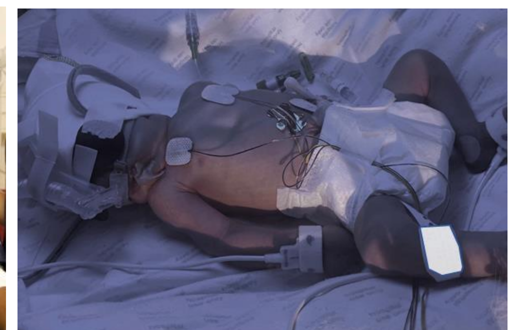
East Kent Hospitals University NHS Foundation Trust

Integrated Performance Report

February 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)?

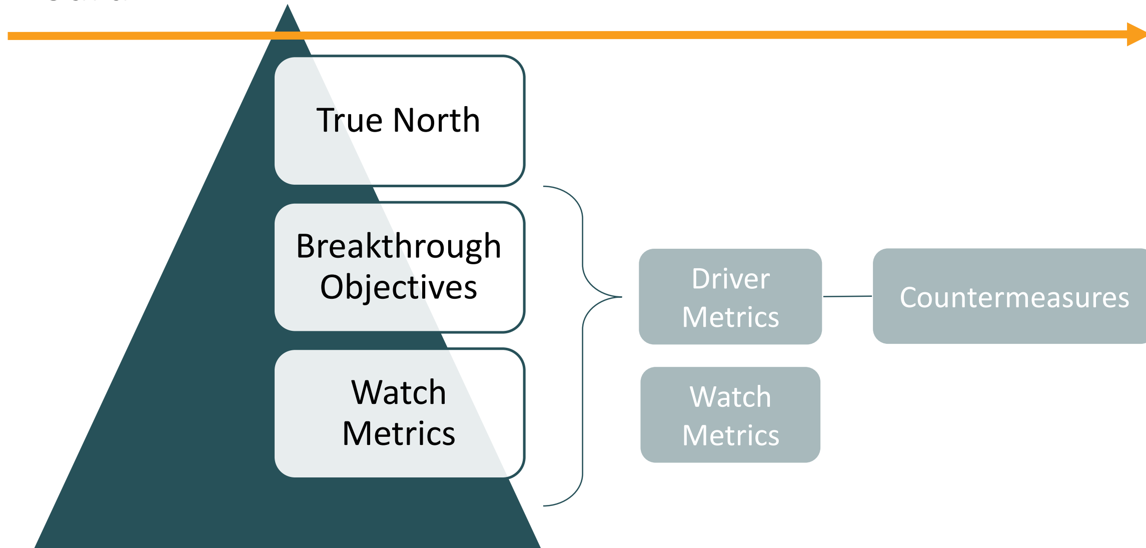
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- 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.



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.

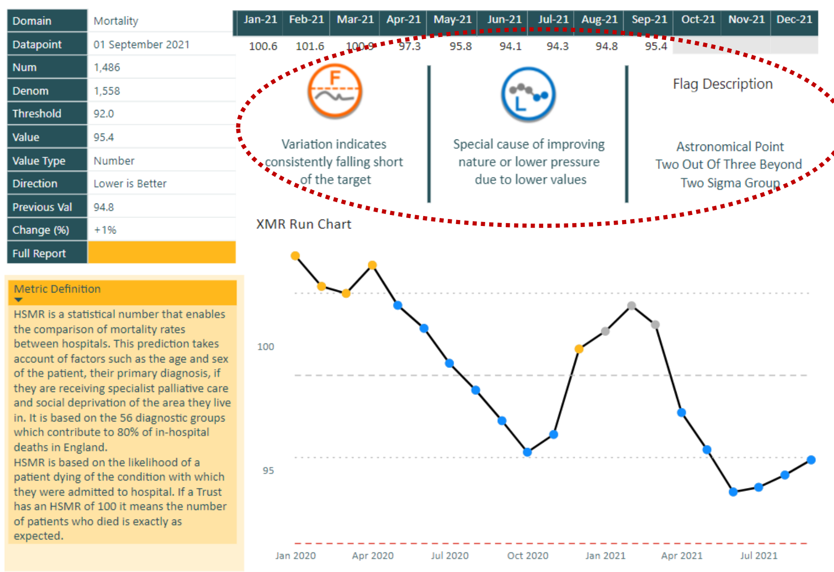
If data point falls outside these levels, an investigation would be triggered.

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?

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)

NHS
East Kent
Hospitals University
NHS Foundation Trust

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
104.3	100.6	98.8	97.8	97.0	97.8	98.8	100.2	97.5			

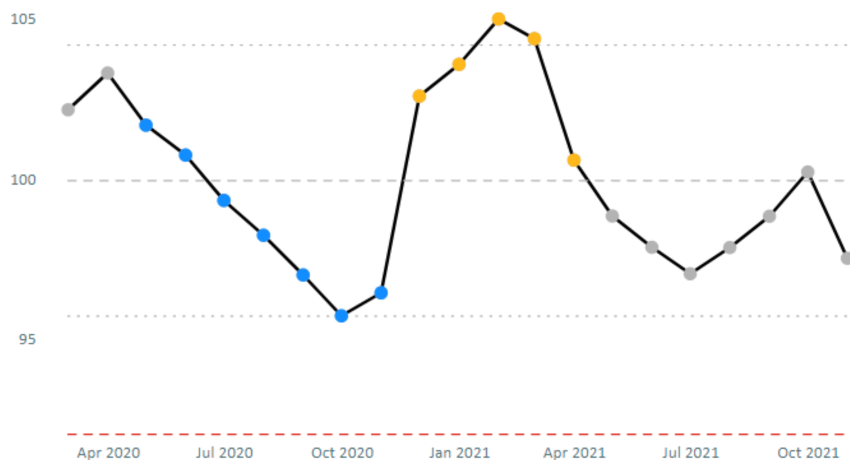
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The Trust HSMR has been improving since the end of the second Covid-19 wave in March 2021 and now sitting above the lower control limit shows common cause variation. The metric demonstrates a 12 month rolling position to November 2021 which is the last data release.
There have been no new mortality alerts since last report.

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 of and is detailed on slide 8. Following review of improvement priorities for 2022/23 the breakthrough objective will be closed and activity monitored through monthly Mortality Steering and Surveillance Group.
- 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 analysed of 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. A TPIP will be launched for 2022/23 to support driving this at WHH and QEQM sites
- The Trust has commissioned a desktop review of our mortality review processes through the NHSIE Better Tomorrow team. Feedback has been received and recommendations reviewed.
- A focussed review of patients with healthcare associated Covid-19 is being undertaken to identify any additional learning and will be presented to Q&SC in May 2022.

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk although the baseline appears to have settled which is sustained will give a clearer impact of improvement activity.

NHS East Kent Hospitals University NHS Foundation Trust

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
130.9	125.2	116.3	109.8	105.9	100.9	100.2	100.7	94.2			

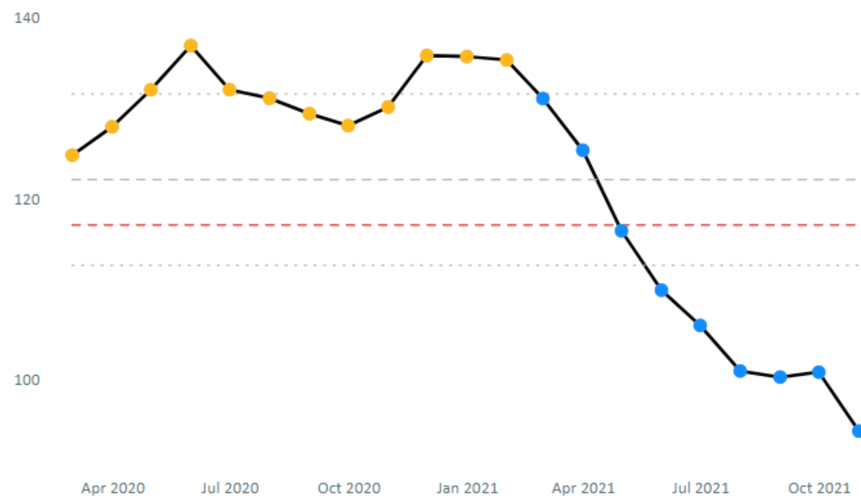
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group
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 this 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 November '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;

- Seabathing ward is now re-established as hip fracture ward at QE
- Sepsis treatment bundle has been widely shared with clinical teams. The digital enablement plan is on track for reporting in April '21

Interventions planned for the next 30 days

- This breakthrough objective and driver meeting needs to be handed over to a business-as-usual process. Options have been discussed and a preferred option identified. Handover is in progress.

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
477	381	431	453	510	456	445	444	461	512	668	603

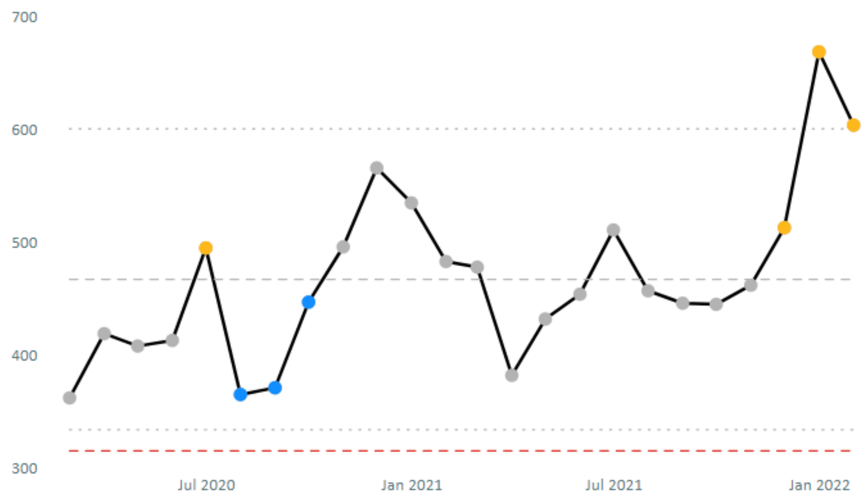
Variation indicates consistently falling short of the target

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

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 is now just meeting the upper control limit on the SPC chart, this increase is driven by the number of C-19 HCAI infections in February '22.
We have seen a reduction in falls and pressure ulcers (category 2,3,4) through February 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 June '22 onwards, being fully established by January '23.

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 recommenced Feb 22
- 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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
112	102	104	132	140	132	146	146	134	151	164	147

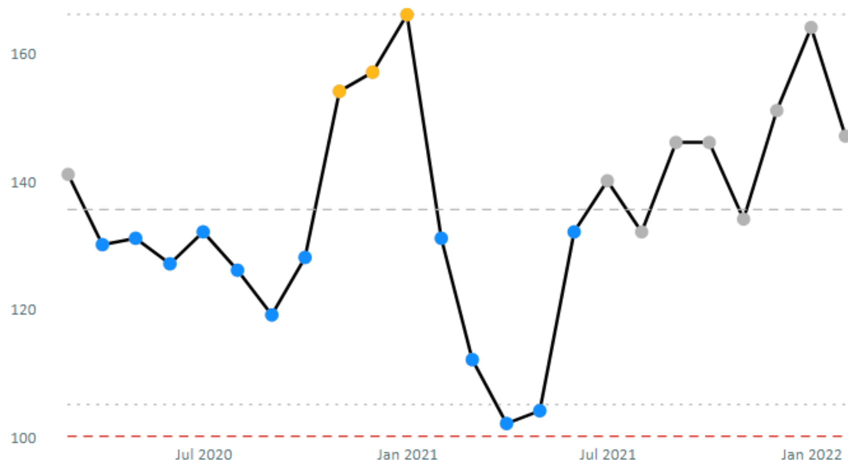
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The number of falls in February across the Trust was 147. The number had plateaued between Jun 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 increased, with additional escalation areas opened. Attendance at the driver meetings reduced to allow that focus. The driver meetings and focus on Falls A3s has now recommenced, with a subsequent improvement seen.
Harm reported in Feb 22: 1 severe, 3 moderate, 143 low/no harm events.
Areas of high numbers of falls include Cambridge L, Quex, Clarke and Sandwich wards.

Intervention and Planned Impact

- The 'Falls Yellow Kits' are now in use in the UEC care group at WHH and QEQM. The pilot predicted their impact would 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. The corporate falls team have been assisting in identifying high risk patients in ED at WHH. This will be rolled out at QEQM with the new band 4 who commenced this week. In recent weeks 50 patients have been identified, with only 1 subsequent fall amongst these patients. A combination of the yellow kits and greater corporate falls team input, continues to result in a significant reduction in numbers of falls across the UEC care group (despite on-going capacity challenges).
- Camb M1 have now completed their Falls A3 and can demonstrate a 50% reduction in ward falls.
- The wards identified above as having high numbers of falls are receiving intensive support from the corporate falls team, to help identify areas of improvement.

Risks/Mitigations

When the BO is closed there is a risk that a lack of focus on falls improvement will result in the local teams not feeling empowered to make the local changes they wish to implement. The CNMO has agreed that the fortnightly, matron led meetings will continue as business as usual to mitigate this risk and will feed into the wider fundamentals of care work which will focus on reducing all harm moderate and above.

NHS East Kent Hospitals University NHS Foundation Trust

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	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Harm Events	W4		Covid-19 HCAI	H	1	15	35	178	138
	W4		Nutrition Incidents	H	60	61	68	66	76
	W4		Serious Incidents		18	35	24	21	18

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, as predicted, has seen 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.

Nutrition Incidents

Short staffing on wards clearly has an impact on omissions in care. It is expected that datix numbers will increase over the next few months, consideration is being given as to whether we need to raise the threshold again.

Increased incidents relating to Parenteral Nutrition line infection risks are currently undergoing greater scrutiny and will be reviewed at the next IPC Committee.

Food and drink incidents relate to delays in meal provision and poor mouthcare, action is being undertaken by 2GSS and Clinical Teams.

Increased incidents for incomplete documentation for NG tubes, food and fluid charts has been raised with care groups.

All of the above issues are raised with HoNs and are being taken to the Care Group Governance meetings over the next four weeks to agree plans of action. Outputs will be overseen by the FOC Committee.

Serious Incidents

SI's have decreased and the categories of SI's reported are more widespread, with less falls and Pressure ulcers this month. Covid outbreaks (4) and delays to treatment/response/diagnosis (5) are the main contributory categories. There were 3 allegations of abuse which are being investigated.

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
59.3%	59.7%	62.7%	64.3%	64.5%	63.6%	62.0%	61.4%	61.3%	59.8%	59.6%	59.5%

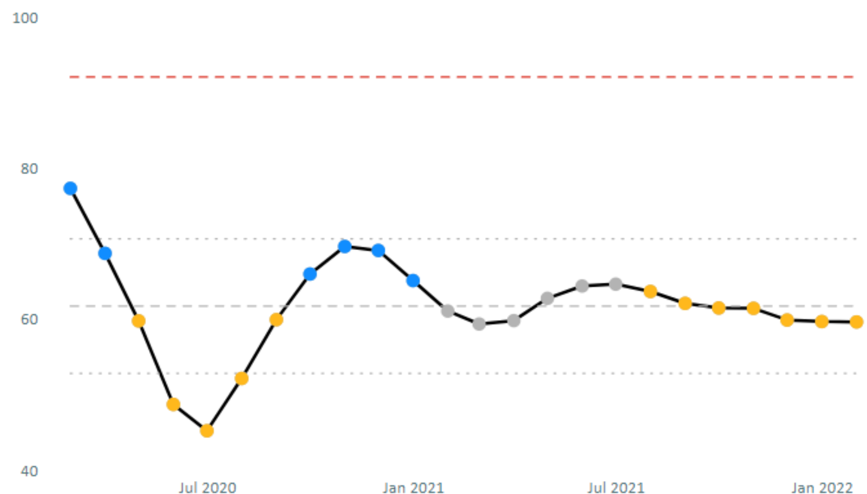
Variation indicates consistently falling short of the target

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

- 2022/23 Business planning underway with care groups to focus on increased activity to reduce the waiting lists and treat long waiting patients. Key actions include:
- Actual Theatre Utilisation 85%
- Reduction of cancellations on the day
- Reduction in OPD DNA's
- Contracts to continue use of the IS and West Kent Shared PTL being finalised to assist with treating our long waiting patients.
- Updated Access Policy approved at CEMG. Teams reminded to follow the access policy to ensure that we have the right patients on the waiting list and we manage patients according to the policy. It is anticipated that we will see an increase in the number of patients removed or placed on active monitoring as they are unfit for surgery.
- TIF submission for continuation of the Vanguard theatre/ or alternative to the system to support elective activity at Kent and Canterbury Hospital.

Risks/Mitigations

- Increased number of patients testing positive to Covid leading to cancellations on the day and 1-3 days prior to admission.
- Increased number of staff testing positive to Covid impacting on available staffed theatre sessions.
- Increased number of Covid positive patients on all sites impacting on bed availability.

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.

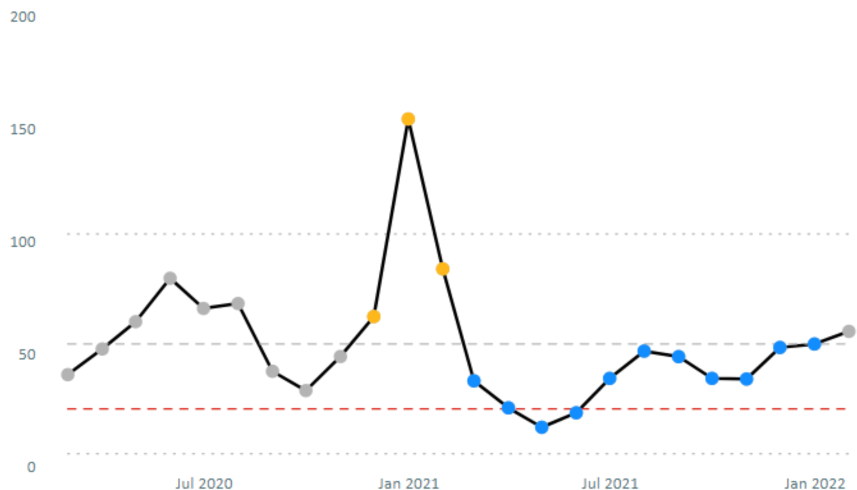
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
38	26	17	23	39	51	48	39	38	52	54	60

Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags



What the chart tells us

Current performance shows an opportunity of 60 sessions of theatre capacity available an increase on the previous month. Review of the data identifies that the opportunity is made up of :
36 cancelled sessions,12 sessions related to early finishes ,5 sessions related to turnaround times, 4 due to late starts and 3 due to cancellations on the day. This data is being validated as the theatre moves do not appear to have been actioned correctly on Theatre man.

Intervention and Planned Impact

- The EOC has been returned to Orthopaedics and joint replacements are now being booked to ensure long waiting patients are treated.
- Ensuring lists are booked to 95% with an actual theatre utilisation of 85% - this has been included as part of the business planning process and is an objective for each care group. It is expected that this increased actual utilisation will support delivery of the 104% activity plans.
- Breakthrough meeting restarted to ensure focus on minimising opportunity and improving utilisation.
- Care groups asked to return to pre-Covid avg cases per list to improve productivity and utilisation.
- Care groups have been asked to work with pre-op to reduce the number of cancellations on the day but noted that the patients that cancel 1-3 days before surgery are having an impact on the ability to fully utilise theatre lists. Patients are unwilling to self isolate without confirmation of surgery.

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.
- Green bed availability at QEQM remains a challenge and will require support around creating a green ward and / or how we use Spencer beds.
- Breakdown / Replacement of essential theatre estates will reduce available capacity- where planned we are reallocating sessions where possible. However we are experiencing a number of repairs that require urgent attention leading to lost capacity.

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
81.9%	81.8%	81.3%	77.1%	73.8%	73.4%	73.2%	70.4%	70.6%	70.3%	70.1%	72.0%

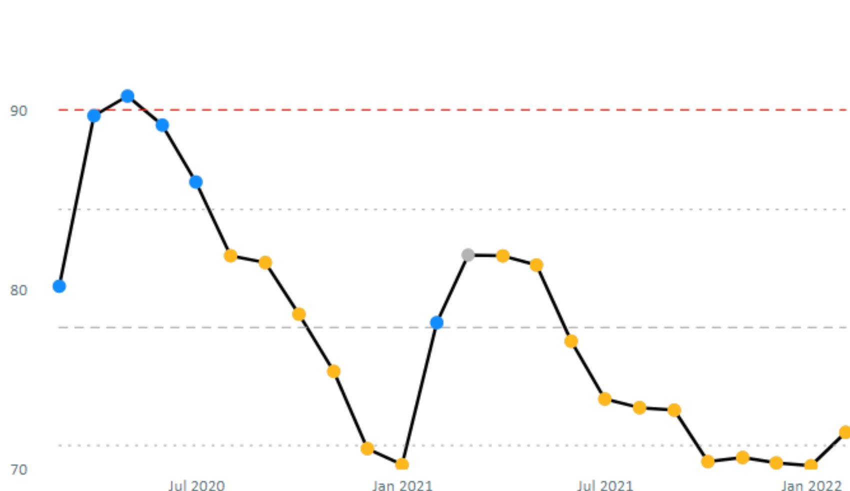
Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

ED performance has improved to 72% in February 2022. Performance improved during Wave 1 of the pandemic due to a reduction in attendances. Performance dipped as demand increased and Wave 2 began. Performance improved in early 2021 until Wave 3 began, elective services restarted and brought with it the increased IPC challenges of managing increased patient contacts and 'Green' pathway elective patients. Winter 2021/22 saw a stabilisation of ED performance in the mid 70's%, together with increased challenge in managing increased Covid patients, Covid contacts and staff sickness.

Intervention and Planned Impact

- ED Restart programme to focus on achieving 80% performance against the 4 hour standard by the end of February 2022 did see an improvement in performance. Focus on patient flow continues to be the highest priority daily.
- ECIST are supporting a review of the Acute Medical Model at WHH to reduce the length of stay to <48 hours.
- Plans to implement the principles of the Modern Board Round and Criteria to Reside are being progressed with clinical champions identified and launch dates agreed for March.
- In February the WHH SDEC service was temporarily transferred to Out Patients, building on the success of the Paula Carr pilot and reducing over crowing in ED.
- Increased operational support in ED 7/7 with a focus on patient flow.

Risks/Mitigations

- Nursing vacancy, particularly at QEQMH – Continued mitigation via a senior nurses being rostered to direct clinical care, Pool Nursing rota is seeing increased uptake.
- 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 continued via whole system working to escalate issues and commission appropriate capacity.

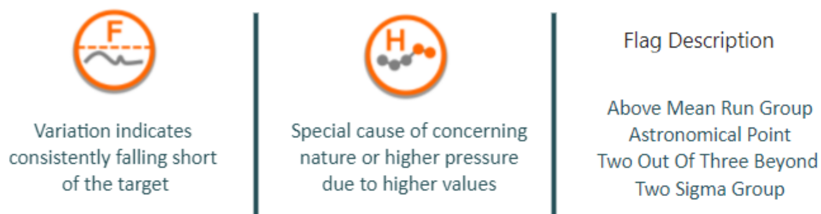
20/21 breakthrough objective

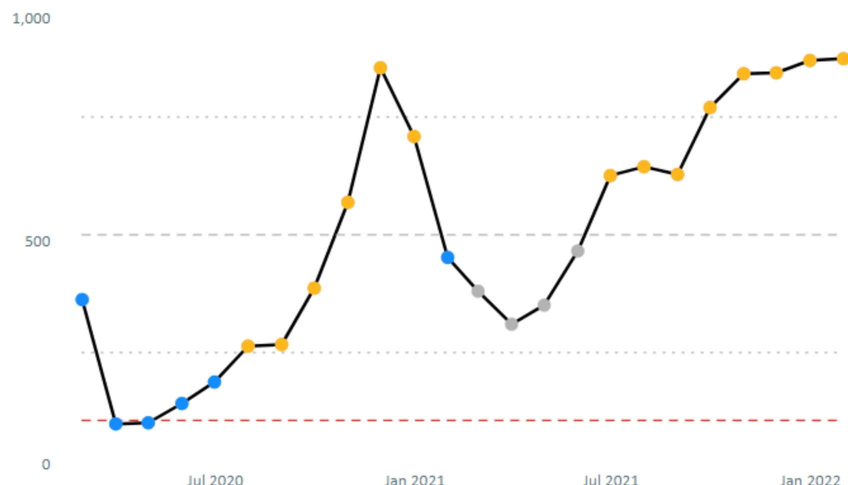
ED Aggregated Patient Delay

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
385	311	353	475	644	664	647	797	873	875	903	907





What the chart tells us

At the start of the pandemic when attendances reduced the aggregated time a patient waited to be transferred to a hospital bed was low and achieved the internally agreed standard. As demand has increased to above normal levels performance has deteriorated. Covid Waves have had an impact on performance. This metric is heavily influenced by bed availability on main wards, which has been a consistent challenge throughout the pandemic due to an increase in the number of patients who no longer meet the criteria to reside in hospital, lack of external capacity, balancing IPC requirements to transfer patients to the correct ward and managing contact patients who become Covid post admission (not hospital acquired).

Intervention and Planned Impact

- To increase the number of patients discharged by midday each day to 30% of total discharges. Current performance is 14.7% at WHH and 16.9% at QEQMH.
- Senior ED management rota continues to provide increased leadership at weekends/evenings.
- 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.
- Working with LHE to escalate patients who no longer meet the criteria to reside (NLFTR) and are delayed for PW1, PW2 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. Simple discharges are also an area of focus.

Risks/Mitigations

- LOS on AMU is >48 hours due to lack of timely bed capacity on wards. Mitigation: to implement 'Modern Ward Round' to maximise morning discharge and reduce LOS.
- The number of patients who are NLFTR in hospital is reducing capacity on wards. Mitigation: Continue to work with LHE to increase community capacity across PW1,2 &3.
- PW0/Simple discharges are delayed due to internal delays in pathways. Mitigation: Daily review of diagnostic requests in place with a senior review of CT/MRI to ensure clinically urgent.
- Increase in Covid Inpatients and the effect of Covid sickness on staffing is having an adverse impact on the length of time patients spend in ED.

East Kent Hospitals University NHS Foundation Trust

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 patients 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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
81.5%	86.7%	83.3%	82.2%	82.5%	80.7%	78.8%	79.3%	84.3%	78.0%	75.8%	70.1%

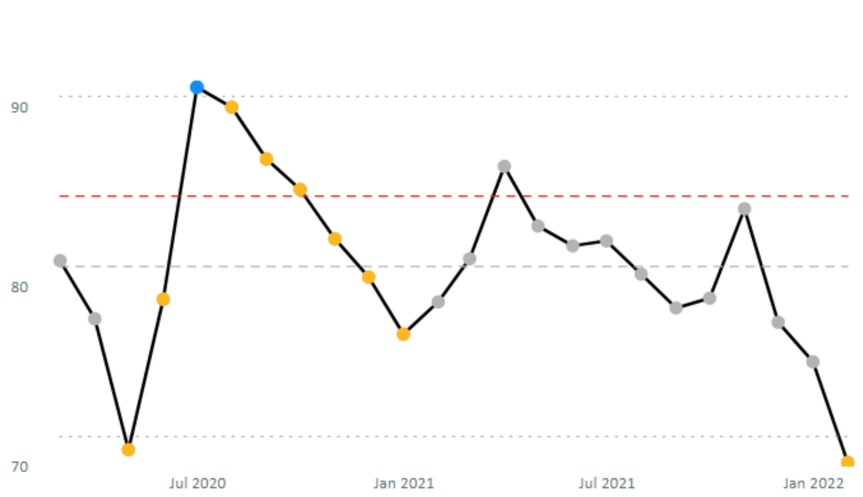
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point

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. Although the performance has deteriorated Kent and Medway Cancer Alliance continued to record the lowest back log of all cancer Alliances, East Kent Hospitals is the largest contributor to this.

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. This is supported by CNS clinical oversight
- 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 CNSs to maximise learning and 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 issues 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

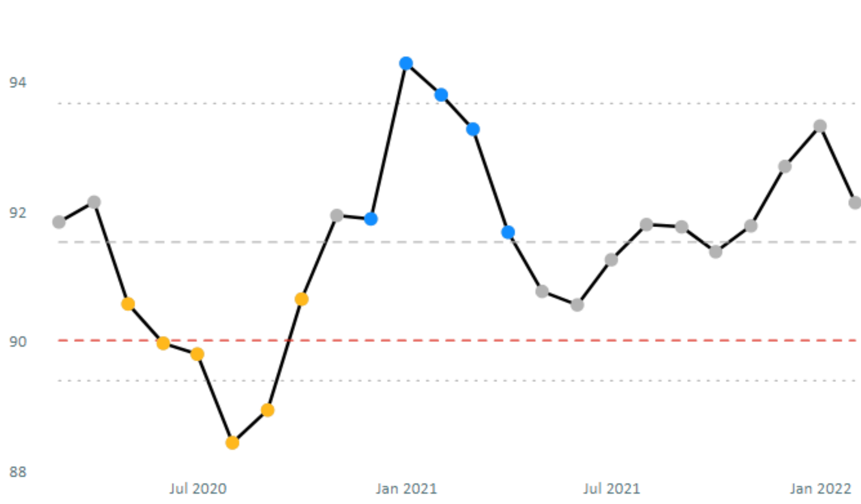
Sarah Shingler

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
93.3%	91.7%	90.8%	90.5%	91.2%	91.8%	91.8%	91.4%	91.8%	92.7%	93.3%	92.1%



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. However, recent performance shows that this improvement has not been sustained, although remaining above the upper control limit – there is still deterioration from January position.

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 has now been approved, with recruitment commencing.

Maternity patient experience project 'Your Voice is Heard' commences April 22, ambition to capture feedback from every woman who gives birth in one of our units (6000 births per year)

Risks/Mitigations

If culture and behaviours do not change there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased 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	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Cancer 62d			Cancer 2ww Performance		93.0%	98.0%	97.7%	96.6%	96.6%
	W4		Cancer 28d Performance		75.0%	69.8%	66.5%	62.6%	70.8%
	W4		Radiology Diags vs Plan		Traj.	16,239	14,957	15,774	15,433
	W4		Endoscopy vs Plan		Traj.	1,368	1,044	1,262	1,396
RTT - 18 Weeks			RTT 52w Breaches		Traj.	4,695	4,475	4,327	3,891
	W4		DM01 Compliance		75.0%	73.3%	65.7%	62.3%	68.0%
	W4		RTT 35w Waiters (w/o TCIs)		8,500	8,894	9,315	9,826	9,514
	W4		RTT OP Booking Breaches		14,000	17,976	19,440	19,193	19,696
	W4		Elective Admissions vs Plan		Traj.	6,183	5,275	5,189	5,603
ED Compliance	W4		Time in Department over 12 Hrs		6.0%	9.8%	9.6%	9.5%	9.2%
	W4		Clinician First Seen within 1h		50.0%	38.1%	38.6%	37.7%	36.0%
	W4		Super Stranded >21D		75	139	151	186	172
	W4		Discharges by Midday		15.0%	13.0%	14.4%	14.1%	14.8%
	W4		NEL Admissions vs Plan		Traj.	6,548	6,265	6,495	6,125
FFT			FFT ED Response Rate		12.0%	12.5%	12.4%	13.2%	14.8%
	W4		FFT Maternity Response Rate		18.0%	4.4%	3.9%	3.8%	10.4%
	W4		Complaint Response		90.0%	23.9%	27.3%	21.9%	12.3%
			PALS Enquiries		550	619	526	677	748

Cancer

28 and 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 increased due to the planned reduction in operating capacity in January to mitigate Wave 3 of Covid-19. Following the restart of elective surgery in February performance has begin to improve as predicted.

ED Compliance

Clinical Assessment within 1hr 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. Although some improvement seen in month

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 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.

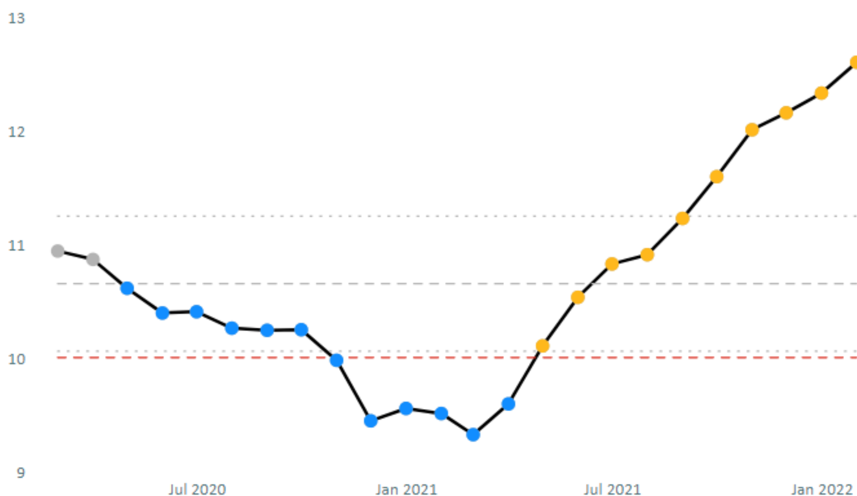
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
9.3%	9.6%	10.1%	10.5%	10.8%	10.9%	11.2%	11.6%	12.0%	12.2%	12.3%	12.6%

Variation indicates consistently falling short of the target

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...



What the chart tells us

Total turnover, when measured as a rolling 12-month average, has risen for an eleventh month in succession and remains above the True North target (10%) at 12.6% (February 2022). It is however important to share that total turnover has actually been improving in real-terms since September 2021 and compares favourably against the South East turnover average of 14.3%. Total turnover, measured in-month, has now improved in four of the last five months and currently sits at 11.27% -the lowest it has been this year. Staff Nurses continue to represent our primary leaver group (193 leavers in 12 months) and so work to drive improvement continues against local, regional and national priorities

Interventions and Planned Impact

Five top turnover areas have been identified: Theatres, KCH, Critical Care, WHH, Pharmacy Clinical Services, Pharmacy Operational Services.

Work is already underway providing wellbeing support into Theatres, Critical Care and Accident & Emergency areas (across all sites). Action plans are also being refined in these areas following the release of National Staff Survey data at Directorate level. Engagement has also taken place with respective leads and Business Partners to better understand the challenges within our Pharmacy Clinical & Operational Services. Turnover in this area appears to have been a direct result of the mandatory Covid-vaccination announcement by the Government (now rescinded). Respective support was offered in this space.

Risks/Mitigations

The drive for increased recruitment will address staffing shortfalls however the strong correlation between high volume recruitment and turnover is evident. Continued and intensive onboarding work, led by East Kent Hospitals, is taking place with our regional colleagues across the Kent & Medway system. This includes the development of a new starter feedback platform, onboarding champion roles and system-wide onboarding checklists and communications

Our people

Andrea Ashman

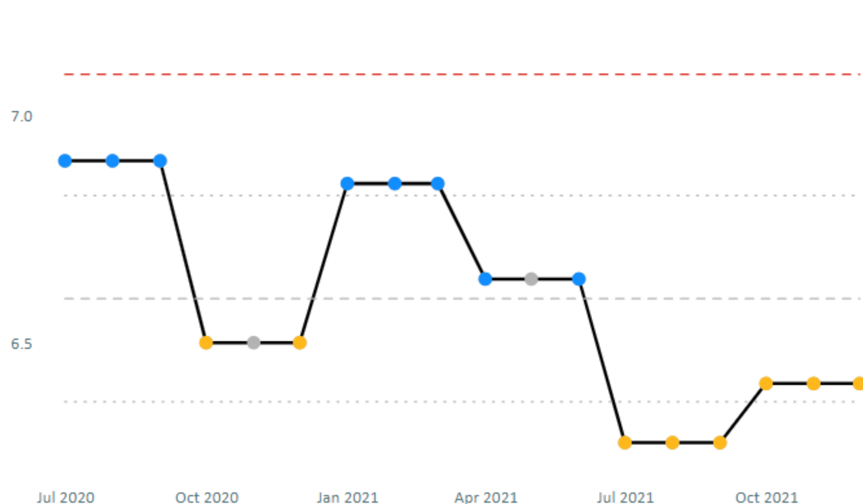
Staff Engagement (score)

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.

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

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

A programme of work has commenced including the establishment of 'Involvement' as a breakthrough objective under Staff Engagement as agreed by the board last month.
A comprehensive overview of the current position was provided at the People and Culture Committee in January. No further data on our overall position is released due to the National Staff Survey embargo, but a report of the survey and associated findings will be provided to the People & Culture committee at the next available opportunity upon lifting of the embargo (30/03/22 09:30hrs).
In the interim considerable work has been undertaken to understand the 2021 National Staff Survey results and to use this evidence-base to refine action plans across each of our Care Groups. The analysis is largely complete and Care Group Triumvirates are now meeting with our Staff Experience Team and developing focussed actions plans to drive improvement. 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 has been received this month and shows a consistent position since October. True North for engagement is to be supported by a breakthrough objective on Involvement. A dashboard to display the NSS results in a more discoverable and accessible way is being developed using the latest data and information to help drive concerted and consistent action at-pace, identify areas of best-practice and to act in a timely manner on concerns raised.

East Kent Hospitals University NHS Foundation Trust

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	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Staff Turnover Rate	W4		Vacancy Rate		9.0%	9.3%	9.9%	9.3%	12.7%
	W4		Staff Turnover: HCA		13.5%	13.6%	13.5%	14.3%	14.1%
	W4		Staff Turnover: Nursing		10.0%	12.0%	11.7%	11.7%	11.8%

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 change 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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
-0.007	-0.548	-0.438	0.030	0.024	0.042	0.021	-1.494	-0.996	-0.941	-0.090	1.307

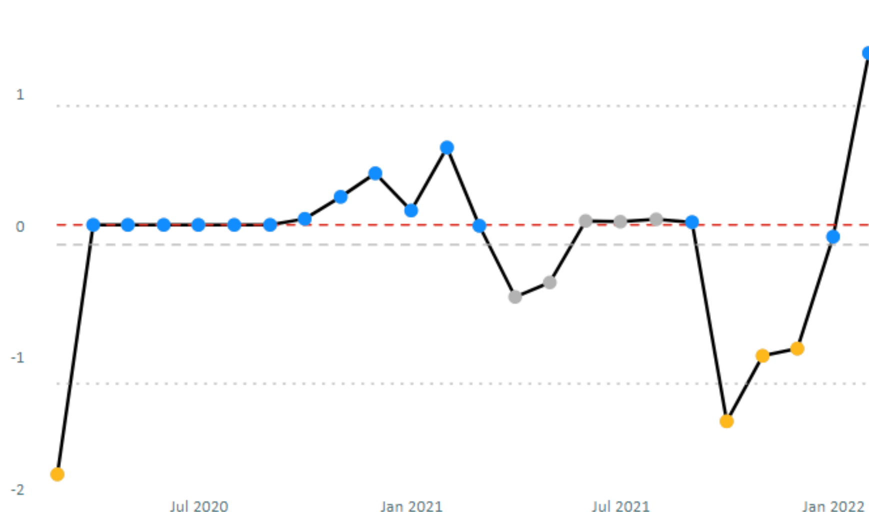
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Outside Moving Range Limit
Astronomical Point
Two Out Of Three Beyond Tw...

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. This month the surplus generated of £1.3m is above the control limits but is broadly a positive movement.

Interventions and Planned Impact

The Trust has a surplus position which is driven by less than expected service development costs.

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

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 (CO_2e)

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.

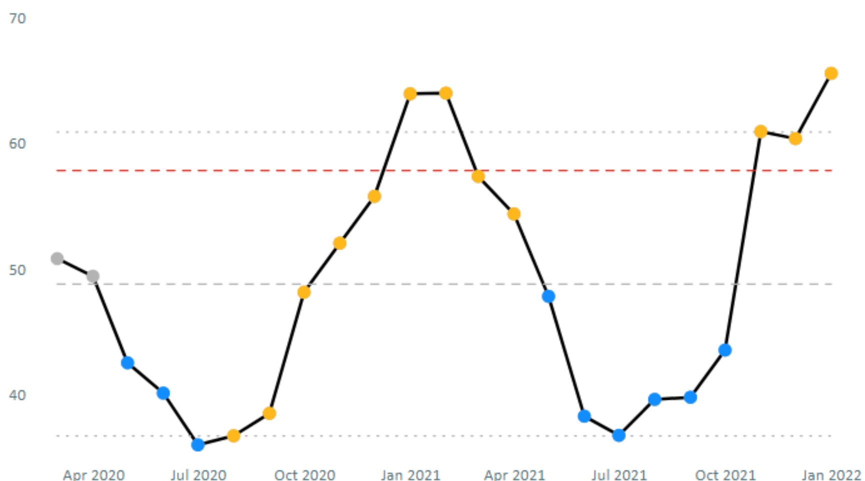
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
57.34	54.35	47.80	38.27	36.74	39.60	39.77	43.52	60.90	60.34	65.53	

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



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 January 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. Electric vehicle charging points have been installed at QEQM and implementation is planned at WHH and K&C in 2022.

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.

NHS
East Kent
Hospitals University
NHS Foundation Trust

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	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Financial Position	W4		Total Pay		0.0%	-1.5%	-1.2%	-1.2%	-1.3%
Carbon Footprint			CO2e Gas (tonnes/day)		38.19	33.96	36.48	41.49	

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.

East Kent Hospitals University NHS Foundation Trust

Our future

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
206.5	220.2	223.2	297.1	309.9	299.6	303.0	299.5	332.0	346.2	314.3	320.4

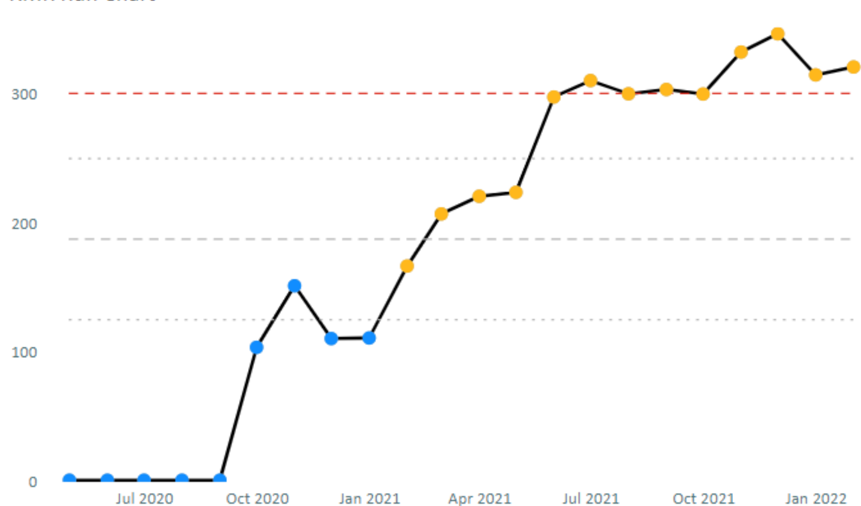
Variation indicates consistently passing the target

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 are 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. February 22 has seen an increase in the number of Covid and Contact presentations which can be more complex to discharge due to lack of designated Covid bed capacity.

Intervention and Planned Impact

- Continuing to work 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.
- 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 support to launch and embed 'Modern Ward Round' document. Clinical champions identified who will provide cascade training to each ward.
- Refocus of patient PTL and recording of C2R categories on board rounds, including identifying discharges for next 24 hours and weekends.

Risks/Mitigations

- Insufficient external capacity, particularly in PW1, PW2 and PW3 to meet patients needs; Mitigation is to work through the LHE to highlight capacity to be commissioned.
- Patients and their families decline 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 and also to ensure that Matrons are involved in discussions with families to support.

Our future

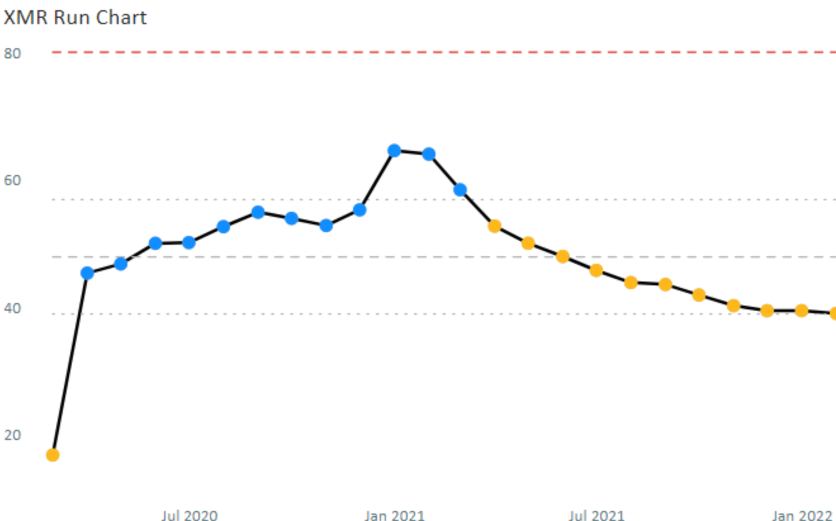
Liz Shutler

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.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
58.4%	52.7%	50.0%	47.9%	45.7%	43.8%	43.5%	41.9%	40.2%	39.4%	39.4%	39.0%



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 February 2022 is at 39.0% which is below our revised threshold of 50%.

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 33.0% and follow-up appointments at 41.5%. The Trust has the highest level of achievement within Kent and Medway

Intervention and Planned Impact

The Outpatient Transformation Steering Group has reviewed the national benchmarking data and 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 roll out has commenced with no reported issues, with full completion by end of March 2022.

Updated Telemedicine SOP has been completed and is expected to be ratified by April 2022.

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.
- Manual allocation of appointments in E-clinic is needed until the technical solution is in place to auto allocate in June 2022.
- 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	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Innovation			Virtual OP Appts - First		25.0%	32.0%	31.0%	33.4%	33.0%
			Virtual OP Appts - Follow Up		25.0%	43.8%	43.0%	41.9%	41.5%

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

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True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Harm Events	W		52w Severe Harm Review		0	0	0	0	0
	W		Medication Errors; All		110	187	191	200	179
	W		Medication Errors; Severity C+		1	2	0	1	3
	W		Pressure Ulcers: Cat 2		32	39	33	33	26
	W		Pressure Ulcers: Cat 3 & 4		3	0	1	1	1
	W		Pressure Ulcers: DTI		10	6	5	8	11
	W		Pressure Ulcers: Unstageable		10	5	10	7	11
	W		IPC: Audits Composite		80.0%	87.5%	87.4%	87.6%	87.7%
	W		VTE Assessment Compliance		90.0%	92.2%	92.1%	91.2%	91.7%
	W		Safeguarding Incidents		20	17	7	14	18
	W		IP Spells with 3+ Ward Moves		500	505	474	497	540
	W		Clinical Incidents		2,500	2,208	1,998	2,291	1,896
	W		Never Events		0	0	0	0	0
	W		Maternity Serious Incidents		2	2	1	1	1
Mortality	W		Extended Perinatal Mortality		6.32	5.47	5.47	4.63	4.77

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Cancer 62d	W		Cancer 31d Performance		96.0%	97.9%	97.9%	97.2%	98.4%
RTT - 18 Weeks	W		OPA vs Plan		Traj.	63,756	54,196	55,755	52,503
ED Compliance	W		A&E Atts vs Plan		Traj.	21,408	19,760	20,262	19,687
	W		Unplanned Re-attendance ED		10.0%	9.0%	10.3%	9.6%	10.6%
	W		NEL Readmissions		15.0%	10.0%	11.2%	11.5%	10.4%
	W		Stroke Ward within 4 Hours		50.0%	60.9%	73.3%	58.7%	63.0%
FFT	W		FFT IP Response Rate		15.0%	17.2%	17.2%	16.5%	18.1%
	W		FFT DC Response Rate		27.0%	26.2%	26.6%	28.3%	30.1%
	W		FFT OP Response Rate		17.0%	15.9%	17.8%	18.5%	18.4%
	W		Complaints		100	103	60	72	86
	W		Mixed Sex Breaches		500	289	69	129	126

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Staff Turnover Rate	W		Premature Turnover Rate		25.0%	19.3%	19.3%	19.9%	19.6%
Staff Engagement	W		Sickness		5.0%	4.8%	5.4%	6.0%	
	W		Appraisals Compliance		73.0%	78.1%	76.9%	77.1%	77.8%
	W		Statutory Training		91.0%	90.3%	91.6%	91.9%	91.6%
	W		Safeguarding Children Training		85.0%	90.6%	91.2%	91.3%	91.3%
Financial Position	W		Premium Pay		Traj.	7,255	6,441	7,168	7,403
	W		Non Pay		0.0%	0.1%	-0.2%	-0.2%	-0.5%
Carbon Footprint	W		CO_2e Electricity (tonnes/day)		18.00	15.42	13.38	13.23	
	W		CO_2e Water (tonnes/day)		0.55	0.23	0.13	0.22	
	W		CO_2e Steam (tonnes/day)		9.21	11.08	10.12	10.39	

Appendix 2
Trust Priority Improvement Projects

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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. • Training Hub facility secured at East Kent College and proposal put forward for central management. • Integrated Education Strategy proposal presented to Integrated Education Board. • Project Lead and Team identified to take forward next stage of space utilisation review. • Demand modelling being reviewed to support the need for additional residential accommodation	• Implement Project Team to progress space utilisation review. • Continue to explore options for education and training space to complement EKC model. Progress the central management team proposal. • Progress review of demand modelling to secure additional residential accommodation.
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	• LNC was delayed until April 4th 2022: Aim is to present changes following discussion at previous LNC and approve • Infographics now updated on the first Tuesday of each month and will be displayed on the email signatures of the Revalidation PM and TPIP SRO • CMO webpage to be expanded to include a job planning section which will display advice and key information .	• Review contract for e-Job plan to understand period of time left and to plan a system review as necessary • Review current license capacity and apply for an increase in licenses as required • Onboard admin support, recently recruited into the CMO team, to support Job planning project manager in releasing capacity to focus on improvement workstreams
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	May 2022	• Director of Pharmacy has reviewed recent data relating to EDN completion and has included patient stories, to support clinician engagement. • Mr Shah (Consultant Surgeon) has shared his teams progress on Kings B ward, and the benefits timely EDN completion is having	• Five wards prioritised to support improvement (CoE team coaching provided). • Share learning from Mr Shah's team. • Clinician engagement and ownership will be the focus

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
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022	• The process of reviewing MicroGuide vs 4 policy and 4 action is in progress. • No date has been confirmed with regards version 2 of 4 policy. • Mike Bedford is addressing choice of MicroGuide	• Meetings with Clin Directors in progress • Continue to chase comments re Clinical Guidelines Policy • Awaiting confirmation of funding for Band 6 post
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 • Engaging Care group stakeholders	• Continue to engage stakeholders and implement countermeasures as per A3
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	• Clinical Audit team to clarify any remaining areas for improvement against the problem statement. • Commence drafting a TPIP Closure Request as relevant	• Recruit to post, as currently no SRO attached to this TPIP. • Clinical Audit team continue to work with Care Groups regarding their compliance
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 (delayed 1 month due to SLT revised agenda)

Appendix 2
Completed Trust Priority Improvement Projects

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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

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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

NHS 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

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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.