify alternative providers to deliver Orthopaedic pathways in 2016/17.
- The CCG's are implementing choice navigators into referral management centres for Orthopaedics and are exploring other avenues to aid other specialities, such as gastroenterology and Gynaecology.
- The CCG are in the process of awarding the contracts for outpatient procedure management of wet macular oedema (Ophthalmology). This will mean patients will receive treatment closer to home in a primary care setting and will no longer have to attend hospital.
- The trust is working with the CCG to explore the development of in-house sleep studies in ENT to enable a one stop service to avoid transfer to the community for diagnostic testing.

The Trust is addressing current shortfalls in capacity with increased demand by;

- Additional outpatient internal capacity is being established for Orthopaedics, ENT, General Surgery, Maxillo Facial and gynaecology
- A tender process is underway to secure additional capacity in Ophthalmology using a company who will utilise our facilities in order to treat our patients.
- Two new consultants commenced in gastroenterology in September to stabilise the service
- Two new consultants commencing in Otology in November
- One new consultant commencing in October in Maxillo Facial
- Seven new consultant posts in recruitment process for Ophthalmology, interviews in November
- Validation process in ENT being reviewed with individual consultants with training being provided on the RTT pathway

- The Trust has identified an alternative provider who will accept tertiary referrals for complex adult ear procedures. The trust is liaising with London for outcomes of these treatments
- Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste has commenced.
- Bring forward the Decision to Treat Date – Identifying patients who have passed the optimal point in patient pathway and securing decision or treatment capacity

Priority 3 - Deliver the Efficiency Programme

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

- The Trust has developed key monitoring documentation and enhanced the booking procedures required to achieve the required Theatre efficiency target.
- Increase in number of sessions run.
- General Surgery, Gynaecology and Ophthalmology continue to be the areas for focus during August and September

6-4-3 Programme – The Trust has established a programme of work to reduce the number of Theatre sessions that are cancelled and not re-established.

- The Trust has developed future focused reports and established meetings to review underutilised and empty theatre sessions.
- Profile of unused theatre lists are addressed at weekly theatre site meetings and weekly Trust theatre efficiency meetings.

Priority 4 – Deliver recurrent demand substantively

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

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

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

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

- Job planning of clinical teams to deliver flexible sessions to achieve cross covering of clinical commitment during leave in outpatient and theatres is now operational

- Identified Ophthalmology sessions to transfer to extended days to release theatre capacity and provide cross cover – commenced
- Capacity to be commissioned from alternative provider for Ophthalmology during August and September until recruitment of consultants and technical staff has been successful. 3,000 appointments to be commenced during August and September – commenced
- The trust has secured additional capacity on behalf of the CCG and has commenced the transfer to the independent sectors for Orthopaedics 279 patients have been transferred to date with a further 150 being validated. The commissioning support unit and our primary care colleagues are continuing to source additional outpatient capacity to divert referrals this is reviewed at the primary care Contract and Performance Notice meetings (CPN)
- The trust has also secured additional capacity (130) on behalf of the CCG with the independent sector for General Surgery and has commenced transfer of patients for treatment.

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

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

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.74 %

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Green
Performance	99.84%	99.86%	99.90%	99.81%	99.65%	99.65%	99.78%	99.87%	99.86%	99.77%	99.56%	99.74%	>=99%
Waiting list Size	13,962	12,799	13,593	12,496	12,993	13,358	13,449	14,812	13,533	13,321	10,269	14,728	<14,000
Waiting > 6 Week Breaches	23	18	13	24	45	47	29	19	19	31	45	39	<60
Average Wait													<4

Sustainability & Transformational Funding Trajectory

0.60 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	99.08%	99.09%	99.15%	99.15%	99.13%	99.14%	99.13%	99.05%	99.10%	99.02%	99.03%	99.13%	Apr
Performance	99.78%	99.87%	99.86%	99.77%	99.56%	99.74%							Apr

Summary Performance

The DM01 is a national monthly report of performance against the 6 week standard for 15 key diagnostic tests. These include Radiology (MRI, CT and Ultrasound), Audiology, Echocardiography, Neurophysiology and Cystoscopy. Around 13/14 thousand tests per month are measured against the 6 week standard. The Division support the pathways for all patients on an 18 week and Cancer pathway. As well as monitoring the % of patients waiting 6 weeks or less for a diagnostic, the waiting list size and number of breaches over 6 weeks are also monitored, as these are key indicators that result in achievement of the DM01 standard.

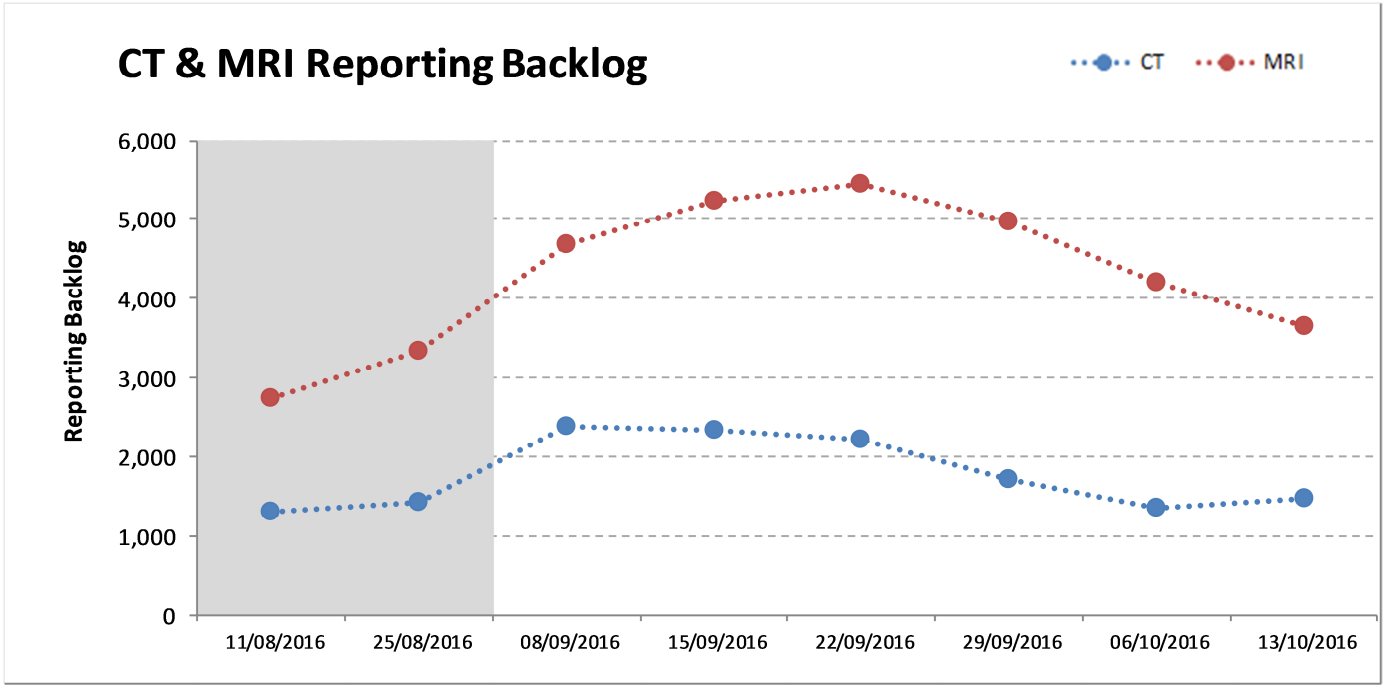
In September 2016 39 patients waited over the 6 weeks standard. The majority of these were in CT (16) and Non-Obstetric Ultrasound (13), with small numbers in other areas. (MRI 4, Neurophysiology 3, Cystoscopy 1, Colonoscopy 1, Flexible Sigmoidoscopy 1)

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

The DMO1 and management of performance were compromised when the GE RIS system failed across Kent and Medway on the 28th August and was not fully restored fully until the 18th September 2016. The root cause of the downtime was the loss of a second disc only hours after a first disc failure, which did not leave time for the first disc to be replaced. The system can only tolerate a single disc failure, the second therefore caused all information to be lost and a full restore from backup was therefore required. The extreme size of the database involved, led to extended backup recovery times. It is advised that the backlog and an improved position for reporting this will not be met until mid-December 16.

Mitigating Actions Taken

The team have been working in business continuity to manage the impact and recover the position. Communication and on-going work with Partner and GP's is in place. The graph below shows the reporting backlog for CT & MRI over the last 2 months.



Snapshot Date	11/08/2016	25/08/2016	08/09/2016	15/09/2016	22/09/2016	29/09/2016	06/10/2016	13/10/2016
CT	1,316	1,437	2,394	2,339	2,220	1,725	1,355	1,481
MRI	2,751	3,329	4,674	5,231	5,435	4,952	4,202	3,661
Total	4,067	4,766	7,068	7,570	7,655	6,677	5,557	5,142

NB/ Grey shading denotes time period prior to failure of GE RIS

Progress since the 6th October has been as follows;

- The number of CT exams outstanding has increased to 1,481 an increase of 126 exams.
- The MRI backlog has decreased to 3,661 exams, a decrease of 541 exams.
- Progress has also been made on the average length of time cancer pathway examinations are waiting for reporting down to 3.94 days for CT and 3.11 days for MRI.

This is a strong reporting position for 2WW which represents the best position for a number of years however this is taking micromanagement on a daily to ensure patients are seen and reporting is completed as patients are often not identified correctly on any of our systems.

We continue to manage variations in demand in all modalities with limited capacity to deliver more. All equipment is working to maximise opportunity. We continue to vet requests, provide information to Trust Divisional clinical teams; CCG's at Consultant/Practice and GP level to enable a greater level of understanding and assessment of need and challenge as to requesting. Additional lists are being undertaken to include both extended days during the week and Saturday lists.

Recruitment of Consultants Radiologists remains a huge risk to delivery concern. There is on-going substantive recruitment with Interviews this month with 4 applicants. We are sourcing locums, paying overtime and outsourcing where it is practical to do so.

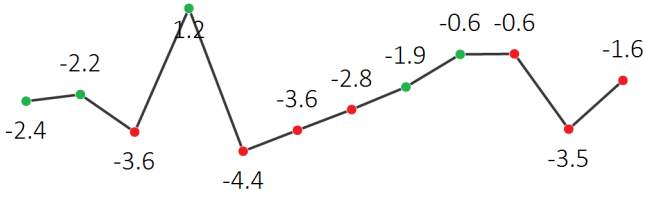
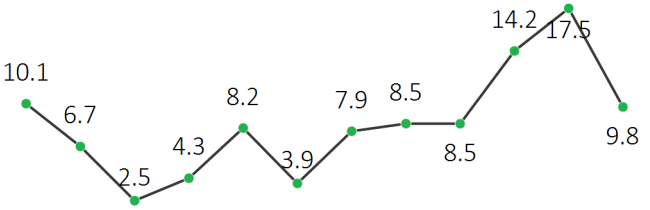
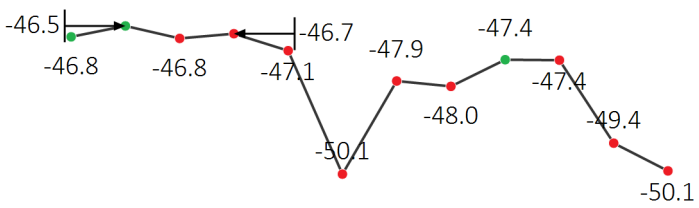
A further reduction to current workforce and reduction to outsourcing would dramatically reduce the ability to deliver and sustain the DMO1 position and it would further compromise the RTT and cancer standards. Daily active monitoring of waiting list and backlog position is in place. We are developing a Radiology/Cancer PTL Tracker to better manage our Cancer patients this will be in place this month. The Division continues to deal with challenging management HR and MHPS issues which may impact further on backlog and performance.

The Trust ageing equipment continues to be monitored closely and serviced as required. We have had interim breakdowns in month on both CT and MRI .The Division have secured capital funding for the replacement of 2 MRIs at KCH. The New CT is in place and operational at the William Harvey. Planning has commenced to deliver MRI solutions to be in place by Jan 2017.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Finance

Sep	I&E £m	-11.0 (-54.1%)		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
Sep	Cash Balance £m	9.8 (-43.9%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Total Cost £m	-50.1 (1.4%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Forecast I&E £m	-19.5 (-20.4%)		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

Sep

Normalised Forecast £m

-23.6
(-14.5%)

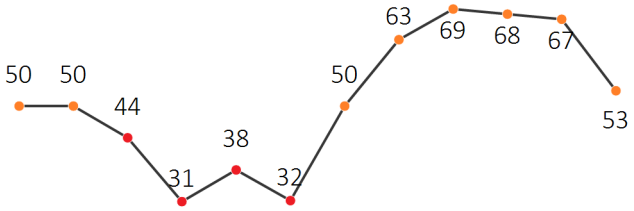
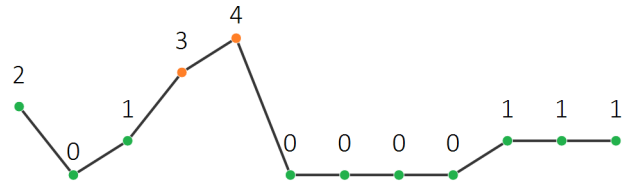
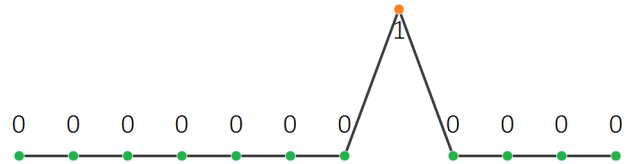
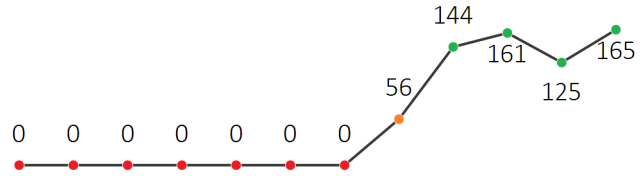
This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: The Trust's I&E deficit in September was £1.6m. This excludes Sustainability and Transformation Fund (STF) income. The year to date I&E deficit stands at £10.99m to month 6 with £4m of STF income relating to Q1 having been received. If STF income was included, the September deficit would have been £0.3m as against £0.8m, £0.6, and £0.6m in the previous three months. The Trust's year end forecast has been revised to a deficit of £19m from £24m against the published NHSI Control Total of a £0.6m surplus, comprising a £7m operational deficit and £12m of lost STF income. In order to deliver the revised forecast the Trust will introduce a range of additional measures including a peer review process against temporary staff usage, quality impact assessed vacancy management, and a range of both cost avoidance and run rate reduction measures. This includes deferral of a number of programmes, a continued focus on clinical productivity initiatives, and a further review of asset lives. Against the initial £20m CIPS target, including income, for the year to date, £7.3m has been delivered against a target of £7.4m. The Trust is continuing to discuss its cash requirements with NHSI and to the end of M6 had accessed £11.8 of its approved interim credit facility of £14.6m. The latest forecast submitted to NHSI indicates a requirement for c£28.5m with the next call down of cash being December.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

Sep	Representation at H&S	614 (23.9%)		% 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.
Sep	RIDDOR Reports (Number)	13 (-43.5%)		RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Sep	Formal Notices	1		Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).
Sep	Health & Safety Training	651		H&S Training includes all H&S and risk avoidance training including manual handling

Comments:

The number of accidents increased for the third successive month. Although still within green, H&S link works will be asked to check at local levels whether all staff are following Trust safety policies and procedures. Fire alarm activations rose to 18 in September, the highest number this year. Only two of these alarms related to actual alarms from minor smoke. The significant remainder relate to false signals from faulty smoke heads in the 1937 building at K&CH. Estates with SIG support has now brought forward (from 17/18) the replacement of the fire detection system in the building so as to ensure appropriate fire management.

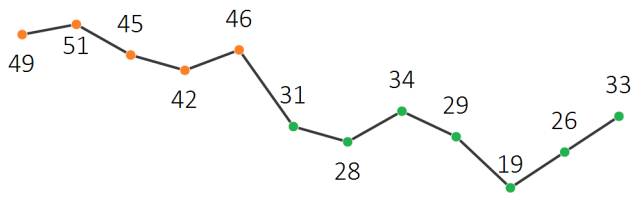
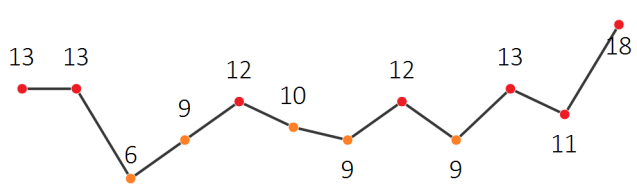
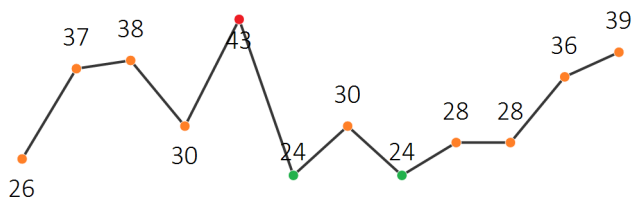
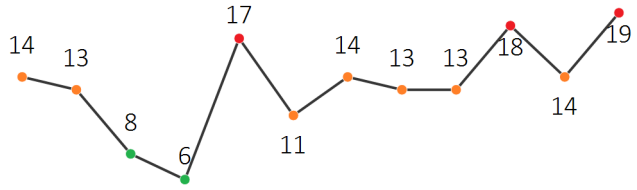
Violence and aggression rose slightly again this month to 39, more work is being undertake to review the data with the Strategic H&S committee being asked to review and report.

The number of sharps incidents remains high year to date and in month. A trial of new sharps bins is being undertaken to help support front line staff safety. The data suggests that human error remains the main issue, Divisions have been asked to consider what additional support, training or information would be required to help reduce preventable incidents.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

Sep	Accidents	433 (-17.0%)		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.
Sep	Fire Incidents	135 (0.7%)		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.
Sep	Violence & Aggression	383 (-16.2%)		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.
Sep	Sharps	160 (138.8%)		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:

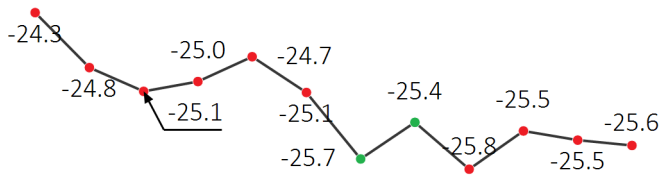
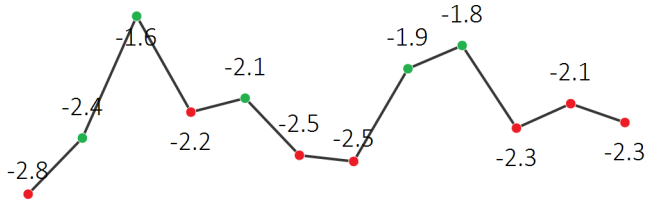
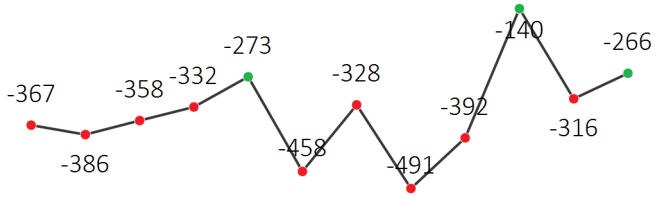
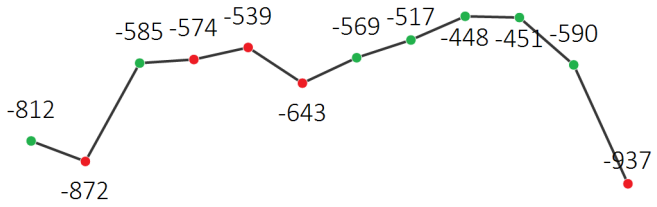
Cleanliness remains relatively static this month at 92% a consistent low 90's record has been the picture for the last 6 months. Operationally the Trust continues to manage cleaning on a daily basis and through its weekly auditing process. The joint Trust/Serco audits, based on the NHS 26 cleaning standards show a consistent average above 98% position as per MD12 audit.

Hospital Food has raised by 1% this month. This is below the 85% green threshold determined in this metric by the Trust. It's worth noting however that random bed side surveying undertaken by Serco each month records a consistent plus 90% return, with September at 93% satisfaction.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

Sep	Payroll Pay £m	-25.6 (0.2%)		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.
Sep	Agency Spend £m	-2.3 (6.0%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Additional sessions £k	-266 (-15.7%)		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.
Sep	Independent Sector £k	-937 (58.9%)		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 month were £28.1m similar to the average in previous months. Agency and locum costs increased to £2.3m as against an average of £2.1m per month, mainly driven by medical staff, and now stand at £13m (£16.2m 2015/16) for the year to date. Pressure remains on the Trust's performance against the NHSI agency ceiling of £23m which will be breached by c£3m if the current average spend continues, but actions are being worked through with divisions to bring this back into line in Q3 and Q4.

East Kent Hospitals University NHS
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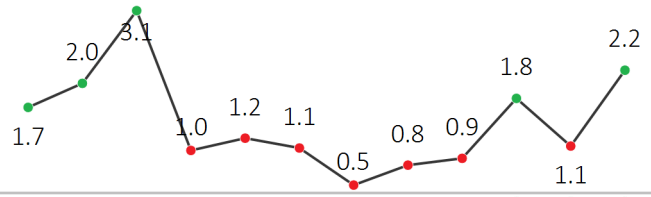
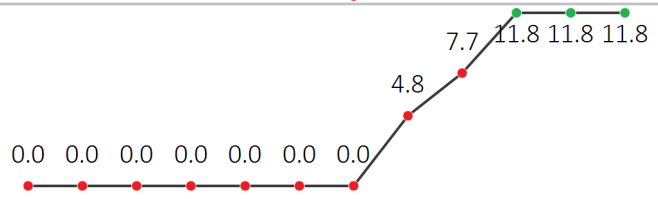
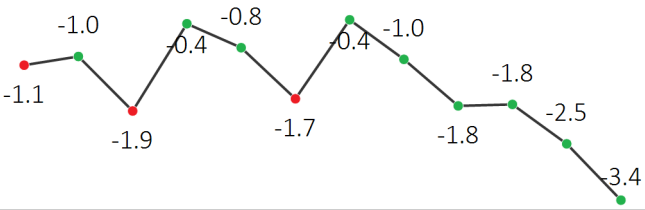
Strategic Theme: Use of Resources

Balance Sheet

Sep	CIPS £m	7.3 (102.2%)		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.
Sep	Cash borrowings £m			Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Sep	Capital position £m	-10.9 (38.9%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.

Comments:

CIPS of £5.9m have been reported ytd which is £1.3m below plan mainly due to the shortfall in theatres efficiency savings, and some slippage on outpatients and workforce. Additionally, an income CIPs contribution of £1.5m ytd has been delivered. The CIPS target for the year is £20m with a further £5m stretch of run rate and cost avoidance measures. As at the end of September, schemes valued at £18.4m had been identified. This reduces to £16.5m when risk adjusted. The forecast for Income Completeness schemes is £2.3m. New CIPs Ideas sufficient to close the gap continue to be developed.

The cash forecast for 2016/17 continues to be extremely challenging with only £2.8m remaining available from the current agreed working capital facility of £14.6m. In August the Trust received the first quarter STF payment £4m, however NHSi have advised Trusts not to assume further STF receipts in cash forecasting unless positive confirmation has been received. The Trust is continuing to work with NHSI to secure additional working capital financing. The latest cash forecast submitted to NHSi highlighted a working capital financing requirement of £28.5m (plan submission £20.8m). The main driver for the increased requirement is the removal of the STF funding relating to future periods and the reforecast to reflect the I&E Trust deficit.

The capital position at the end of September is 24% under plan. It is expected that the full £14.2m plan will be delivered by year end.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Productivity

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

Comments:

Theatres: £0.8m has been booked against this scheme year to date with a £3.1m target. The programme of improvement put in place supported by Four Eyes is being rolled out and further efficiency improvements, resulting in higher levels of clinical productivity and reduced IS and additional session spend is planned for the second half of the year.

Outpatients: £0 has been booked against this scheme year to date. Divisions are struggling to implement cost reductions given high levels of demand.

An update on productivity improvement schemes will be provided at the Finance and Performance Committee in November.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Improvement Journey

		May	Jun	Jul	Aug	Sep
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	82.69	85.40	82.88	82.25	84.19
MD03 - Maternity Capacity	Midwife:Birth Ratio (%)	28	25	30	29	30
MD06 - Pathway Flow	IP - Discharges Before Midday (%)	14	14	15	15	15
	DToCs (Average per Day)	62	62	62	58	52
MD07 - Medicines Management	Pharm: Fridges Locked (%)	94	94	90	92	79
	Pharm: Fridge Temps (%)	85	83	83	81	70
	Pharm: Drug Trolleys Locked (%)	100	100	97	99	97
	Pharm: Resus. Trolley Check (%)	88	88	92	90	82
	Pharm: Drug Cupboards Locked (%)	89	91	91	92	95
MD08 - Staffing Levels	Vacancy (%)	9.2	9.7	10.4	10.5	10.6
	Shifts Filled - Day (%)	101	98	91	91	93
	Shifts Filled - Night (%)	105	103	103	102	100
MD09 - Workforce Culture	Sickness (%)	3.8	3.8	3.8	3.8	3.2
	Appraisal Rate (%)	70.0	73.1	75.4	79.5	81.2
	Staff Turnover (%)	11.3	11.8	12.1	12.0	12.6
	Corporate Induction (%)	100	100	100	100	100
	Staff FFT - Work (%)	58	58	58	58	58
	Staff FFT - Treatment (%)	78	78	79	79	79
MD11 - Clinical Audit	Clinical Audit Prog. Audit	3	3	3	3	3
	Clinical Audit Review	3	3	3	3	3

MD12 - Environment	Cleanliness Audits (%)	98	98	98	98	98
MD17 - Incident Reporting	Clinical Incidents: Total (#)	1331	1370	1251	1263	1329
MD19 - Major Incident Planning	Major Incident Training (%)	27	29	32	33	35
MD22 - Agency Staffing	Unplanned Agency Expense	68	68	98	100	115
	Clinical Time Worked (%)	73	73	74	71	70
	Temp Staff (WTE)	205	202	205	226	229
	Employed vs Temporary Staff (%)	91.0	90.3	89.8	89.6	89.5
	Local Induction Compliance %	8.5	15.0	15.0	9.2	14.9
MD26 - Complaints Process	Complaint Response in Timescales %	84	94	96	97	92
MD30 - Medicines Management	Medicines Mgmt. Incidents	103	119	91	109	114

East Kent Hospitals University NHS
NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
				0 %
A&E	ED - 4hr Compliance (%)	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge.	>= 95	100 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	<= 90	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 28	30 %
	Extra Beds	Number of extra 'unfunded' beds available		0 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Outliers	Number of Bed Outliers in the Trust, where the intended use of the bed is used for another service		0 %
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %
Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	Cleanliness Audits (%)	Cleaning Schedule Audits	>= 98	5 %
	Clinical Audit Prog. Audit	Agreed Clinical Audit programme meets national programme requirements	>= 3	5 %

Clinical Outcomes	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 %
	PROMs EQ-5D Index: Groin Hernia	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Hip Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Knee Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Policies in Date (%)	All documents that are marked as policies are in date on the SharePoint system	>= 95	10 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 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 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code %	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	< 7	0 %
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	0 %
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		0 %
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	0 %
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £5.2m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %

Health & Safety	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %
	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	1	15 %
	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.		0 %
	Blood Transfusion Errors	The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Falls (per 1,000 bed days)	Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 94	10 %

Incidents	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 98	20 %
	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.	< 1	30 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls	>= 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.		0 %
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	Blood Culture Training	Blood Culture Training compliance	>= 85	0 %
	C Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	< 1	0 %
	C. Diff Infections (Post 72h)	The number of Clostridium difficile cases recorded at greater than 72h post admission. Data source - VitalPAC (James Nash).	< 1	0 %
	Cases of C. Diff (Cumulative)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Position in arrow shows YTD cumulative position and variance against previous month. Graph shows last 12 months, noting that C. Diff is reported as a cumulative YTD position, which explains the drop from 28 (as at March-16) down to 4 (new financial year at April-16).	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %

Infection	E Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	0 %
	E. Coli	The total number of E-Coli bacteraemia recorded, 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 %
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	0 %
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	< 1	0 %
	MSSA	The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	0 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	0 %
Initiatives	75+ Frailty Pathway CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	0 %
	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 %
	COPD CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and improve referral rates to the Stop Smoking Service and to the Community Respiratory Team	>= 100	0 %
	Dementia Diagnosed CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to monitor the diagnosis for Dementia. Green = on target for case finding, assessment and referral to reach 90% for each indicator for 3 consecutive months, AND staff training on target for improvement, AND on target to provide support to carers	>= 100	0 %
	Diabetes CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	0 %
	End of Life Pathway CQUIN Delivered %	CQUIN linked to current improvement work and multi-agency policy	>= 100	20 %
	Heart Failure CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and sustain EQ HF measures	>= 100	0 %
	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 %

Initiatives	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 together with variance against previous 12 months.	< 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 (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.95	15 %
Observations	Cannula: Daily Check (%)	The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-9pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 9pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant.	>= 95	20 %
Patient Experience	Care Explained? %	Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 89	4 %

Patient Experience	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 %	Audit due to commence in January - Percentage of controlled drugs signed off by two nurses	>= 85	5 %
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	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 %
	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.		0 %
	Number of Compliments	The number of compliments recorded per ward. 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 %
	Returning Complaints	Number of complaints returned		4 %

Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use – allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 90	20 %
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		0 %
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		0 %
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total non-clinical cancellations.	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	< 5	10 %
	Pharmacy TTAs Dispensed (%)	The percentage of Discharge Prescriptions (known as TTAs, TTOs or EDNS) dispensed by Pharmacy before the time required on the ward	>= 80	0 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	< 1	0 %
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency %	% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).	<= 10	0 %
	Agency & Locum Spend	Total agency spend including NHSP spend		0 %
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	0 %
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
	Local Induction Compliance %	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	0 %

Staffing	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	< 28	2 %
	NHSP Use % of Agency	% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).	> 90	0 %
	Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	0 %
	Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
	Roster Effectiveness (%)	The time ward staff attribute to clinical duties as a % of the ward duty roster. Data source - eRoster.		15 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA)	>= 97	15 %
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 97	15 %
	Sickness (%)	% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 3.6	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		0 %
	Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		0 %
	Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	15 %
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Temp Staff (WTE)	Count of Temporary Staff in post	< 182	1 %
	Time to Recruit	Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	0 %
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Total Staff In Post (SiP)	Count of total staff in post		1 %
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %

Staffing	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 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	0 %
	EME Planned Maintenance (%)	Planned maintenance of EME managed medical equipment	>= 95	0 %
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	0 %
	Mandatory Training (%)	The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.	0	0 %
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	0	0 %
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	0	0 %
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		0 %
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		0 %
	Independent Sector £k	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %

Data Assurance Stars

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

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

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

East Kent Hospitals University NHS
NHS Foundation Trust

Patient Safety Heatmap

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Cases of MRSA (per month)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
KCH - Kent & Canterbury																	
Specialist																	
FDC - FRIENDS DERMATOLOGY CENTRE		0	1	0	0	0	0	0									
KBRA - BRABOURNE (KCH)	100.0	0	1	0	0	0	0	0				65	100	0.0		76	106
MARL - MARLOWE WARD	100.0	4	1	0	0	0	0	76				16	100	0.0	87.8	88	95
Surgical																	
CLKE - CLARKE WARD	94.6	0	5	0	0	0	1	1				24	99	1.1	91.1	84	103
DSSC - DAY SURGERY		0	0	0	0	0	1	0									
KENT - KENT WARD	93.8	7	1	0	0	0	0	75	100	98	99	41	100	0.0	94.0	108	93
KITU - KCH ITU	100.0	0	0	0	0	0	0	0							89.5	85	100
WURO - UROLOGY SUITE		0	0	0	0	0	1	0									
Urgent Care																	
HARB - HARBLEDOWN WARD	100.0	4	7	0	0	0	1	0	100	96	97	53	94	5.9	72.8	91	95
HARV - HARVEY WARD	94.7	0	0	0	0	0	0	0								94	131
INV - INVICTA WARD	100.0	0	3	0	0	0	1	63	91	67	87	37	100	0.0	90.2	97	121
KCDU - EMERGENCY CARE CENTRE	100.0	0	0	0	0	0	0	0	92	94	100				96.1		
KING - KINGSTON WARD	100.0	0	0	0	0	0	1	1	100	94	99	29	100	0.0	103.1	96	97
KNRU - EAST KENT NEURO REHAB UNIT		0	2	0	0	0	0	0				50	100	0.0	84.6		
MTMC - MOUNT/MCMASTER WARD	100.0	0	5	0	0	0	1	7	100	88	98	46	97	0.0	87.4	82	129
SLA - ST LAWRENCE WARD		0	1	0	0	0	0	0									
TAY - TAYLOR WARD	100.0	0	1	0	0	0	0	1	100	100	100	82	100	0.0	82.7	67	100
TREB - TREBLE WARD	100.0	0	7	0	0	0	1	13	89	91	96	61	98	2.3	92.0	86	132
QEH - Queen Elizabeth Queen Mother																	
QMAT - MATERNITY		0	0	0	0	0	2	0									
Specialist																	
BIR - BIRCHINGTON WARD	100.0	1	1	0	1	0	1	0				58	99	0.0	100.5	103	97
KIN - KINGSGATE WARD	100.0	0	0	0	0	0	0	38							91.0	78	84

Apdx.

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Cases of MRSA (per month)	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 (%)
QSCB - QEH SPECIAL CARE BABY UNIT	100.0	0	0	0	0	0	0	0							88.7	102	101
RAI - RAINBOW WARD	100.0	0	1	0	0	0	0	0				0			94.8	90	102
Surgical																	
BIS - BISHOPSTONE WARD	95.2	2	5	0	0	0	1	1				39	100	0.0	94.2	85	94
CSF - CHEERFUL SPARROWS FEMALE	90.5	1	1	0	0	0	1	25	85	88	93	33	93	0.0	82.2	77	96
CSM - CHEERFUL SPARROWS MALE	100.0	0	3	0	0	0	0	22	89	91	92	49	93	1.9	85.6	75	93
QITU - QEH ITU	100.0	0	0	0	0	0	0	37							96.7	82	96
QX - QUEX WARD	100.0	1	2	0	0	0	1	63	98	90	93	81	100	0.0	89.9	83	91
SAL - SURGICAL ADMISSIONS LOUNGE		0	0	0	0	0	1	0									
SB - SEA BATHING WARD	91.7	0	0	0	0	0	0	0	100	100	100	38	96	0.0	94.0		
Urgent Care																	
DEAL - DEAL WARD	100.0	0	9	0	0	0	2	0	100	100	99	23	90	10.0	92.9	117	112
FRD - FORDWICH WARD STROKE UNIT	100.0	0	4	0	0	0	0	0	100	100	100	59	100	0.0	77.2	98	98
MW - MINSTER WARD	100.0	1	9	0	0	0	3	42				63	94	0.0	84.0	106	103
QCCU - QEH CCU	100.0	1	2	0	0	0	0	1	100	100	100	63	100	0.0	89.7	78	102
QCDU - QEH CDU	100.0	0	0	0	0	0	0	239				24	79	14.0	87.0		
SAN - SANDWICH BAY WARD	100.0	1	2	0	0	0	2	0	95	86	98	13	100	0.0	95.5	135	142
SAU - ST AUGUSTINES, THE REHAB. WARD	96.2	1	9	0	0	1	0	0	92	97	100	252	90	7.4	83.2		
STM - ST MARGARETS WARD	95.8	0	2	0	0	0	0	0				25	100	0.0	97.5	104	99
WHH - William Harvey																	
EYE - EYE UNIT		0	0	0	0	0	1	0									
WXRY - X-RAY (WHH)		0	0	0	0	0	1	0									
Specialist																	
CBC - CELIA BLAKEY CENTRE		1	0	0	0	0	0	0									
FF - FOLKESTONE	100.0	0	0	0	0	0	2	128	100	100	100					85	89
KEN - KENNINGTON WARD	100.0	0	2	0	0	0	2	2				29	92	5.6	90.2	91	98
PAD - PADUA	100.0	0	1	0	0	0	0	0				24	99	1.3		82	91
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	0	35								91	95
SING - SINGLETON MLU		0	0	0	0	0	0	0								98	87
Surgical																	

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Cases of MRSA (per month)	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 (%)
DSC - DAY SURGERY CENTRE		0	0	0	0	0	1	0									
ITU - WHH ITU	100.0	0	0	0	0	0	0	1							101.3	121	103
KA2 - KINGS A2	100.0	1	3	0	0	0	1	87	90	91	94	65	100	0.0	88.0	103	111
KB - KINGS B	92.0	2	5	1	0	0	0	100	95	95	98	67	99	0.0	89.6	100	144
KC - KINGS C1	95.8	5	5	0	0	0	0	220	100	93	93	23	73	9.1	91.7	105	100
KC2 - KINGS C2	100.0	0	5	1	0	0	1	88	96	97	99	84	100	0.0	88.2	87	97
KDF - KINGS D FEMALE	100.0	1	6	0	0	0	1	89	91	90	93	60	92	8.0	93.3		
KDM - KINGS D MALE	96.0	2	2	0	0	0	0	80	94	94	98	47	97	0.0		100	102
RW - ROTARY WARD	100.0	0	2	0	0	0	1	45	96	90	96	47	100	0.0	90.6	101	99
SEAU - SURGICAL EMERGENCY ASSESS WHH		2	0	0	0	0	0	0				148	98	0.0			
Urgent Care																	
CCU - CCU	90.9	3	0	3	0	0	0	11				89	100	0.0	82.5	88	85
CJ2 - CAMBRIDGE J2	87.9	2	3	0	0	0	1	0				19	75	8.3	79.5	97	102
CK - CAMBRIDGE K	100.0	1	5	0	0	0	0	12	93	89	98	92	95	1.7	96.9	111	99
CL - CAMBRIDGE L REHABILITATION	92.3	2	13	0	1	0	0	26	91	73	89	40	90	10.0	86.5	80	112
CM1 - CAMBRIDGE M1 SHORT STAY		0	2	0	0	0	1	0				66	100	0.0			
CM2 - CAMBRIDGE M2	100.0	2	4	0	0	0	0	13	97	94	95	83	100	0.0	97.6	96	98
OXF - OXFORD	100.0	0	1	0	0	0	0	17				33	90	0.0		99	99
RST1 - RICHARD STEVENS 1 STROKE UNIT	95.7	5	6	0	0	0	1	0				47	100	0.0	91.8	94	97
WCDM - WHH CDU MIXED	97.4	0	0	1	0	0	0	1	95	89	98	22	93	2.2			

East Kent Hospitals University NHS
NHS Foundation Trust

Human Resources Heatmap

	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term
Agency %	6.3	0.0	4.3	7.1	12.5	0.7	23.5	46.7
Appraisal Rate (%)	82.1	85.3	73.7	79.1	81.8	74.9	89.2	73.9
Employed vs Temporary Staff (%)	89.0	92.8	87.5	88.3	91.6	88.8	91.8	86.3
Mandatory Training (%)	91	88	91	82	84	86	88	91
NHSP Use % of Agency	100.0		100.0	100.0	100.0	100.0	100.0	100.0
Sickness (%)	3.3	1.4	2.0	2.2	3.7	2.9	3.2	3.1
Staff Turnover (%)	13.9	12.8	16.8	16.8	12.1	12.8	10.4	13.3
Vacancy (%)	11.0	7.2	14.6	13.9	8.4	11.2	8.2	13.8

Apdx.