NHS
East Kent Hospitals University NHS Foundation Trust

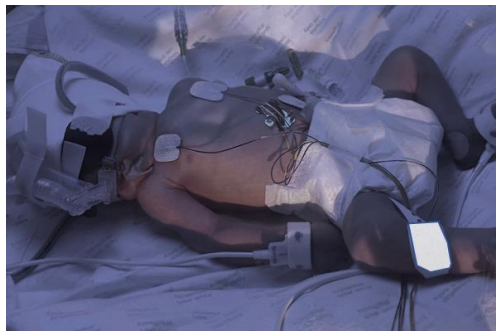
Integrated Performance Report

April 2021







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 strategic focus centres on five themes:

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

What is the Integrated Performance Report (IPR)?

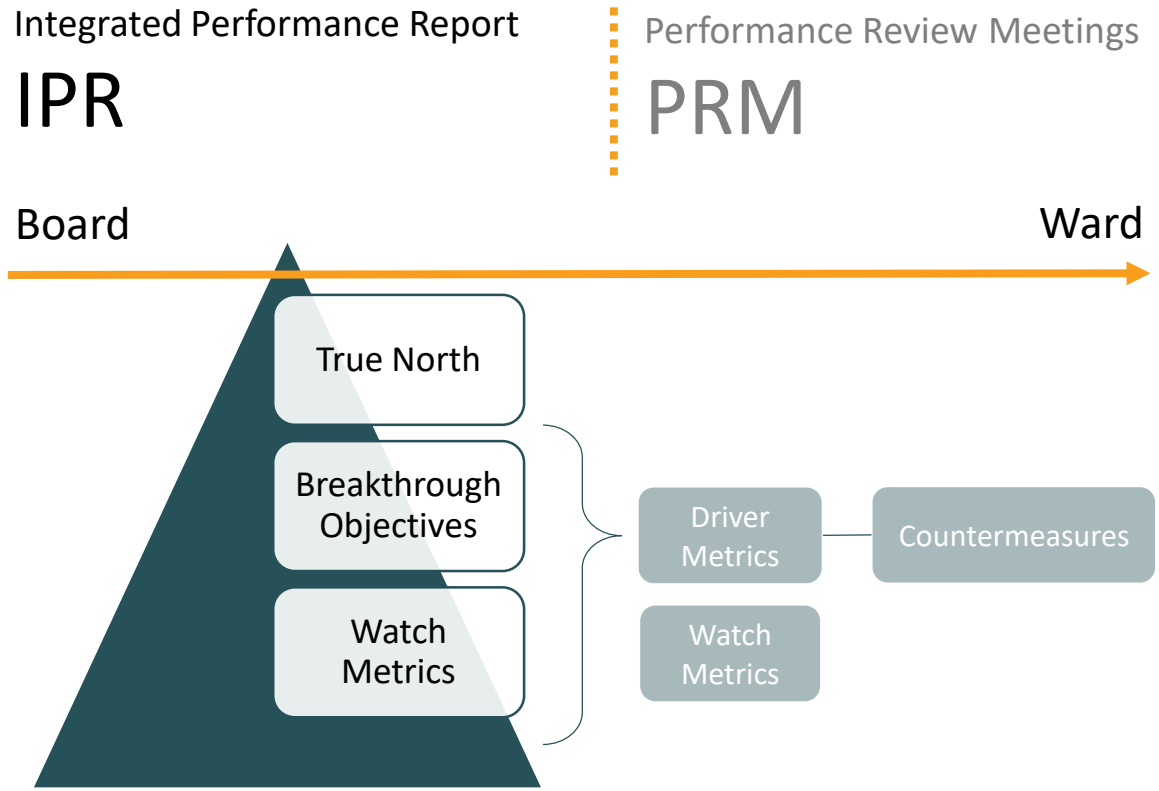
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year.

- Reducing falls
- Reducing healthcare acquired infections
- Reducing deaths from sepsis
- 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 we can make the most significant improvements by focusing our efforts. We'll also use data to measure how much we're making a difference.

Frontline teams will lead improvements in these areas of focus. They will be supported by our Improvement Office, which will help give teams the training and tools they need, and 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.

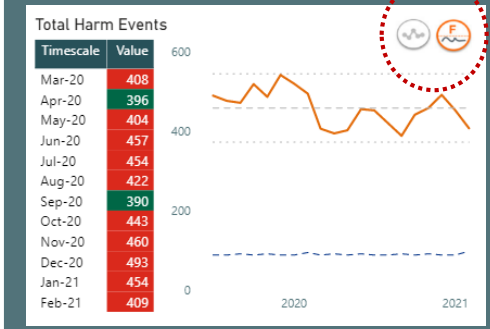
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (ie no significant change.

NHS Improvement SPC icons

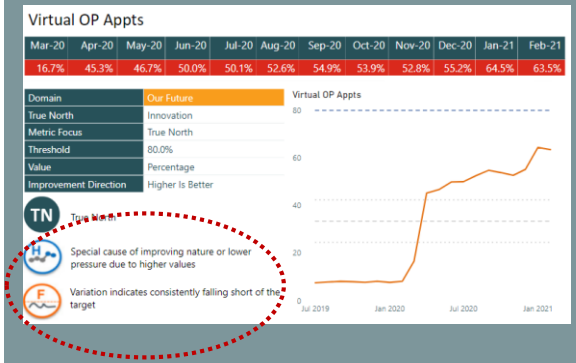
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them

True North



Breakthrough Objectives



What are the Business Rules?

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)

East Kent Hospitals University NHS Foundation Trust

Our Quality & Safety

Siobhan Jordan

Rebecca Martin

Incidents Potentially Contributing to Harm
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.

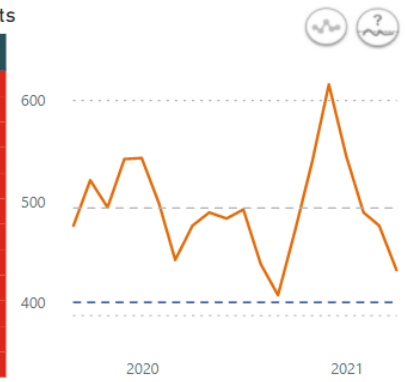
Mortality (HSMR)
Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in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

Our aim is to reduce mortality and be in the top 10% of all Trusts for the lowest mortality rates in 5 to 10 years.

Incidents Potentially Contributing to Harm
To achieve and sustain zero avoidable harm.

Total Harm Events

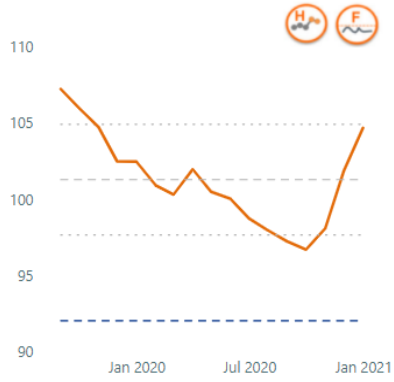
Timescale	Value
May-20	489
Jun-20	483
Jul-20	492
Aug-20	438
Sep-20	407
Oct-20	470
Nov-20	539
Dec-20	616
Jan-21	545
Feb-21	489
Mar-21	476
Apr-21	432



Hospital Standardised Mortality Ratio (HSMR)
To reduce our Hospital Standardised Mortality Ratio and be in the top 10% of all Trusts.

HSMR

Timescale	Value
May-20	100.5
Jun-20	100.0
Jul-20	98.7
Aug-20	97.9
Sep-20	97.2
Oct-20	96.7
Nov-20	98.1
Dec-20	101.9
Jan-21	104.7
Feb-21	
Mar-21	
Apr-21	



Executive Summary

East Kent Hospitals University NHS Foundation Trust

Our Patients

Rebecca Carlton

Trust Access Standards (Cancer, RTT & ED)
It is poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, financial and regulatory risk for the Trust.

The Trust has struggled to achieve consistently the national access standards for ED, RTT and Cancer, for a number of years. It is therefore important that these form a key part of our True North strategy for the coming years.

Siobhan Jordan

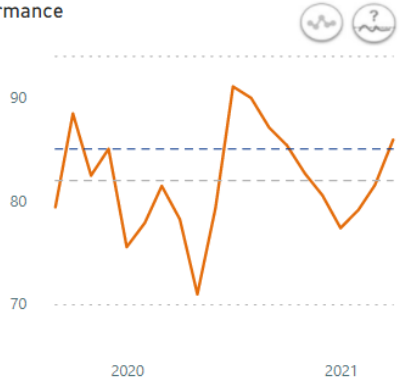
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

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.

Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.

Cancer 62d Performance

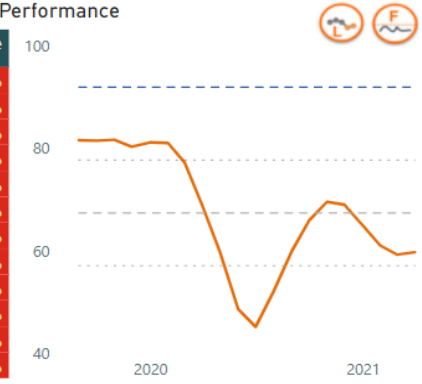
Timescale	Value
May-20	70.9%
Jun-20	79.2%
Jul-20	91.1%
Aug-20	90.0%
Sep-20	87.1%
Oct-20	85.4%
Nov-20	82.6%
Dec-20	80.5%
Jan-21	77.3%
Feb-21	79.1%
Mar-21	81.5%
Apr-21	85.9%



RTT: 18 Week Compliance
To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.

RTT Incomplete Performance

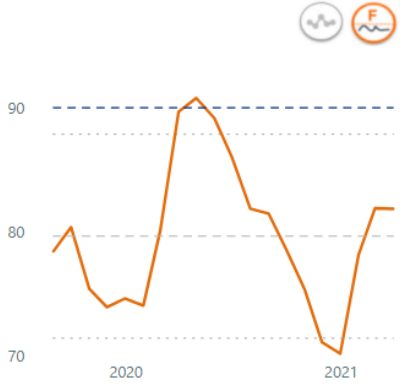
Timescale	Value
May-20	59.7%
Jun-20	48.6%
Jul-20	45.1%
Aug-20	52.1%
Sep-20	59.8%
Oct-20	65.9%
Nov-20	69.5%
Dec-20	69.0%
Jan-21	65.0%
Feb-21	61.0%
Mar-21	59.3%
Apr-21	59.7%



ED 4 Hour Compliance
To achieve and sustain 95% of all patients attending ED receiving treatment or admission with 4 hours.

ED Compliance

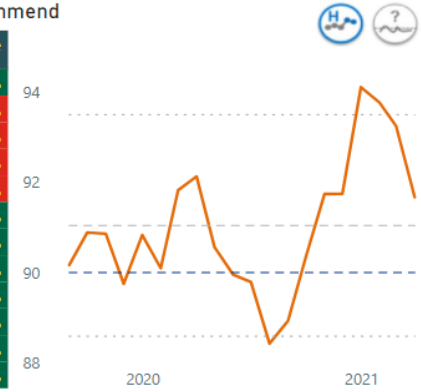
Timescale	Value
May-20	90.8%
Jun-20	89.2%
Jul-20	86.0%
Aug-20	81.9%
Sep-20	81.5%
Oct-20	78.6%
Nov-20	75.4%
Dec-20	71.1%
Jan-21	70.2%
Feb-21	78.1%
Mar-21	81.9%
Apr-21	81.8%



Patient Experience (Friends & Family Test)
To achieve consistent recommendation rates in excess of 90% from patient friends and family.

FFT Trust Recommend

Timescale	Value
May-20	90.6%
Jun-20	90.0%
Jul-20	89.8%
Aug-20	88.4%
Sep-20	88.9%
Oct-20	90.4%
Nov-20	91.7%
Dec-20	91.8%
Jan-21	94.1%
Feb-21	93.8%
Mar-21	93.3%
Apr-21	91.7%



Executive Summary

East Kent Hospitals University NHS Foundation Trust

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.

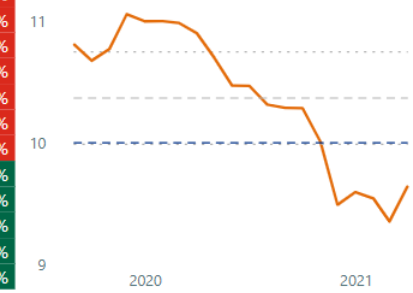
Staff Engagement (score)
Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention.

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.

Staff Turnover
To achieve and maintain a 10% staff turnover rate.

Staff Turnover Rate

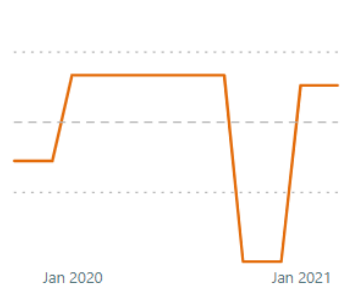
Timescale	Value
May-20	10.7%
Jun-20	10.5%
Jul-20	10.5%
Aug-20	10.3%
Sep-20	10.3%
Oct-20	10.3%
Nov-20	10.0%
Dec-20	9.5%
Jan-21	9.6%
Feb-21	9.5%
Mar-21	9.4%
Apr-21	9.6%



Staff Engagement
To improve our staff engagement score as demonstrated in the annual staff survey.

Staff Engagement Score

Timescale	Value
May-20	6.9
Jun-20	6.9
Jul-20	6.9
Aug-20	6.9
Sep-20	6.9
Oct-20	6.5
Nov-20	6.5
Dec-20	6.5
Jan-21	6.9
Feb-21	6.9
Mar-21	6.9
Apr-21	



East Kent Hospitals University NHS Foundation Trust

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 terms 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.

Liz Shutler

Carbon Footprint (CO2e)
Being environmentally sustainable is a key element of our Trust; True North.

Implementing environmentally sustainable principles and reducing our greenhouse gas emissions, adds value to our patients and reflects the ethics of our staff.

The Trust's carbon emissions are made up of:

- Direct emissions: natural gas
- Indirect and direct emissions: from for example electricity consumption, waste and water
- Waste

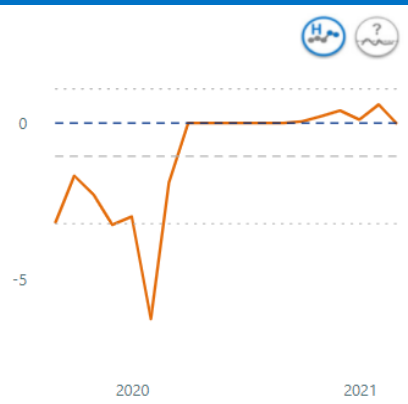
It is these areas we will be focussing on improving over the coming five to ten years.

Financial Position

To achieve and sustain a break even financial position.

I&E Margin (£M)

Timescale	Value
May-20	0.000
Jun-20	0.000
Jul-20	0.000
Aug-20	0.000
Sep-20	0.000
Oct-20	0.046
Nov-20	0.213
Dec-20	0.392
Jan-21	0.109
Feb-21	0.588
Mar-21	-0.007
Apr-21	



Carbon Footprint

To achieve an organisational carbon neutral footprint.

CO2e Total (tonnes/day)

Timescale	Value
May-20	31.87
Jun-20	32.69
Jul-20	29.23
Aug-20	29.33
Sep-20	31.84
Oct-20	38.59
Nov-20	40.90
Dec-20	45.83
Jan-21	55.64
Feb-21	55.69
Mar-21	46.43
Apr-21	

NHS
East Kent
Hospitals University
NHS Foundation Trust

Our Future

Liz Shutler

Medically Fit for Discharge
Across the Trust, patients are deemed as 'ready' and 'medically fit for discharge' but continue to remain under our acute care.

Unnecessary bed stays can negatively affect patient experience. In addition prolonged stays in hospital (especially for those who are frail or elderly) can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning.

By working with our partners in the wider heath & social care community to ensure patients return to their usual place of residence, or other care setting, as soon as it is safe to do so patient flow will improve thought the system. This metric was chosen as it represents the system working in an integrated way. As the system matures this metric my change to 'criteria to reside'.

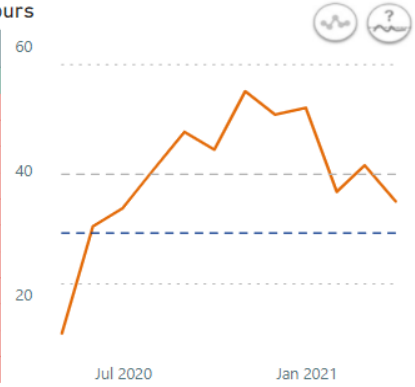
Innovation (Virtual OP Apps)
The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process.

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 via telemedicine, where clinically appropriate, and to that end we have developed an enhanced engagement plan to meet this target and also to encourage the shift to Web from phone were possible. We have also set a stretch target of 80% to drive innovation in this area.

Medically Fit for Discharge
To ensure patients are cared for in the appropriate setting in a timely manner.

MFFD: Over 24 hours

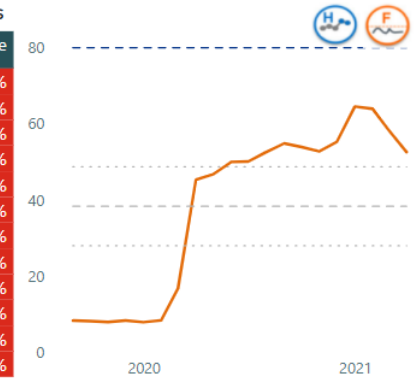
Timescale	Value
May-20	13.9
Jun-20	31.1
Jul-20	34.0
Aug-20	40.2
Sep-20	46.3
Oct-20	43.4
Nov-20	52.8
Dec-20	49.1
Jan-21	50.1
Feb-21	36.6
Mar-21	40.9
Apr-21	35.1



Innovation
To increase the use of technology and innovation in the delivery of high quality care for the East Kent population.

Virtual OP Appts

Timescale	Value
May-20	46.7%
Jun-20	50.0%
Jul-20	50.1%
Aug-20	52.6%
Sep-20	54.9%
Oct-20	53.9%
Nov-20	52.8%
Dec-20	55.2%
Jan-21	64.5%
Feb-21	64.0%
Mar-21	58.3%
Apr-21	52.6%



2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Falls

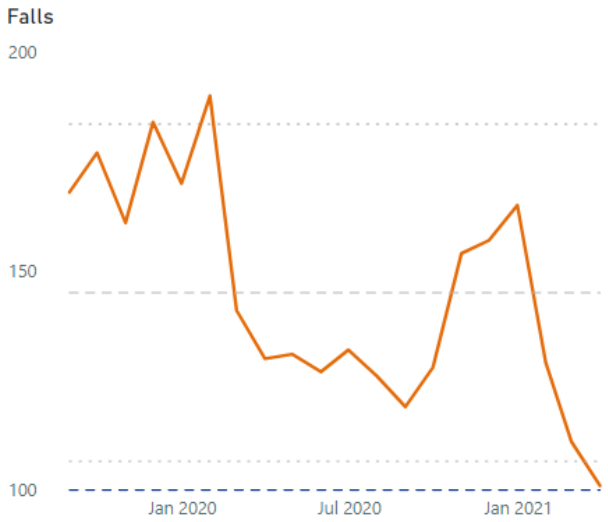
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
131	127	132	126	119	128	154	157	165	129	111	101

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	100
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

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

Variation indicates consistently falling short of the target



Understand the data

Total number of recorded falls. Assisted falls and rolls are excluded.
Data source - Datix

We are driving this measure because...

The Quality & Safety True North target is to achieve zero avoidable harm within 5-10 years. Our analysis shows that currently falls are the greatest contributor (40%) 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.

... | M_00320_Falls

Last Updated | 17/05/2021 08:04:00

Performance

Current Performance: 101 falls recorded in April 2021.This reducing trend for the last three months represents an improving picture.

Key areas of focus for this breakthrough objective are:

- Improving ward level visibility/focus on falls reduction/ level of harm.
- Standardising the trusts approach to reporting of falls on Datix.
- Improving the falls knowledge and access/visibility of ward level data.

Key achievements include:

- development of A3s at ward level with targeted understanding of route causes and focused actions.
- Sharing of learning/improvements through A3 presentations at driver meetings.
- development of a falls dashboard with accessible ward level data, co-designed and challenged at driver meetings.
- development of an MDT approach to reviewing falls through utilisation of a falls decision tool and a multi-professional falls/pressure ulcers panel to support the SI process.
- progression towards a self directed driver meeting with SRO co-chairing with surgical/medical matrons.

Risks

Risk of PDSA improvement cycles becoming 'stuck' in historical process. Mitigation is through escalation of blockages at We Care EMT discussions and through work progressed through the Governance Improvement Group.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Composite HSMR: Sepsis/Resp

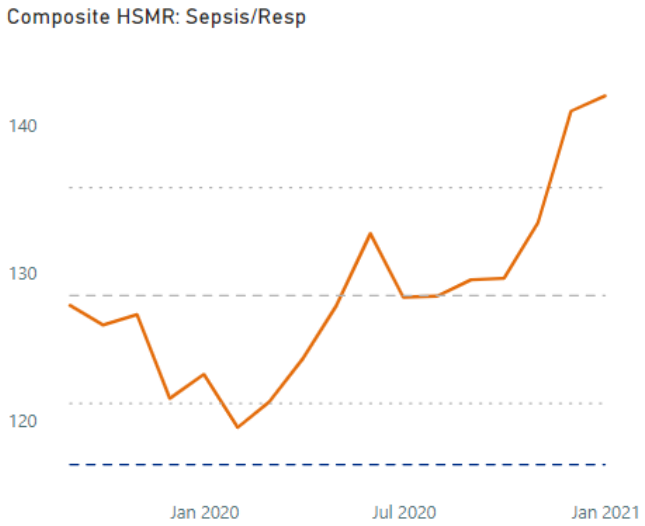
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
127.8	132.7	128.4	128.4	129.6	129.7	133.5	141.0	142.0			

Domain	Our Quality & Safety
True North	Mortality
Metric Focus	Driver
Threshold	117.0
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

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

Variation indicates consistently falling short of the target



Understand the data

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality comparing a Trust's actual number of deaths to its expected/predicted number of deaths. This Composite HSMR metric is a subset of HSMR and only accounts for two of the 56 diagnosis groups: "Septicemia (except in labour)" and "Respiratory failure, insufficiency, arrest (adult)".

If a Trust has an HSMR of 100, this means that the number of patients who died is exactly as would be expected. Values above 100, suggest a higher than expected mortality and those below as within an acceptable range. HSMR is an important indicator that acts as a smoke signal for potential problems with the quality of care. The figures represent a 12-month rolling position.

We are driving this measure because....

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.

... | M_00133_Deteriorating_Patient

Last Updated | 17/05/2021 09:20:00

Performance

Current performance shows a rolling 12-month composite Hospital Standardised Mortality Ratio (HSMR) for respiratory failure and sepsis of 142.0 for January 2021. This data reflects the impact of the second wave of the COVID pandemic.

Key areas for focus to achieve the overall goal

- Recognition, escalation and response to patients deteriorating from sepsis and respiratory failure by clinical teams
- Sepsis
- Embedding learning from harm incidents

Achievements over the last 30 days

- Ongoing plan-do-study-act cycles of improvements by frontline teams
- Clinical discussions about what a good Morbidity & Mortality meetings looks like with Specialty and Care Groups based on outcome of gap analysis
- Engagement with Children's team to review their process with sepsis

Ambition for the next 30 days

- A3 conference 16 June 2021
- Sepsis engagement workshop 20 May 2021
- Learning from Deaths workshop 27 May 2021
- Include Maternity as a specialty in the deteriorating patient work

Risks

There are no identified risks to delivery of this breakthrough objective at this point.

Risks are identified and managed through weekly driver meetings and where needed escalated at We Care Executive Management meetings.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

IPC: Total Infections

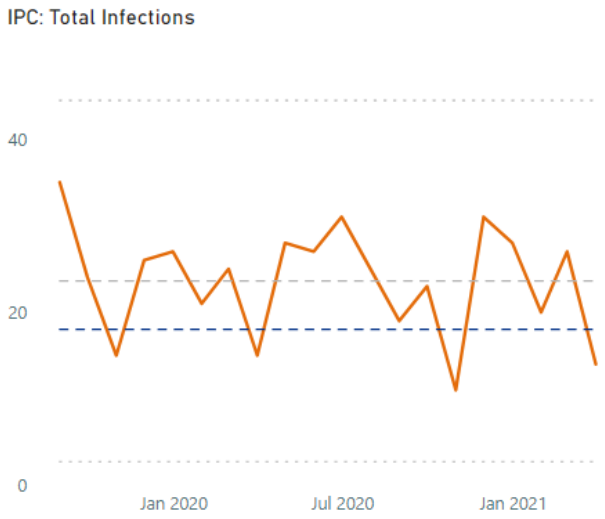
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
28	27	31	25	19	23	11	31	28	20	27	14

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	18
Value	Number
Improvement Direction	Lower is Better

D1 Driver is green for

Common cause (no significant change)

Variation indicates inconsistently passing and falling short of the target



Understand the data

"Healthcare associated infection" (HCAI) also known "nosocomial" or "hospital" infection is an infection occurring in a patient during the process of care in a hospital or other health care facility which was not present of incubating at the time of admission. This aggregate measure will be updated to include a count of the number of MSSA*, MRSA, C diff, MRSA, E coli*, Klebsiella species* (spp.) and Pseudomonas aeruginosa* cases.

*bloodstream infections only

We are driving this measure because....

Infection prevention control has been a focus of the organisation throughout 2020 and great strides have been made to improve performance across all sites.

It is important to continue the good work set in place during the global pandemic and apply learning to reduce all in hospital infections.

... | M_01142_IPC_Infections_Combined

Last Updated | 19/05/2021 10:18:00

Performance

Current Performance for total in-hospital infections is 14 in April, Performance has shown common cause variation over the last three months.

In the last month:

- The metric and threshold have been revised as described in the previous update
- Quality assurance of the data flow is in progress
- Wards at the QEQM site and KCH sites have completed their A3s and begun work on their countermeasures
- Front line teams have been invited to the weekly driver meetings now chaired by the DIPC
- The Pareto analysis has been changed to focus on the organisms with the greatest impact on the metric
- Further analysis will lead to wards at WHH being selected to join the breakthrough objective
- Antimicrobial stewardship team have completed A3 training and have been invited to the weekly driver meetings as above

Next month

- Active engagement in the weekly driver meeting by all parties
- Identification of further front line teams based on specific organisms (Cdiff in particular)

Risks

The Director of Infection Prevention and Control (DIPC) as Senior Responsible Officer (SRO) has reviewed the metric associated with this breakthrough objective and decided that it should include the other infections that are the subject of the national reduction ambition (Klebsiella species and Pseudomonas aeruginosa). This has required a recalculation of the threshold and performance which may cause some temporary uncertainty.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

ED - Aggregated Patient Delay

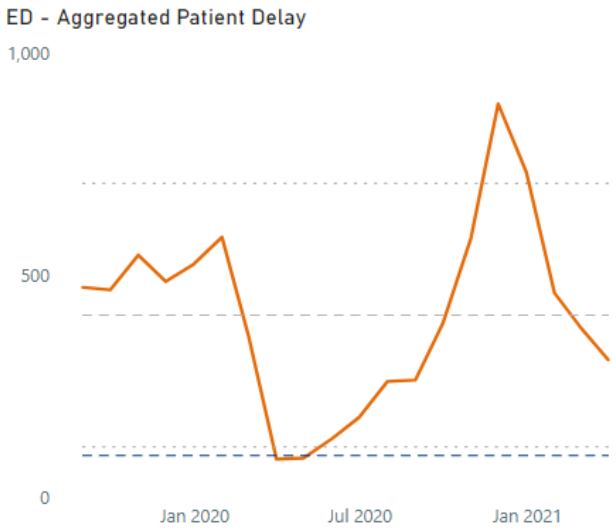
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
89	133	181	261	265	392	584	886	732	460	385	311

Domain	Our Patients
True North	ED Compliance
Metric Focus	Driver
Threshold	95
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

Common cause (no significant change)

F Variation indicates consistently falling short of the target



Understand the data

A&E performance is directly dependent on the number and flexibility of available admitted beds, the aggregated patient delay measure counts the amount of time patients who breached the 4 hour standard spent in A&E awaiting admission to an Acute Medical Unit, Medical or Surgical Bed.

We are driving this measure because....

Long waits across our Emergency Departments have been a challenge to the organisation for several years, thought to be driven by a lack of access to inpatient beds. Recent improvements in bed availability have shown improvements in compliance. Consolidating and building on these improvements and improving timely care within ED will continue to improve patient care and the compliance against this metric.

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.

Performance

Performance for April is an aggregated delay of 311 hours. Performance improvement of this metric is now in its third month running.

Key areas of focus for this breakthrough objective are;

- Emergency Portals
- Time in Hospital
- Discharge Process

Activities for the coming period include:

- Implementation of agreed metrics related to ED processes and development of escalation actions to ensure that patient care is delivered in a timely and safe way at all times.
- Continued implementation of new Same Day Emergency Care (SDEC) pathways and alignment across sites to quickly stream patients from ED to appropriate care locations
- Implementation of Urgent Treatment Centre (UTC) actions to improve the numbers of patients seen and reduce crowding in ED
- Focus on improving the accurate collection of criteria to reside data and how this can help timely discharge
- Implementation of a new hospital discharge policy with a focus on early discharges and use of the discharge lounge

Risks

Engagement with ED leadership to improve focus on metrics and escalation actions

Engagement with specialty teams to reduce the risk of delays in the ward discharge process and delays in ED to access a bed.

Increase in demand to ED beyond planned levels

... | M_00888_Agg_Delay

Last Updated | 17/05/2021 11:24:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

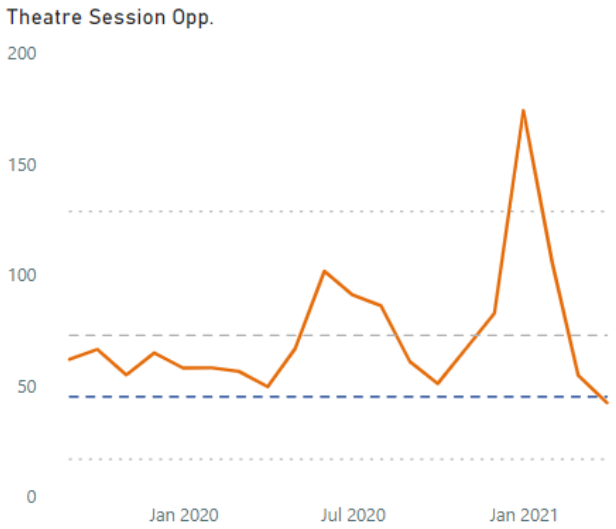
May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
67	102	91	86	61	51	67	83	174	106	55	42

Domain	Our Patients
True North	RTT - 18 Weeks
Metric Focus	Driver
Threshold	45
Value	Number
Improvement Direction	Lower is Better

D1 Driver is green for

Common cause (no significant change)

Variation indicates inconsistently passing and falling short of the target



Understand the data

Total excess minutes (represented as 4 hr theatre lists) associated with specified non operative events during scheduled theatre time.

Non Operative Events (Cancelled Sessions, Turn Around Times Exceeding 10 Minutes, On The Day Cancellations, Early Finishes Exceeding 45 Minutes, Late Starts Exceeding 15 Minutes)

Exclusions (Emergency Lists, Non Bookable Lists (e.g. Trauma), Sessions Cancelled Due to Audit / Bank Holiday, Sessions Cancelled in Specialised Theatres (e.g. Ophthalmic Suite / Buckland), Sessions where Total available Opportunity <60 Minutes

We are driving this measure because....

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.

Emerging from the second wave of COVID-19 it is imperative that deferred elective surgery 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.

... | M_00146_Theatres_Utilisation

Last Updated | 18/05/2021 09:31:00

Performance

Current Performance shows the equivalent of 42 sessions unused i.e. opportunity for April 2021. We have been displaying an improving performance for the last three months due to the national directive to recommence routine elective surgery, which is in line with our recovery plan. We are opening more theatres week on week in line with the recovery programme. Theatres continue to be allocated to the specialties delivering cancer and priority two (P2) surgery., but as more theatres come back on line we are now beginning to treat our long waiting patients.

Our investigations so far have led to three areas of focus for the coming month, booking processes, in session utilisation and staff cover to run our theatres 50 weeks per year. There is a Trust Priority Improvement Project (TPIP) that will focus on the availability of theatre sessions vs job planned activity.

Actions for next period continue to include review of booking processes to deliver six week advance booking of theatres as we move into our elective recovery programme (4R), Care Group root cause analysis on in session 'lost' time (eg late starts, early finishes) and creation of a rota system to optimise theatre allocation and booking. All patients cancelled on the day are reviewed to understand the reason for the cancellation, lessons learnt and how this may align with improving pre operative assessment processes.

Risks

3rd Wave of COVID could significantly impact on theatre utilisation if there is a directive to cease routine work.

Theatre staff recruitment has been challenging previously. This includes anaesthetic cover along with theatre personnel.

Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Harm Events			Nutrition Incidents	20	13	20	28	33
	W4		Optimal Cord Clamping <32w	85.0%	16.7%	71.4%	75.0%	0.0%

Performance

Harm Events

The main areas where incidents have been raised relating to nutrition during April remain delays in referring to specialist dietitians and Speech and Language Teams, provision of incorrect texture meals to patients with dysphagia (swallowing difficulties) and incomplete documentation of care for patients with Nasogastric feeding tubes. All incidents are shared with Care Groups and the Nutrition and Oral Hydration Steering Group. Additional support will be provided to ward teams once the Nutrition and Hydration Nursing Team have been recruited.

The Women's Health Care Group has selected optimal cord clamping as one of their focused improvement projects recognising there has been inconsistent performance in this area. The latest data represents a single case that was born rapidly within the triage area and optimal cord clamping was not applied. Continued work on countermeasures within the care group continues to focus actions to consistently deliver unless clinical reasons exist to preclude.

Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
RTT - 18 Weeks	W4		RTT 52w Breaches	2,586	3,613	4,632	5,232	4,942
	W4		DM01 Compliance	99.0%	64.7%	67.7%	73.6%	73.9%
			RTT 35w Undated	8,500	7,088	7,523	8,122	8,440
			RTT 1st OPA Booking Breaches	14,000	12,331	12,346	12,888	13,288
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	44.1%	42.5%	41.6%	39.1%
	W4		DTAs within 4hrs	600	777	1,137	1,326	1,420
	W4		Unplanned Re-attendance ED	10.0%	10.7%	10.5%	10.6%	10.3%
	W4		Super Stranded >21D	75	100	103	125	93
FFT	W4		FFT IP Response Rate	25.0%	16.6%	16.1%	17.3%	15.9%
			FFT ED Response Rate	12.0%	14.9%	14.6%	14.6%	14.5%
	W4		FFT Maternity Response Rate	18.0%	6.3%	5.5%	5.7%	4.8%
	W4		Complaint Response	90.0%	65.1%	77.1%	65.5%	77.8%

Performance

RTT 18 Weeks

All RTT measures are alerting due to the significant impact of the second Covid-19 wave on elective services. The Trust is focussed on rapidly increasing access to elective services in order and in line with the national elective recovery programme. Booking teams are focussed on dating patients with an urgent requirement for surgery and long waiting patients. The Trust has a positive OP and Endoscopy schedule which has helped reduce risk and ensure priority patients are supported.

ED Compliance

Work is underway with local system and regional partners to understand the increase in walk-in ED patients attending post lock down.

The unplanned reattendance rate is inflated due to planned returns not recorded accurately. Work has commenced to understand and improve data quality.

There is positive engagement with community colleagues to work closely to identify patients and address process delays impacting on discharge to community inpatient beds or services which aims to reduce the number of super stranded patients.

Friends & Family Test (FFT)

The Trust is working to improve FFT response rates across all settings and has observed a slight improvement across the board in March. Workstreams have been initiated to trouble shoot specific areas, particularly the low rates in Maternity. Whilst the ED response rate remains above the national average it was trending down below the mean which is causing the metric to alert.

Alerting Watch Metrics: Our People

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Staff Turnover Rate	W4		Staff Turnover: Nursing	10.0%	10.5%	10.6%	11.0%	11.7%
Staff Engagement	W4		Appraisals Compliance	85.0%	69.5%	68.8%	69.8%	70.0%
	W4		Mandatory Training	93.0%	90.3%	90.7%	91.1%	91.7%

Performance

Staff Turnover

Although overall turnover (9.6%) is below the True North target of 10%, nurse turnover remains higher and has increased significantly over the last 3 months. Work to address this links to both the national and regional approaches and focuses on key areas – generational (those coming in and those leaving), international recruitment, flexible working and key elements of the NHS People Plan (Wellbeing, EDI). There is also recognition that there could be further attrition due to the aftermath of the pandemic and a perceived 'lack of value' of the nursing profession.

Staff Engagement

Appraisal compliance is continuing to improve as the year progresses. Although this is an alerting metric rather than a driver, it continues to be a good indicator of staff engagement and personal development planning and more recently has also included wellbeing conversations and personal risk assessment reviews.

Although mandatory training compliance is improving it remains below the threshold and continues to be an important 'watch' at monthly Performance Review Meetings.

Alerting Watch Metrics: Our Future & Our Sustainability

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Financial Position			Premium Pay	18.6%	17.4%	17.5%	17.7%	
	W4		Non Pay	0.0%	-3.2%	-3.1%	-11.3%	
Carbon Footprint			CO2e Gas (tonnes/day)	38.19	37.43	37.65	29.12	
Med. Fit for Disch.	W4		MFFD: Spot Purchase	5.0	19.3	12.1	11.3	9.3
	W4		MFFD: Community Hospital	5.0	7.6	5.9	10.1	8.6
	W4		MFFD: Home With Support	5.0	7.6	7.6	10.3	9.4

Performance

Financial Position

The financial position watch metrics are alerting because pay and non-pay are up on the expected position or have shown a deteriorating position . This increase has been driven by
the Covid-19 response costs and have therefore been funded centrally but needs careful oversight during 21/22. The metrics for April are delayed whilst the targets are amended in line with the latest planning guidance. At M1 the overall position is a £0.5m deficit against a breakeven plan.

Carbon Footprint

Gas tonnage per day has breached the upper control limit in February 2021 and is therefore alerting this month. It is likely that usage will remain high into March due to seasonal variation and return back within the control limits as we move into the later part of spring.

Medically Fit for Discharge

The number of patients MFFD is alerting due to seven consecutive monthly data points above the threshold. This is being addressed and closely monitored through the 'Criteria to Reside' implementation to improve compliance throughout the Trust.

Appendix 1: Non-Alerting Watch Metrics

NHS
East Kent
Hospitals University
NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Covid-19 HCAI	1	112	95	53	1
	W		Medication Errors	90	54	62	60	49
	W		Pressure Ulcers: Cat 1 & 2	200	169	153	178	203
	W		Pressure Ulcers: Cat 3 & 4	40	25	19	30	35
	W		IPC: Audits Composite	80.0%	86.4%	85.6%	87.5%	87.0%
	W		VTE Assessment Compliance	90.0%	93.3%	93.6%	93.8%	93.1%
	W		Safeguarding Incidents	20	8	7	12	26
	W		IP Spells with 3+ Ward Moves	500	452	419	541	530
Mortality	W		Extended Perinatal Mortality	6.35	12.87	7.05	6.78	2.62
Cancer 62d	W		Cancer 2ww Performance	93.0%	98.3%	98.1%	98.8%	98.0%
	W		Cancer 31d Performance	96.0%	97.3%	98.4%	94.1%	98.4%
	W		Cancer 28d Performance	75.0%	59.4%	73.6%	79.7%	72.3%
	W		Radiology Diags vs Plan	Traj.	13,276	13,061	15,470	15,781
	W		Endoscopy vs Plan	Traj.	983	896	1,119	1,031
RTT - 18 Weeks	W		Referrals vs Plan	Traj.	34,630	36,970	48,098	42,464
	W		OPA vs Plan	Traj.	61,667	63,171	81,691	71,663
	W		Elective Admissions vs Plan	Traj.	3,223	3,298	4,604	4,474

Appendix 1: Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jan-21	Feb-21	Mar-21	Apr-21
ED Compliance	W		ED Non-Admitted Compliance	90.0%	84.7%	89.7%	91.2%	90.0%
	W		Ref to Spec 2.5h	40.0%	43.2%	45.0%	45.0%	43.3%
	W		A&E Atts vs Plan	Traj.	13,905	14,407	18,872	20,527
	W		Discharges by Midday	15.0%	17.4%	18.0%	17.7%	18.3%
	W		NEL Admissions vs Plan	Traj.	5,003	5,316	6,602	6,819
	W		NEL Readmissions	15.0%	11.3%	10.7%	12.3%	12.2%
	W		Stroke Ward within 4 Hours	50.0%	57.1%	58.4%	55.3%	57.1%
FFT	W		FFT DC Response Rate	30.0%	37.1%	33.2%	33.9%	32.4%
	W		FFT OP Response Rate	20.0%	20.2%	19.5%	19.2%	17.2%
	W		Complaints	100	60	60	65	63
	W		PALS Enquiries	550	493	447	599	507
Staff Turnover Rate	W		Vacancy Rate	9.0%	6.6%	6.4%	6.3%	6.5%
	W		Staff Turnover: HCA	13.5%	10.9%	11.6%	11.1%	10.6%
	W		Premature Turnover Rate	25.0%	20.8%	20.4%	20.1%	20.3%
Staff Engagement	W		Sickness	5.0%	6.3%	4.2%	3.5%	
	W		Safeguarding Children Training	85.0%	85.5%	86.8%	86.0%	90.7%
Financial Position	W		Total Pay	0.0%	0.5%	1.7%	0.2%	
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.21	0.21	0.22	
	W		CO2e Electricity (tonnes/day)	18.00	17.44	17.31	16.61	
	W		CO2e Water (tonnes/day)	0.55	0.56	0.52	0.48	
Med. Fit for Disch.	W		MFFD: Assessment	5.0	3.7	1.3	0.7	1.1
Innovation	W		Virtual OP Appts - First	25.0%	53.1%	54.5%	49.0%	44.9%
	W		Virtual OP Appts - Follow Up	60.0%	69.0%	67.8%	62.2%	55.7%

Appendix 2: Glossary of Terms

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 2: Glossary of Terms

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 2: 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.