NHS
East Kent
Hospitals University
NHS Foundation Trust

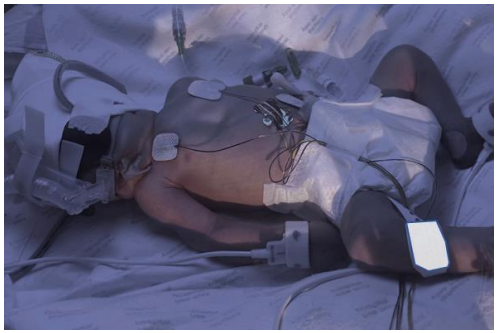
Integrated Performance Report

January 2022







We care

Our vision, mission and values

We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our focus centres on five "True North" themes. These are the Trust-wide key strategic objectives which it aims to significantly improve over the next 5 years:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**

True North metrics, once achieved, indicate a high performing organisation.

What is the Integrated Performance Report (IPR)?

To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- Reducing falls
- Reducing healthcare acquired infections
- Reducing deaths from sepsis/respiratory failure
- Improving theatre capacity
- Reducing patient time in ED once there has been a decision to admit.

We have chosen these five objectives using data to see where focusing our efforts will make the biggest improvement. We'll use data to measure how much we're making a difference.

Frontline teams will lead improvements supported by our Improvement Office, which will provide the training and tools they need. Our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

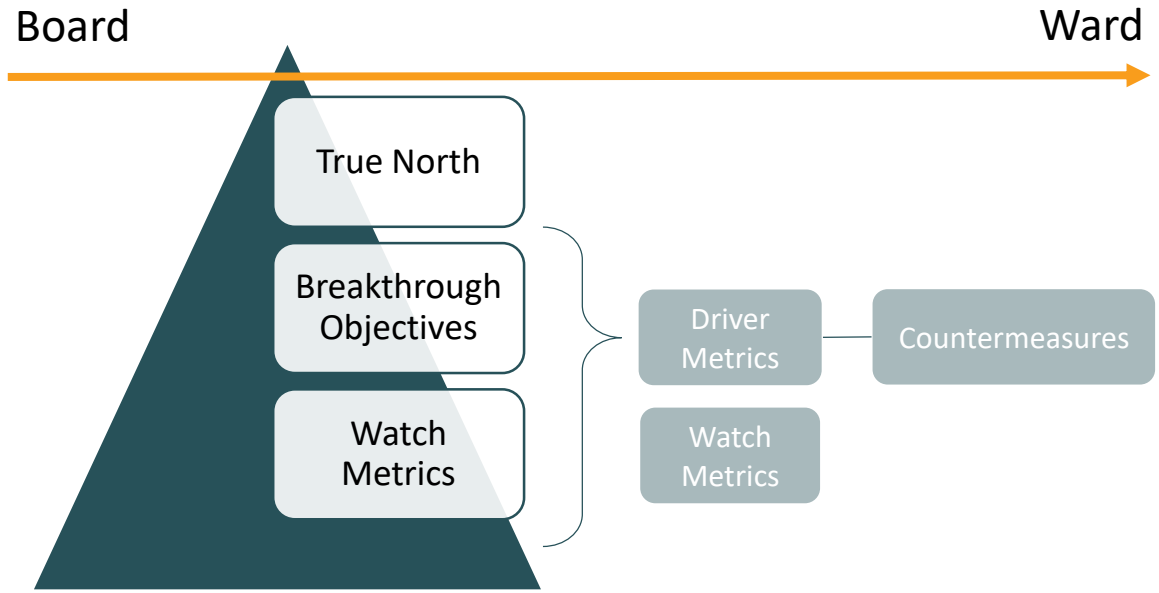
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.

Integrated Performance Report

IPR

Performance Review Meetings

PRM



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2020/21. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them

What are the Business Rules?

East Kent Hospitals University NHS Foundation Trust

Breakthrough objectives will drive us to achieve our "True North" (strategic) goals, and are our focus for this year.
These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen.

Metrics that are not included in the above are placed on a watch list, where a threshold is set by the organisation and monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate.

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
101.6	100.9	97.3	95.8	94.1	94.3	94.8	95.4	97.6			

F

Variation indicates consistently falling short of the target

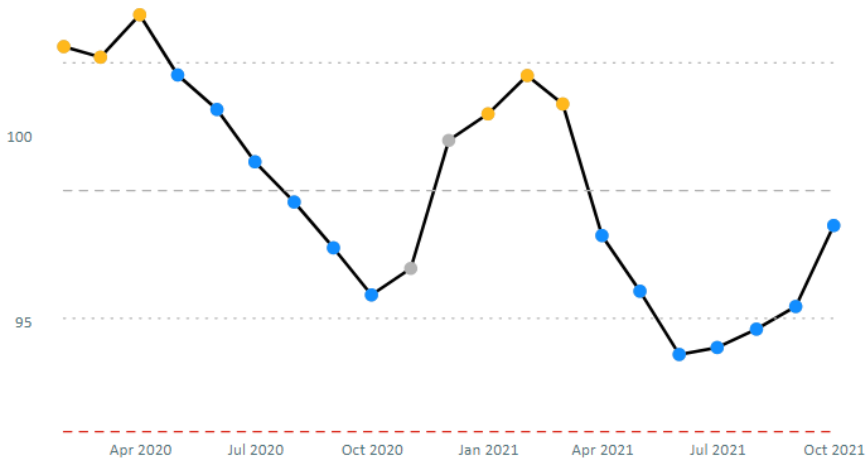
L

Special cause of improving nature or lower pressure due to lower values

Flag Description

Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The Trust HSMR has been improving since the end of the second Covid-19 wave in March 2021 falling below the lower control limit of the SPC chart since June 2021. Quarter two performance is showing an upward trend and currently lies within control limits.
The metric demonstrates a 12 month rolling position.

Intervention and Planned Impact

Interventions planned to drive our improvement are:

- Breakthrough Objective focussed on improving outcome for patients admitted to our hospitals with sepsis or respiratory failure as their admission diagnosis. This has reached its target and is detailed on slide 8. Due to the challenge of tracking this metric against specific interventions it is being reviewed for 2022/23.
- The fracture Neck of Femur pathway is being revised to improve outcomes for this group of patients and this is reported as a driver metric for Surgery and Anaesthetic Care group. We are analysing the impact of reducing our current HSMR for fractured neck of femur from 118 to 100 on the overarching metric to give us an reduction of 2 points on overarching HSMR.
- The Trust has commissioned a desktop review of our mortality review processes through the NHSIE Better Tomorrow team. This will allow us to recognise good current practice and implement recommendations so our Learning from Deaths programme delivers improvements in patient pathways that deliver improved outcomes. The expected impact will be quantified when the outcome of the review is received (due Feb 2022).
- A focussed review of patients with healthcare associated Covid-19 is being undertaken to identify any additional learning

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk as yet unquantified.

20/21 breakthrough objective

Sepsis & Respiratory Failure (Composite HSMR)

Sepsis and respiratory failure have consistently triggered as primary diagnostic categories making the greatest contribution to the Trust's HSMR over the last few years. We believe that understanding and acting on the drivers behind this performance will help us provide a safer service for our patients.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
134.2	128.7	122.2	114.7	112.8	112.8	110.7	111.3	112.4			

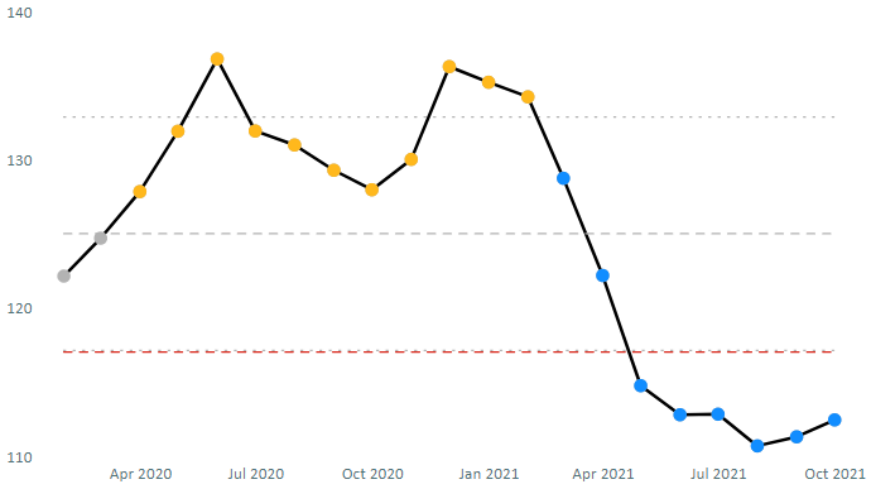
Variation indicates consistently falling short of the target

Special cause of improving nature or lower pressure due to lower values

Flag Description

Below Mean Run Group Astronomical Point Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

The Trust composite HSMR began to rise at the beginning of the global C-19 pandemic peaking around June '20. The rolling 12 month position dropped slightly following the first wave, peaking again following the second wave in early '21. Since then the rolling 12 month performance has consistently improved, achieving threshold in May '21. Performance has been sustained below threshold up to and including the most recent data point in October '21.

Intervention and Planned Impact

The improvement tool used to investigate this breakthrough objective has focused on 3 areas with a 4th being identified via a national mortality alert in November 2020; Recognition, escalation and response to the deteriorating patient, Advance care planning, Learning from deaths and harm & Excess mortality in hip fracture patients.

Interventions over the last 30 days;

- Clinicians engaged NHSE/I support (Better Tomorrow) with review of Trust process in Mortality and Learning from deaths; initial analysis completed; feedback awaited with recommendations.
- Clinical teams introduced to new advance care planning tool (ReSPECT) due to be implemented across Kent & Medway in April 2022; clinical working group assembled.

Interventions planned for the next 30 days

- Confirm the digital methodology to operationalise Sepsis compliance audit from Sunrise system
- Engage Care Groups in updates through Learning from Deaths roadshow
- Re-establish Seabathing ward as nominated hip fracture ward (compromised by the latest Omicron wave of pandemic)

Risks/Mitigations

There are currently no considered risks with this breakthrough objective.

Our quality and safety

Sarah Shingler

The True North target is to achieve zero avoidable harm within 5-10 years. Our calculation includes incidents with harm or those that have the potential to lead to harm and aggregates the following;

- Falls, Pressure Ulcers, C Difficile (in-hospital), E.Coli (in-hospital), Covid Infections (in-hospital), Nutrition Incidents, Medication Errors

The effects of patient safety incidents go beyond the impact of the physical injury itself. Patients and their families can feel let down by those they trusted, and the incident may also lead to further unnecessary pain and additional therapy, or operative procedures and additional time in hospital or under community care.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
482	471	381	431	453	490	436	445	442	459	497	643

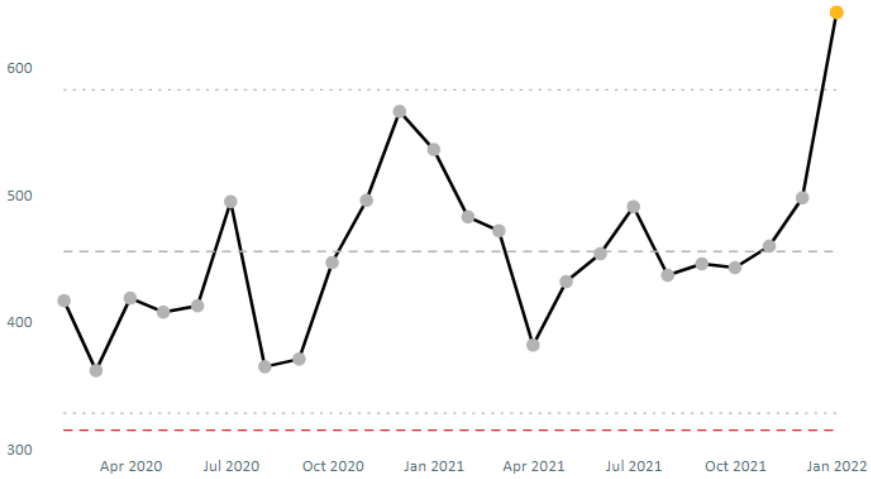
F — Variation indicates consistently falling short of the target

H — Special cause of concerning nature or higher pressure due to higher values

Flag Description

Astronomical Point

XMR Run Chart



What the chart tells us

The number of total harms has been fluctuating around the mean and within normal variation for the period since February 2020.

The most recent month's data point has breached the upper control limit on the SPC chart, this increase is driven by the number of C-19 HCAI infections in January '22.

Intervention and Planned Impact

Safe staffing is a major factor contributing to patient harms, we are now beginning to see a direct correlation between low staffing levels and harm. A business case has been approved and recruitment pipeline in place. We expect to see a demonstrable change in staffing levels from May '22 onwards, being fully established by December '22.

Terms of Reference and membership have recently been refreshed for the pressure ulcer and falls multi disciplinary team (MDT) steering groups, both chaired by the Site Director of Nursing. Oversight of progress is reported through the Fundamentals of Care Committee with exception reporting into Quality & Safety Committee (QSC).

An improvement plan is in place for nutrition, falls and pressure ulcer care.

Risks/Mitigations

- Fundamentals of Care training and We Care meetings recommencing.
- Temporary staffing strategies in place to support QEQM ED and AMUs and other wards where staffing is significantly compromised and where enhanced care is required.
- Ward leaders and Matrons out on the floor supporting ward teams, increasing oversight that risk assessment and falls/pressure strategies are being used.

20/21 breakthrough objective

Falls

Analysis shows that falls are currently the greatest contributor to harm events. Currently 45% of falls are reported as not resulting in harm and 54% of falls are reported as resulting in low harm. The assessment of falls is not currently standardised across the Trust.

Any fall can leave patients and their families feeling let down by those they trusted, with the potential need for further therapy, pain, operative procedures or additional time under community care or in hospital. All can impact long term outcome.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
131	112	102	104	132	140	132	146	146	134	148	165

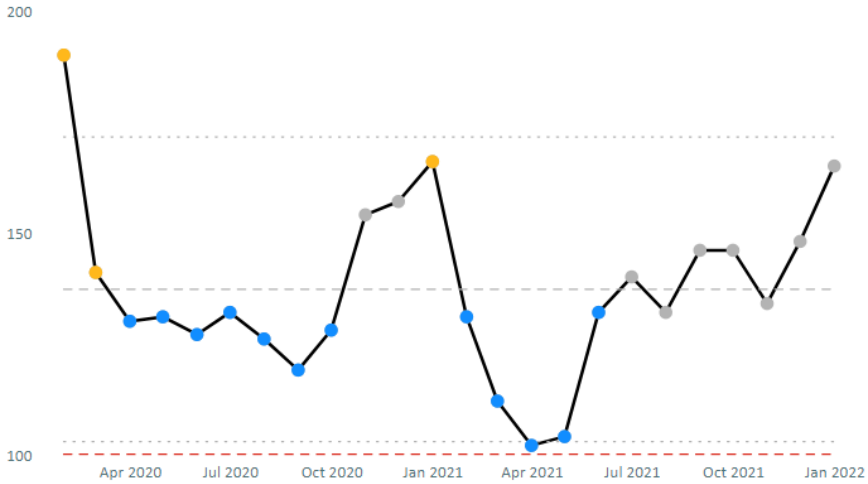
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The number of falls in January across the Trust was 165. The number had plateaued between June to Nov '21 during a period of intensive focus on harm reduction from falls, by wards/care groups and driver meetings. In Dec/ Jan operational pressures around hospital flow have increased, with additional escalation areas opened and attendance at the driver meetings reduced to allow that focus.

Harm reported in Jan 22: 2 severe, 59 low and 102 low harm events.

Areas of high numbers of falls include UEC areas and Harbledown; hyperacute stroke ward.

Intervention and Planned Impact

- The Dec/Jan driver meetings have been utilised to support the corporate Falls leads in bringing the 'Falls Yellow Kits' into use in the UEC care group. These have now been successfully procured and rolled out at WHH and QEQM. The pilot predicts the impact of the roll out will be greater identification and visibility of patients at high risk of falls, with a significant reduction in falls across UEC (up to 20 fewer falls per month) which continues into the ward admission.
- Harbledown ward currently have the highest numbers of falls across the Trust (10 falls). All of these were either no harm (8 falls) or low harm (2 falls), 8 were unwitnessed. As a hyperacute stroke ward, higher numbers of falls would be expected as a consequence of mobilisation during rehabilitation. The goal is to minimise harm from these through: falls focus at daily handovers, focus on lying/standing BPs, tag 1-1 handovers via yellow arm bands, refocus on falls training. Work is ongoing around enhanced observation training, with weekly (Monday) falls specialist nurse updates.

Risks/Mitigations

Harbledown Ward;

- Out of hours mobility assessments with reduced provision of walking aids. Mitigated by reviewing assess to Yellow Frames on the ward and their placement in the proximity of the nursing station/ bathroom.
- Issues around ward call bells: HoN is reviewing the current arrangements.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Harm Events	W4		Covid-19 HCAI	1	14	15	36	178
	W4		VTE Assessment Compliance	90.0%	89.2%	89.6%	90.0%	88.3%
	W4		Serious Incidents	18	24	35	24	21

Covid-19 HCAI

The Omicron variant surge presented new and complex challenges, with increased transmissibility compared with Delta (circa X3) and the original Covid-19 virus (circa X10). In common with other trusts locally and nationally there have been a number of outbreaks and clusters of HCAI cases. A second smaller surge in February will see lower but still significant numbers of HCAI cases. Conversely mortality and morbidity appear to be very much reduced in all cases; many cases are incidental findings in patients presenting for other reasons.

VTE Assessment Compliance

The stratified data showing underperformance being driven by number of spells across GSM specialties, general surgery and trauma and orthopaedics without VTE risk assessment. The relevant care group clinical directors are leading on focussed improvement work in their respective areas and are updating the impact via their quality governance reports.

Serious Incidents

The number of SI's remain consistent, with the main themes continuing to be delays in care, falls and pressure ulcers. This reporting period also included 4 Covid-19 outbreaks, and 2 historical maternity cases that are being re-opened.

Our patients

Our patients

Rebecca Carlton

Trust Access Standards: 18wk Referral to Treatment

The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the 'sustaining access' Strategic Initiative early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
61.0%	59.3%	59.7%	62.7%	64.3%	64.5%	63.6%	62.0%	61.4%	61.3%	59.8%	59.6%

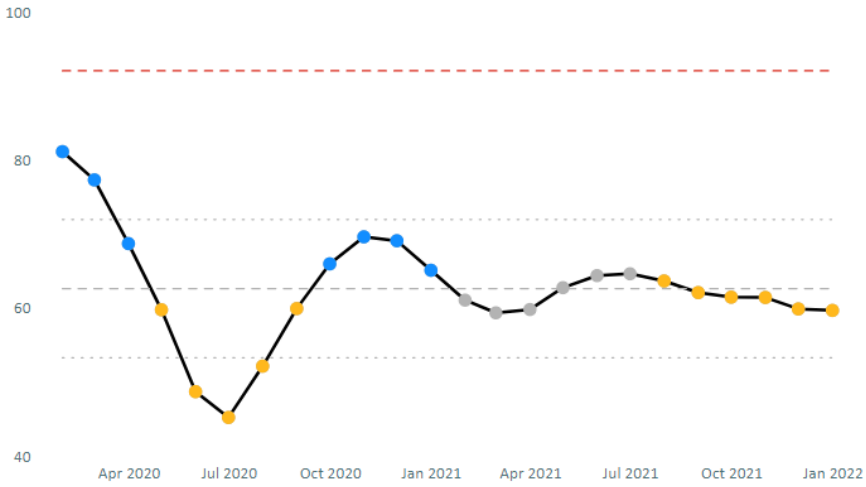
F — Variation indicates consistently falling short of the target

L — Special cause of concerning nature or higher pressure due to lower values

Flag Description

Descending Run Group

XMR Run Chart



What the chart tells us

Performance reduced rapidly at the beginning of the pandemic with the lowest performance occurring in July 2020. During the initial elective recovery phase in spring/summer 2020 performance improved, dipping to a lesser extent during waves two and three. Performance is demonstrating a special cause variation of a decreasing nature over the last 6 months with performance now below the mean for the period.

Intervention and Planned Impact

- Breakthrough Objective focussed on improving theatre utilisation and reducing opportunity i.e. "lost capacity" to ensure that we treat as many patients as possible and reduce waiting times. The current opportunity for January is 51 sessions.
- Continue to use the Independent Sector in both East and West Kent to treat long waiting patients.
- Following the planned cessation of routine elective work during C-19 wave three we will ensure that theatre capacity is aligned to specialties who have urgent, cancer and long waiting patients to facilitate treating long waiting patients internally.
- Align green bed capacity at the QEQM and WHH to ensure that we can treat long waiting, routine patients.
- Continue with clinical and administrative validation to ensure waiting lists continue to be prioritised in order of clinical need. Optimise the preoperative assessment pool from 19% to 25% of the elective waiting list.

Risks/Mitigations

- Varying case mix creates challenges in balancing the available bed allocation between emergency, Covid-19 and elective streams. Work is being undertaken with site teams to agree plans moving forward into our next recovery phase.
- Loss of theatre capacity at K&C due to essential theatre works which had been deferred during the pandemic is being managed using the Vanguard theatre at K&C and any available capacity at the acute sites to minimise disruption.

20/21 breakthrough objective

Theatre Session Opportunity

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.
It is imperative that elective surgery deferred during the global pandemic is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
87	38	26	17	23	39	51	48	39	38	53	51

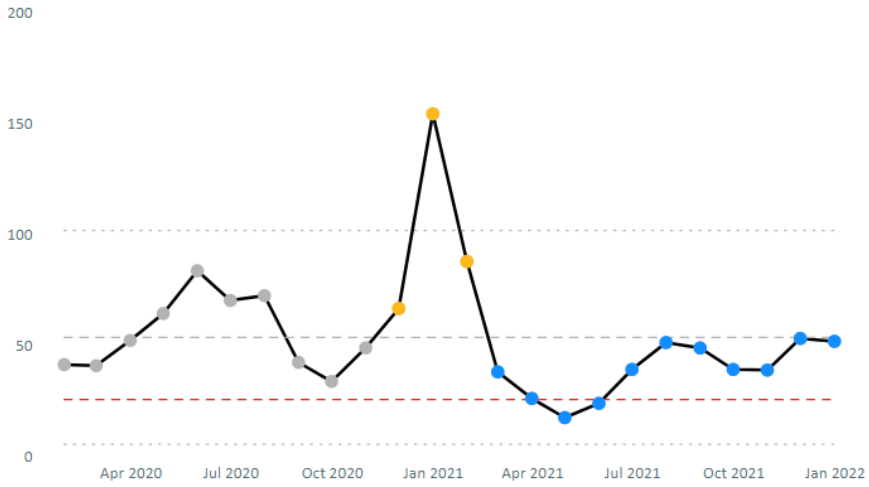
Variation indicates inconsistently passing and falling short of the target

Special cause of improving nature or lower pressure due to lower values

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

Current performance shows the equivalent of 51 sessions unused i.e. opportunity for January 2022. This has been compounded by the Covid surge and limited availability of green beds at the WHH and QEQM. Colorectal Surgery was relocated to K&C which led to the cancellation of orthopaedic sessions to accommodate the temporary move. Cancellations remain an area of focus.

Intervention and Planned Impact

- Ensuring our waiting lists are validated and patients are fit and ready for surgery therefore reducing the volume of clinical and non-clinical cancellations on the day
- Develop improvement trajectory to increase the pre operative pool which will improve opportunity to re-schedule patients at short notice
- Allocation of theatres aligned to treating cancer/urgent/longest waiting patients to reduce waiting times of our longest waiting patients (risk areas are ENT Otology, Paediatric ENT, Orthopaedics and General Surgery)
- Revise the 6-4-2 theatre scheduling process to improve 6 and 4 week scheduling enhancing the opportunity for other specialities to backfill under utilised lists in advance
- Care Groups to adopt a more flexible approach covering theatre sessions within their specialities to minimise dropped sessions due to availability of workforce

Risks/Mitigations

- Winter pressures remain a challenge impacting on availability of green beds.
- Short notice patient cancellations due to Covid-19 impacting ability to fully utilise theatre lists.
- Theatre staff recruitment remains a significant risk, this includes anaesthetic staffing – there is a national shortage due to increased demand.
- Increasing the pre operative pool of patients to mitigate short notice cancellations
- Any revision to the national IPC recommendations would increase the opportunity from short notice cancellations

Our patients

Rebecca Carlton

Trust Access Standards: ED Compliance

The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department where clinically appropriate.

Performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
80.2%	83.6%	83.6%	83.1%	79.2%	75.5%	75.7%	75.4%	73.8%	73.9%	73.5%	73.8%

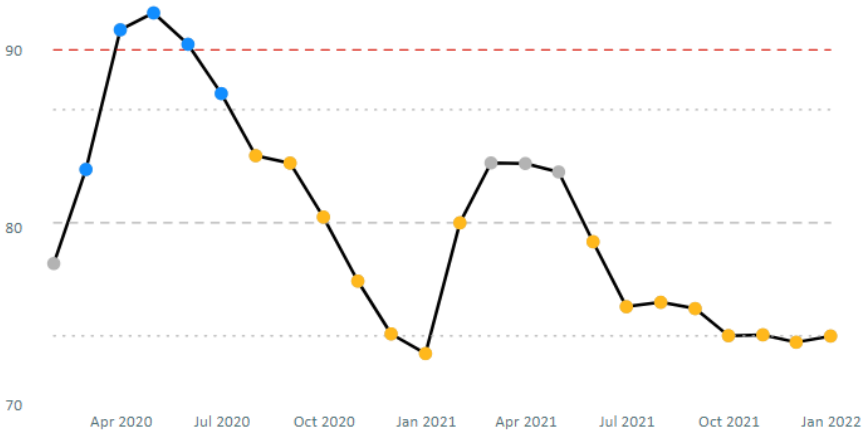
F — Variation indicates consistently falling short of the target

L — Special cause of concerning nature or higher pressure due to lower values

Flag Description

Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

ED performance has remained static at approx. 73.8% since Oct '21. Performance improved during Wave 1 of the pandemic due to the reduced number of attendances, it then slowly deteriorated throughout 2020 as demand increased. Performance improved in early 2021 until Wave 3 began and brought with it the increased IPC challenges of managing patient contacts, together with Covid-19 positive, non Covid-19 and 'Green' pathway elective patients.

Intervention and Planned Impact

- ED Improvement plan has been in place since Oct '21 and now includes an ED Restart programme to focus on achieving 80% performance against the 4 hour standard by the end of February 2022.
- ECIST support the review and increasing the number of patients streamed directly to Same Day Emergency Care (SDEC) pathways. Current performance is 18% and driving improvement to 30%.
- ECIST are also supporting the Trust to review and implement the principles of the Modern Board Round and Criteria to Reside, which will improve patient flow for emergency admissions.
- Reducing the length of stay on the Acute Medical Unit to < 48 hours.
- In February a 7 day working pilot was implemented at WHH and QEQMH for 3 weekends with the aim of achieving consistency for discharges and to assess the impact on length of stay.
- In February the WHH SDEC service was transferred to the Paula Carr Unit for a weekend to test whether there would be a positive impact on patient flow in ED by protecting space for speciality treatment services.

Risks/Mitigations

- Nursing vacancy, particularly at QEQMH – mitigated via senior nurses being rostered to direct clinical care.
- Increasing number of patients with a LOS of >21 days due to insufficient PW1 (domiciliary care) and PW3 (residential/nursing home care) awaiting supported discharge. – mitigation via whole system working to escalate issues and commission appropriate capacity.

20/21 breakthrough objective

ED Aggregated Patient Delay

Long waits across our Emergency Departments (ED) have been a challenge to the organisation for several years, extending length of stay in ED is often a consequence of reduced bed availability for specialist ward areas and admissions.

It is recognised that extended stays in ED can have an impact on patient outcomes. It is a priority for the organisation to reduce time between the decision to admit a patient in ED and the transfer of the patient to a ward environment. We are making this an area of clinical and operational focus to drive down the wait times, improve flow and the standard of care for our patients.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
460	385	311	353	475	644	664	647	797	873	875	897

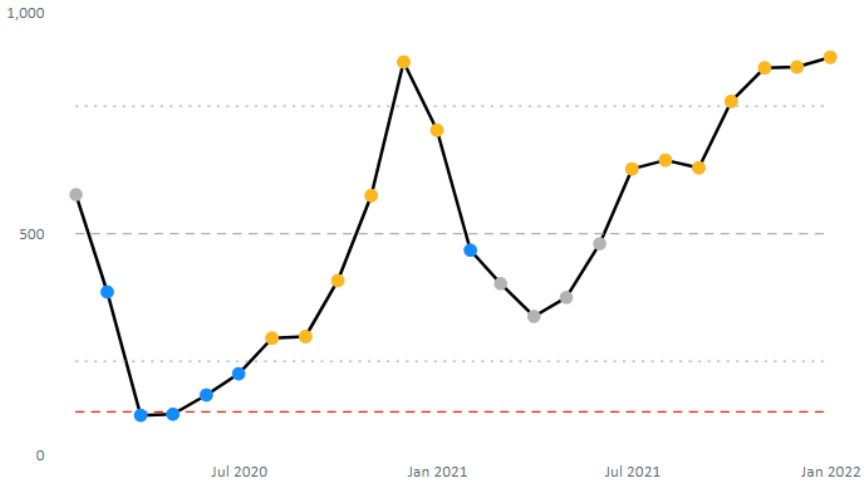
F — Variation indicates consistently falling short of the target

H — Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

At the beginning of the pandemic when attendances reduced, the aggregated patient delay for patients requiring a bed was low and achieved target. Since then as demand has returned to normal performance has deteriorated. Similarly to the 4hr performance the 3 Covid-19 waves have affected the delivery of this standard. This metric is heavily influenced by bed availability on main wards which has been a consistent challenge throughout the pandemic. Performance has recently breached the upper control limit for the period.

Intervention and Planned Impact

- To increase the number of patients discharged by midday each day to 30% of total discharges. Current performance is 14.1% at WHH and 15.5% at QEQMH.
- Senior ED management team have implemented a weekend and evening rota to improve patient flow and timely transfers to wards.
- Achieve a maximum 48 hour LOS on Acute Medical Unit (AMU) which will enable patients to be transferred from ED for assessment.
- Increase the number of patients streamed to SDEC pathways, including direct access for SECAMB.
- Implemented 08:30 speciality in-reach into the AMU to review patients with an agreed speciality condition and agree transfer to a speciality ward or discharge.
- Senior decision makers are rostered to work out of hours, particularly at weekends and to 22:00 when sites are in OPEL 4.
- Working with LHE to escalate >21 day delays for PW1 and PW3. Chief Operating Officer is involved in daily meetings to escalate operational delays and monthly meetings to engage with LHE re commissioning appropriate capacity for local population.

Risks/Mitigations

- Acute Physician vacancy impacts on ability to provide extended working day rota – posts are out to advert, including overseas recruitment.
- LOS on AMU will be >48 hours due to lack of timely bed capacity on wards – mitigation to implement 'Modern Ward Round' to maximise morning discharge and reduce LOS.

Our patients

Rebecca Carlton

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patient are seen, diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
79.1%	81.5%	86.7%	83.3%	82.2%	82.5%	80.7%	78.8%	79.3%	84.3%	78.7%	75.3%

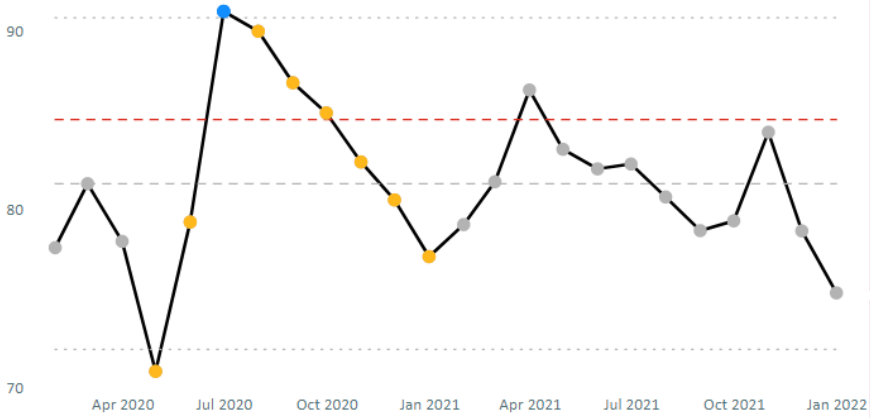
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Performance increased significantly following the prioritisation of Cancer pathways at the beginning of the pandemic achieving the standard for four consecutive months. With the exception of May 2020 all data points fall within control limits. Performance began to dip during the first recovery phase as demand into the Trust began to resume normal levels. The target has been met 5 times in the last 20 months and was narrowly missed, post validation, in November 21.

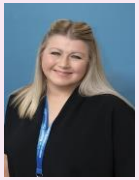
Intervention and Planned Impact

- Using the patient tracking list (PTL), review each pathway for every patient ensuring an optimal plan is in place to improve patient experience.
- All surgical patients escalated at point of known surgical intervention request. Processes to highlight all breach dates to the relevant teams to ensure patients are booked within breach. This will strengthen working relationships between the Cancer Care Groups and other Clinical Care Groups leading to an improvement in tumour site performance.
- Continue to work closely with lead CNS's to reduce waiting times for patients
- Restore face to face out-patient appointments where appropriate and continue reviews of current clinic capacity and support provision to ensure consistency on each site where appropriate

Risks/Mitigations

One of the biggest risks to delivery of the cancer standards is the availability of ring-fenced capacity for MRI and CT scans impacting the cancer pathway. This is being mitigated with support from the Clinical Support Services Care Group who are working up a plan to reduce diagnostic wait times.

Our patients



Sarah Shingler

Patient Experience (FFT)

The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall recommended score together, we have therefore added completion rates as watch metrics to our overall scorecard.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
93.8%	93.3%	91.7%	90.8%	90.5%	91.2%	91.8%	91.8%	91.4%	91.8%	92.7%	93.3%

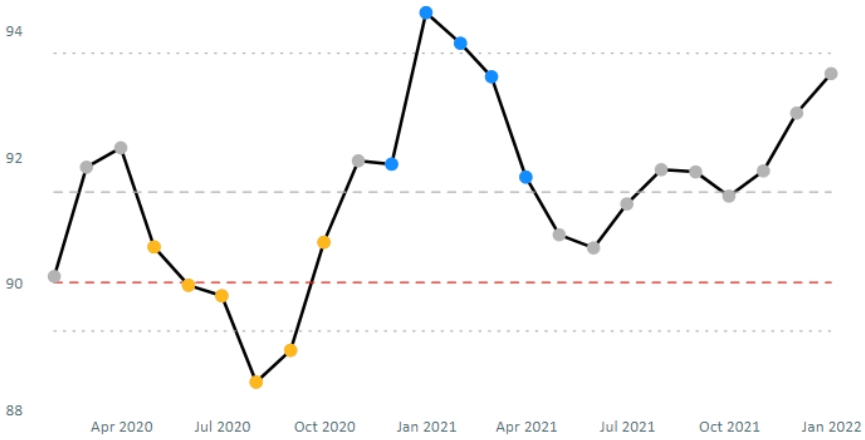
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The Trust has achieved the threshold target of 90% consistently since October '20 for patients who would recommend the Trust as a place for treatment. Performance peaked in Jan/Feb '21 outperforming the upper control limit for the period. Recent performance appears to be showing an upward trajectory but it is too early to say whether this will be statistically significant or natural variation.

Intervention and Planned Impact

The True North for Our Patients has been recently reviewed; moving forwards in addition to FFT the breakthrough objective will focus on ten questions from the in-patient experience survey. Alongside this the ward accreditation project commences roll out in April '21. All in-patient adult wards will complete 50 in-patient surveys per month, with ward leaders and matrons having responsibility and oversight for addressing concerns and driving improvements. This will link into the We Care improvement work.

The Patient Voice and Involvement Strategy has been approved. A business case to resource the Patient Voice team is currently going through approvals process.

Risks/Mitigations

If culture and behaviours do not change there is a risk that patient experience does not improve or deteriorates further, impacting on patients, increasing the risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Cancer 62d	W4		Cancer 28d Performance	75.0%	72.2%	69.8%	66.6%	62.3%
	W4		Radiology Diags vs Plan	Traj.	16,432	16,239	14,957	15,774
RTT - 18 Weeks	W4		DM01 Compliance	75.0%	74.2%	73.3%	65.7%	62.3%
	W4		RTT 35w Undated	8,500	9,434	8,894	9,315	9,826
	W4		RTT 1st OPA Booking Breaches	14,000	17,779	17,976	19,440	19,193
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	34.7%	38.6%	39.0%	38.4%
	W4		Time in Dept over 12 hrs	6.0%	8.3%	9.5%	9.5%	9.2%
	W4		Super Stranded >21D	75	127	139	151	186
	W4		Discharges by Midday	15.0%	11.4%	10.7%	12.4%	13.2%
	W4		NEL Admissions vs Plan	Traj.	6,533	6,548	6,264	6,475
FFT	W4		FFT DC Response Rate	27.0%	24.9%	25.9%	26.3%	20.4%
	W4		FFT ED Response Rate	12.0%	12.5%	12.6%	12.7%	10.0%
	W4		FFT Maternity Response Rate	18.0%	4.2%	4.3%	3.9%	2.6%
	W4		Complaint Response	90.0%	34.6%	23.9%	28.1%	21.9%

Cancer

28And 62 day performance has deteriorated in month due to delays in diagnostics, particularly radiology. Actions include Medical Director engagement with Radiology leads to identify ring fenced capacity to reduce waiting times. This will positively impact on 28 and 62 day compliance.

RTT 18 Weeks

The number of 35wk patients undated has increased due to the planned reduction in operating capacity in January to mitigate Wave 3 of Covid-19. Elective surgery will restart in February which will improve performance.

ED Compliance

Clinical Assessment within 1hr is an improving metric. This is a driver for the UEC Care Group in order to improve patient experience and ensure compliance with the 12 hour total time in ED metric.

Super stranded patients are being actively managed via regular calls with the local health economy however, of note, the winter plan modelling was based on a maximum number of 130 long stay patients. This is an external capacity issue in the main.

FFT

Maternity; The appropriate touch point times when the FFT questions will be asked during pregnancy have been agreed and the numerator and denominator has been adjusted to reflect the agreement. This was put in place mid February therefore improvement is expected in next round of reporting.

EDs: both EDs were extremely challenged throughout December and January, with overcrowding and long waits. FFT data triangulates with PALS concerns and formal complaints received during this period.

Our people


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our people

Andrea Ashman

Staff Turnover (rate)

The annual turnover rate provides us with a high-level overview of Trust health. Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Our Aim is to achieve and maintain a 10% staff turnover rate.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
9.5%	9.3%	9.6%	10.1%	10.5%	10.8%	10.9%	11.2%	11.6%	12.0%	12.2%	12.3%

F

Variation indicates consistently falling short of the target

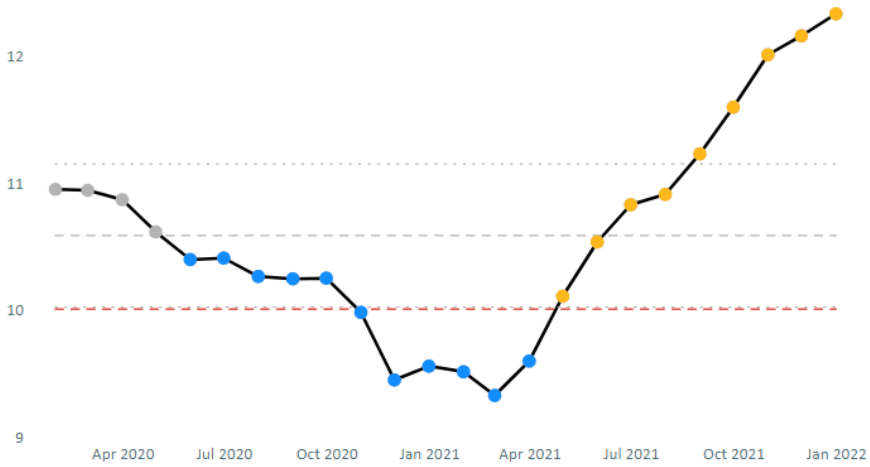
H

Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group
Astronomical Point
Ascending Run Group
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

The overall staff turnover rate is displayed as a rolling average percentage over the last 12 months. The figure demonstrates voluntary turnover so does not include doctors in training, fixed term contract completion, employee transfers or dismissal. Total turnover has risen for a tenth month in succession and remains above the True North target (10%) at 12.3% (Jan '22). In context, the Trust has recruited 1,264 new staff and lost 803 this financial year, an increase of 460 staff in 10 months. Premature recruitment turnover has risen slightly which correlates with an increase in recruitment.

Interventions and Planned Impact

Five top turnover areas have been identified: Theatres, KCH, Critical Care, WHH, Pharmacy Clinical Services, Pharmacy Operational Services. Targeted interventions are in place to support each area including extensive wellbeing support in theatres and critical care. Care group leads and HR Business Partners are working to understand the challenges in Pharmacy Clinical and Operational Services. Staff nurses are a continual focus with emphasis on the general wellbeing of our nursing workforce.

Premature turnover remains below the gold standard which is positive, but is benefitting from the development of a new starter platform introduction of onboarding champion roles and system wide onboarding communications. An online exit survey has been launched (fully automated upon generation of notification of resignation) and stay conversations introduced to support staff through their lever process with the aim of encouraging withdrawal of the resignation in some situations.

Risks/Mitigations

The drive for increased recruitment will address staffing shortfalls however there is a strong correlations between high volume recruitment and turnover. Especially premature turnover. Additional resources are proposed to support the onboarding process and have been factored into the nursing and recruitment business cases recently approved by the board.

Our people

Andrea
Ashman

Staff Engagement (score)

Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention. The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

Our aim is to improve our staff engagement score as demonstrated in the annual staff survey.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
6.9	6.9	6.6	6.6	6.6	6.3	6.3	6.3	6.4	6.4	6.4	

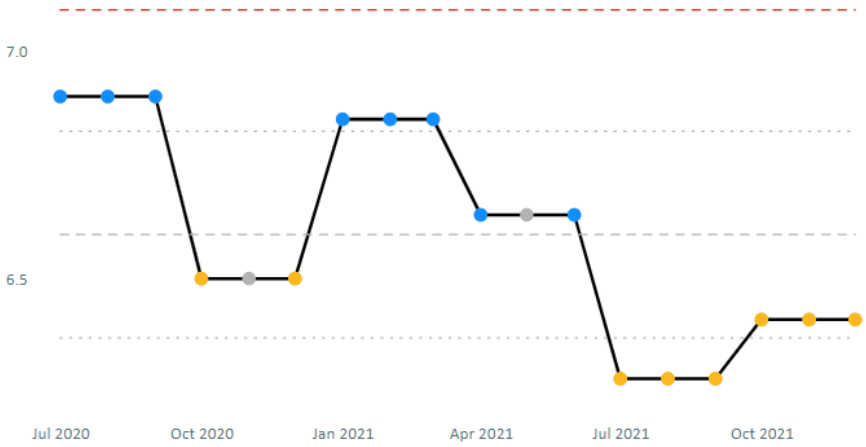
F — Variation indicates consistently falling short of the target

L — Special cause of concerning nature or higher pressure due to lower values

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Since July 2020 the data has broadly been following a downward trend with quarter two 21/22 data falling below the lower control limit of the SPC chart.

The most recent data returns just within control limits but remains well below mean performance and is consistently missing the desired threshold.

Interventions and Planned Impact

Work is underway to develop a dashboard to display the National Staff Survey results in a more discoverable and accessible way. This will, using the latest data and information, help drive concerted and consistent action at-pace providing greater confidence that the organisation is able to both identify areas of best-practice and to act in a timely manner on concerns raised. Once complete, this will be shared with the People and Culture committee.

Since the Staff Engagement results were made available, work has taken place to identify the areas of best practice and high challenge. The top and bottom ten performing areas have been established and the key domain driving this result identified. A programme of work is being proposed including the **establishment of 'Involvement' as a breakthrough objective under Staff Engagement.**

Work is also underway with our Chief Medical Officer as we begin to commission a 5-year plan around Medical Engagement, specifically aligned with the Medical Engagement Scale. Initial conversations have taken place and local questions are being developed based on respective need for local intelligence. A provider recommended by NHSE/I is being considered and timescales for implementation, to drive a 5 year plan of sustained improvement.

Risks/Mitigations

The National Quarterly Pulse Survey data for Q4 is expected this month. True North for engagement to be supported by breakthrough objective on Involvement.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Staff Turnover Rate			Staff Turnover: HCA	13.5%	12.9%	13.6%	13.5%	14.3%
	W4		Staff Turnover: Nursing	10.0%	11.7%	12.0%	11.7%	11.7%

Staff Turnover

Total turnover measured in-month (12.76%) has **risen for the first time since September 2021** despite following a promising downward trend for three consecutive months. This appears to be driven primarily by premature and nurse turnover.

The inflection in turnover this month **correlates very strongly with an almost trebling in recruitment** from 78 joiners in December to 194 joiners in January

Nurse turnover remains **above the alerting threshold** (10%) and although there have been promising signs of improvement throughout the last 5 months, this has risen in January following the turnover of almost 20 nurses.

There is recognition that Staff Nurses continue to represent our primary leaver group (154 leavers this year)

Healthcare Assistant turnover remains stable at just under 15%. Substantial growth has been seen nationally as colleagues were able to seek alternative employment, but this continues to be blunted locally by continued support activity in the form of the 'Ready to Care' programme.

Our sustainability

Our sustainability

Phil Cave

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the last 3 years at the Trust, in the current year a breakeven position was delivered. This metric will measure us against our long term aim to maintain a breakeven position. The impact of Covid-19 has paused the NHS business planning process nationally and has limited the ability of the Trust to hit its cost efficiency targets.

Our aim is to achieve and sustain a break even financial position.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
0.588	-0.007	-0.548	-0.438	0.030	0.024	0.042	0.021	-1.494	-0.996	-0.941	-0.090

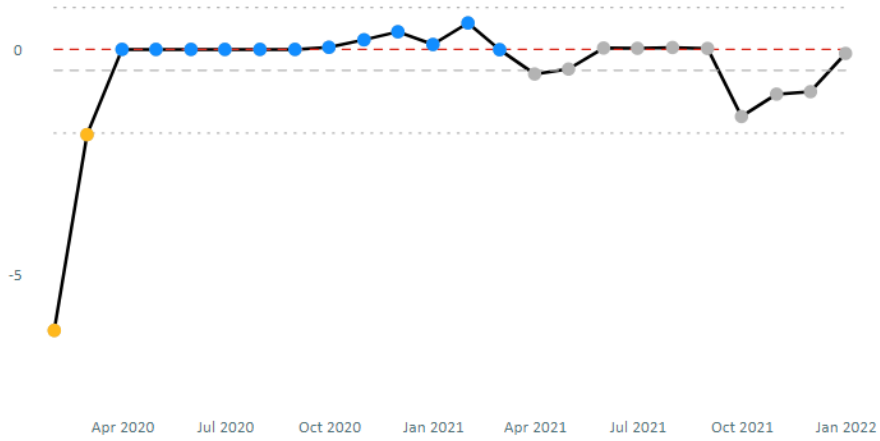
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Since April 2020 the Trust's I&E margin has been broadly achieving a breakeven position. The data for the second half of the 2021/22 financial year (H2) has fallen below the mean but remains within common cause variation. As long as the threshold remains within common cause variation the Trust cannot be sure of consistently hitting the target.

Interventions and Planned Impact

The deficit position in Q3 2021/22 is driven by the unplanned Omicron variant meaning additional costs incurred for treating patients with Covid-19 combined with treating less elective patients than planned therefore receiving less variable Elective Recovery Fund (ERF) income.

The Trust is working with the regional Kent & Medway system partners and NHSEI to ensure we are appropriately reimbursed for unavoidable costs and additional funding has been agreed for the increase in patients seen through the emergency department.

The impact of this is that the Trust is forecasting to deliver a breakeven for the second half of the 2021/22 financial year which would mean a breakeven position for the full 2021/22 financial year consistent with the plan and threshold.

Risks/Mitigations

The main risks relate to continued additional costs due to treating patients with Covid-19 and reduced capacity to treat elective patients.

The mitigating actions are to continue to work with system partners to ensure appropriate reimbursement of costs and continue to reduce discretionary costs where appropriate to appropriately reflect the volume of patients we are treating.

Our sustainability

Liz Shutler

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North.

The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water and steam usage. It is these areas we will be focussing on improving over the coming five to ten years, although as metrics are developed we will add in other scope one, two and three measures such as travel, freight transport and food and catering.

Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
63.95	57.34	54.35	47.80	38.27	36.74	39.60	39.77	43.52	60.90	60.34	

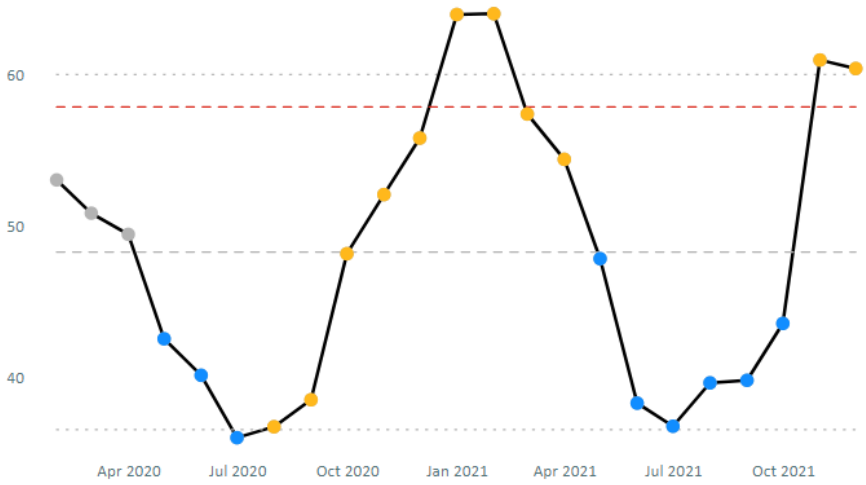
Variation indicates inconsistently passing and falling short of the target

Special cause of concerning nature or higher pressure due to higher values

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's Carbon Footprint as demonstrated in the chart. In the main, the position remains below the threshold with the exception of the winter months.

The November position is above the threshold of 60 and is above the same period last year.

Interventions and Planned Impact

The Trust is working with Breathe Energy to recommend opportunities for a continuing programme of carbon reduction and to bid, on the Trust's behalf, for central monies to enable long term carbon reduction as part of the Public Sector Decarbonisation Scheme. Schemes are currently being developed and analysed to determine the carbon reduction savings.

In addition to electricity, gas, waste and steam, work is ongoing to include additional data and measures aligned to NHSE/I's report "Delivering a Net Zero NHS". Those currently being explored include: Anaesthetics Usage; Medicines Waste; NHS Fleet and leased vehicles; and Staff Travel.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions.

Risks/Mitigations

- Appropriate funding to trigger significant change is not available.
- Potentially lack of behaviour change and culture in the organisation to promote net zero carbon target.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Financial Position	W4		Total Pay	0.0%	-1.9%	-1.5%	-1.2%	-1.2%
Carbon Footprint			CO2e Gas (tonnes/day)	38.19	21.68	33.96	36.48	

Total Pay

The pay position is adverse to plan due to higher than planned usage of temporary staffing primarily to backfill staff who were either sick or isolating due to Covid-19 Omicron variant. It is proposed that the pay metric is not promoted to a driver metric at this time as the financial plan and pay expenditure budget will be reset in April due to the start of the new financial year. Additionally, the Trust Board has approved a breakthrough objective in 2022/23 of agency expenditure which will monitor this position.

Carbon Footprint

Gas tonnage per day is alerting due to the latest data points breaching the upper control limits of the SPC chart. This is due to the seasonality of the metric and high usage during the winter months, we would envisage a reduction as we head into spring and therefore do not at this time consider that this metric should be promoted to a driver metric.

Our future


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our future

Rebecca Carlton

Not fit to reside (pats/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. As such this allows us to easily identify the ongoing support and care patients need to facilitate discharge.

Patients are delayed in hospital awaiting a supported discharge which may be Domiciliary care such as a Care Package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works closely with local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
166.1	206.5	220.2	223.2	297.1	309.9	299.6	303.0	299.5	332.0	346.2	314.3

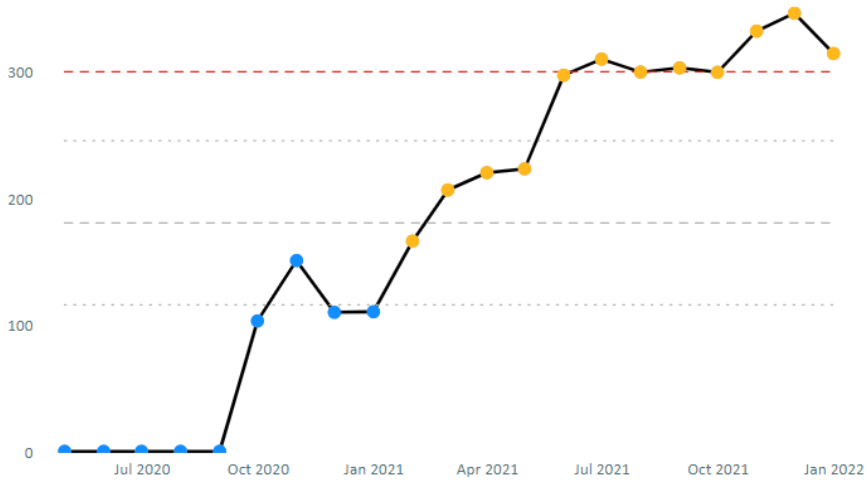
P — Variation indicates consistently passing the target

H — Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The number of patients who no longer meet the criteria to reside (C2R) in hospital is increasing however this chart also reflects improved data capture since the inception of C2R. In June '21 the levels stabilised at approx. 300 patients. A more recent increase to 346 occurred during the Covid-19 third wave due to insufficient capacity available outside of secondary care.

Intervention and Planned Impact

- Working very closely with the local health economy (LHE), meeting 3 times p/w, inclusive of KCHFT, KCC, CCG, Hospice and Mental Health Trust colleagues ensure appropriate capacity is available externally to meet the discharge needs of our local population.
- LHE multi agency discharge events (MADE) to review all patients with a length of stay (LOS) over 7 days (>7d) with a view to identifying alternative pathways to support safe discharge.
- Weekly MDT meeting with a Consultant lead, Matrons, Ward Managers, Senior Therapist and members of the Discharge Team to review all patients with a LOS >7d to confirm patients pathway is optimal and reduce risk of internal and external delays.
- Daily board rounds include documentation of the C2R category, reported daily within Trust &LHE.
- ECIST have reviewed our processes on Board Rounds in January and will be working with the Trust in February to train clinical champions who will lead the embedding of 'Modern Ward Round' document. Cascade training to each ward will follow.

Risks/Mitigations

- Insufficient external capacity, particularly in PW1 and PW3 to meet patients needs; Mitigation is to work through the LHE to highlight capacity to be commissioned.
- Patients and their families refuse to be discharged into an alternative discharge pathway; Mitigation is to provide every patient with a letter from the CMO and CNO confirming discharge arrangements.

Our future

Liz Shutler

Innovation (Virtual OP Apps)

The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process. Outpatients are working towards the targets set by our commissioners of at least 25% of all patient appointments and 60% of all follow ups to be conducted virtually, where clinically appropriate, and to that end we have developed an enhanced engagement plan to encourage the shift from face to face to virtual mediums such as phone and telemedicine.

Our aim is to increase the use of technology and innovation in the delivery of high quality care for the EK population.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
64.0%	58.4%	52.7%	50.0%	47.9%	45.7%	43.8%	43.5%	41.9%	40.2%	39.4%	39.4%

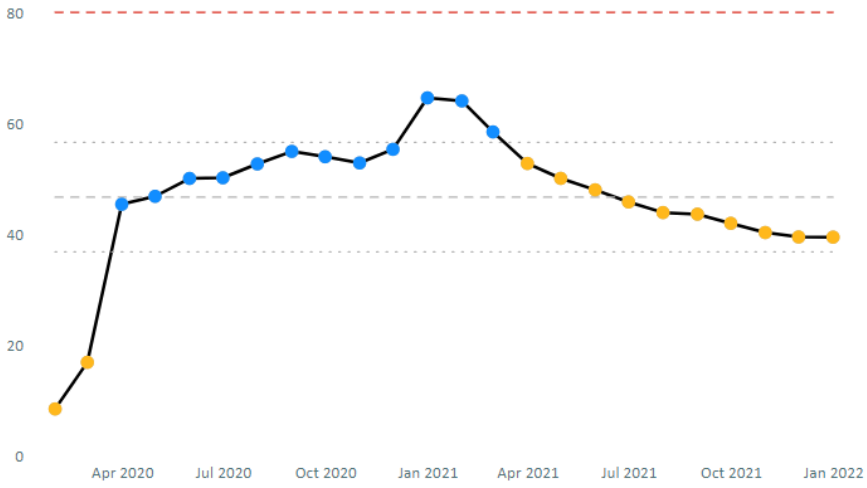
Variation indicates consistently falling short of the target

Special cause of concerning nature or higher pressure due to lower values

Flag Description

Below Mean Run Group
Descending Run Group
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

Performance has remained static with a very slight downward trend within a few percentage points over the last six months. Performance for January 2022 is at 39.4% which is below our current threshold of 80%.

Nationally the target is for 25% of all outpatients to be via telemedicine and our current position shows we achieve this, with first appointments at 33.5% and follow-up appointments at 41.8%

Intervention and Planned Impact

The Outpatient Transformation Steering Group has reviewed the national benchmarking data and recommended that the Trust needs to review the ambitious threshold of 80%. The Trust is currently 23rd in the rankings for delivery within the benchmarked data. Following discussion and review of individual specialty data, it was felt reasonable to aspire to move into the top 10 providers by setting a new threshold of 50%.

HCC E-clinic will roll out at the end of February with full completion by end of March 2022.
Updated Telemedicine SOP has been completed and is in the ratification stages
Further engagement with specialties to improve telemedicine usage will commence in March 2022 following the deployment of E-Clinic

Care Groups are liaising with other providers to identify best practice opportunities

Risks/Mitigations

- Lack of clinical /operational buy in.
- More patients are being brought back to face-to-face appointments.
- There are IG concerns about how long the patient data is held which may affect the E-clinic launch in Feb/March.

To mitigate the above, an enhanced engagement plan and focused project work, champions and advocates for virtual consultations are being put in place.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Innovation			Virtual OP Appts - First	25.0%	33.2%	32.0%	31.0%	33.5%
			Virtual OP Appts - Follow Up	25.0%	45.6%	43.8%	43.0%	41.8%

Virtual Appointments

Both virtual outpatient metrics are alerting due to the latest data points breaching the lower control limits of the SPC charts. Following the high performance in the percentage of virtual outpatient appointments carried out during the pandemic levels are now beginning to stabilise to what we feel is a clinically appropriate level. The percentage achievement remains above the national threshold of 25% and the Trust continues to be the highest performer in the Kent & Medway region. At this point we do not feel it is appropriate to drive any further improvement in this metric.

Appendix 1
Non-Alerting Watch Metrics

NHS
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True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Medication Errors; All	110	169	187	179	175
	W		Medication Errors; Severity C+	1	1	2	0	2
	W		Nutrition Incidents	60	54	61	68	66
	W		Pressure Ulcers: Cat 2	32	32	37	33	32
	W		Pressure Ulcers: Cat 3 & 4	3	2	0	0	1
	W		Pressure Ulcers: DTI	10	7	6	6	8
	W		Pressure Ulcers: Unstageable	10	7	5	9	7
	W		IPC: Audits Composite	80.0%	88.0%	87.5%	87.4%	87.6%
	W		Safeguarding Incidents	20	14	17	12	30
	W		IP Spells with 3+ Ward Moves	500	516	505	474	497
	W		Clinical Incidents	2,500	2,058	2,202	1,962	2,113
	W		Never Events	0	0	0	0	0
Mortality	W		Extended Perinatal Mortality	6.32	7.08	5.47	5.47	4.63

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Staff Turnover Rate	W		Vacancy Rate	9.0%	8.8%	9.3%	9.9%	9.3%
	W		Premature Turnover Rate	25.0%	19.6%	19.3%	19.3%	19.9%
Staff Engagement	W		Sickness	5.0%	4.8%	4.8%	5.4%	
	W		Appraisals Compliance	73.0%	76.6%	78.1%	76.9%	77.1%
	W		Statutory Training	91.0%	90.1%	90.3%	91.6%	91.9%
	W		Safeguarding Children Training	85.0%	90.6%	90.6%	91.2%	91.3%
Financial Position	W		Premium Pay	Traj.	6,783	7,255	6,441	7,168
	W		Non Pay	0.0%	0.8%	0.1%	-0.2%	-0.2%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.22	0.21	0.22	
	W		CO2e Electricity (tonnes/day)	18.00	13.04	15.42	13.38	
	W		CO2e Water (tonnes/day)	0.55	0.20	0.23	0.13	
	W		CO2e Steam (tonnes/day)	9.21	8.38	11.08	10.12	

True North Domain	Type	BO	KPI	Thres.	Oct-21	Nov-21	Dec-21	Jan-22
Cancer 62d	W		Cancer 2ww Performance	93.0%	98.2%	98.0%	97.7%	96.6%
	W		Cancer 31d Performance	96.0%	98.6%	97.9%	97.7%	97.3%
	W		Endoscopy vs Plan	Traj.	1,401	1,367	1,044	1,262
RTT - 18 Weeks	W		RTT 52w Breaches	Traj.	4,863	4,695	4,475	4,327
	W		OPA vs Plan	Traj.	57,589	63,756	53,807	52,330
	W		Elective Admissions vs Plan	Traj.	5,957	6,183	5,272	5,105
ED Compliance	W		A&E Atts vs Plan	Traj.	22,964	21,408	19,760	19,748
	W		Unplanned Re-attendance ED	10.0%	9.7%	9.0%	10.3%	10.9%
	W		NEL Readmissions	15.0%	10.6%	10.0%	11.2%	11.5%
	W		Stroke Ward within 4 Hours	50.0%	50.0%	60.9%	74.3%	58.7%
FFT	W		FFT IP Response Rate	15.0%	16.3%	16.8%	16.9%	12.1%
	W		FFT OP Response Rate	17.0%	16.9%	15.8%	17.7%	13.2%
	W		Complaints	100	93	105	60	70
	W		PALS Enquiries	550	607	619	527	677
	W		Mixed Sex Breaches	500	272	289	69	129

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	May 2022	• Delay due to growth in scope of project to cover the accommodation strategy, office space and medical education.	• A3 to be reviewed along with delivery plan
Job Planning (Trust wide)	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	April 2022	• Asked for data to be run at specialty level with names • Plan to do info graphics to drs every month to get positive friendly competition going • JP policy will be presented at next meeting end of Oct. Also looking at JP of 10 or less PAs	• CThe job planning policy was deferred to February 2022 LNC meeting. LNC Chair was not in agreement and wanted to receive views from doctors before going ahead with approval. • Develop 1st draft of infographics.
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	May 2022	• Dec & Jan meetings cancelled • Lack of medical engagement has been highlighted and could inhibit progression of project. • VP organising meetings with Clinicians	• Frontline attendance at Driver meetings remains variable. • Will Willson to collate data relating to EDN completion to support Consultant engagement.
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022	• Post recruited to but candidate withdrew • Clinical Guidelines draft policy completed and in circulation for comments. • No decision made on either upgrade of micro-guide or to look at another software solution	• Re-attempt to recruit or provide cover from NHSP • Clinical Guidelines Policy to be finalised • Decision required with regards IT solution.
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	TBC Scoping as new project	• Collect and collate the data for analysis and discussion	• Collect and collate the data for analysis and discussion

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	April 2022	• Share vision statement at an away day booked for 15th Nov • Alison D has revised the monthly exception report to show trends by CG to be presented at Nov meeting • Reporting schedule now in place 1st CGs to participate C&YP and Women's health. For Nov will be UEC & GSM	• Clinical Audit team to clarify any remaining areas for improvement against the problem statement. • Commence drafting a TPIP Closure Request as relevant
Safeguarding	Sarah Shingler	Assessment of Mental Health risk to determine the level of support required carried out for 100% of patients	Dec 2021	• Communicate changes to Enhanced Observation tools and audits • Communicate roles and responsibilities around safeguarding • Produce first dashboard report on Information Portal • Focussed work at QEQM to reduce KASAFs	• Safeguarding team to draft a TPIP Closure Request, to enable the progress to continue as Business as Usual

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to: (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 3: Glossary of Terms

NHS
East Kent Hospitals University NHS Foundation Trust

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.