NHS
East Kent Hospitals University
NHS Foundation Trust

Integrated Performance Report

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

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

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

What is the Integrated Performance Report (IPR)?

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

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

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

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

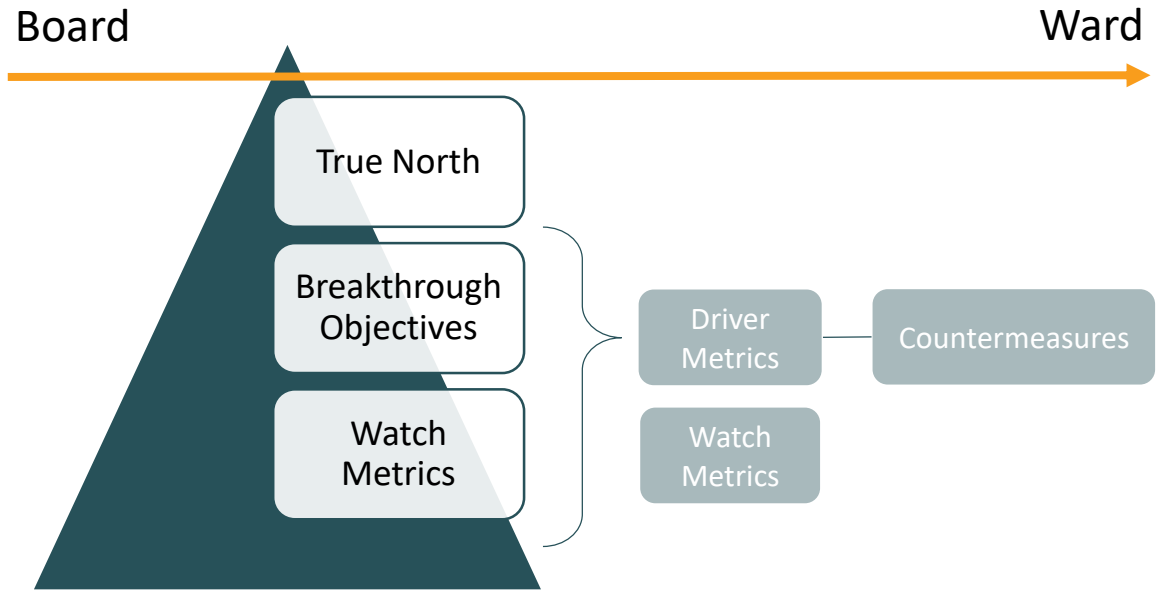
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

Integrated Performance Report

IPR

Performance Review Meetings

PRM



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

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

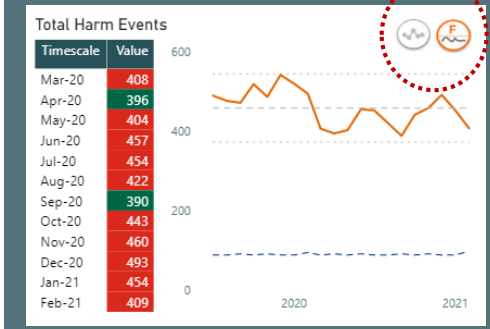
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (ie no significant change.

NHS Improvement SPC icons

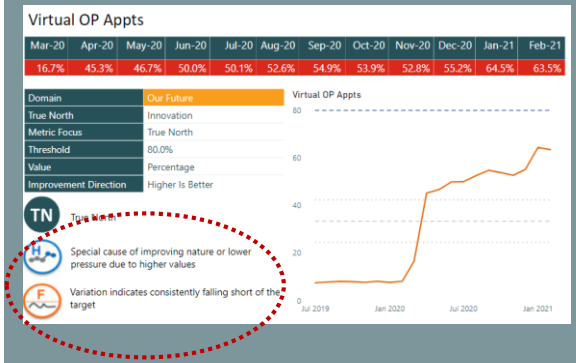
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling 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?

East Kent Hospitals University NHS Foundation Trust

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

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

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

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

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

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

East Kent Hospitals University NHS Foundation Trust

Our Quality & Safety

Sarah Shingler

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;

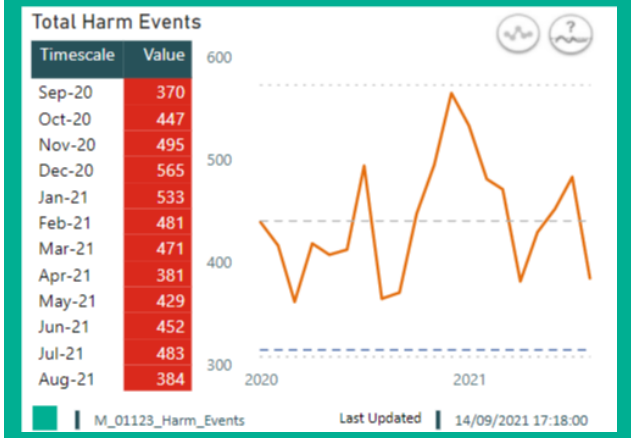
- Falls
- Pressure Ulcers
- C Difficile (in-hospital)
- E.Coli (in-hospital)
- Covid Infections (in-hospital)
- Nutrition Incidents
- Medication Errors

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.

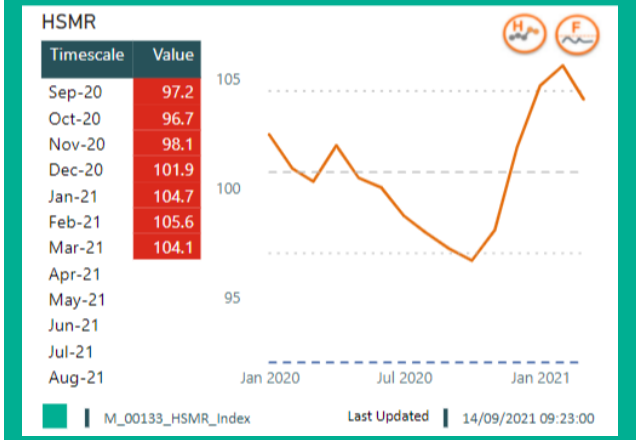
Mortality (HSMR)
Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in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



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



Executive Summary

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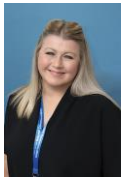
Our Patients

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.

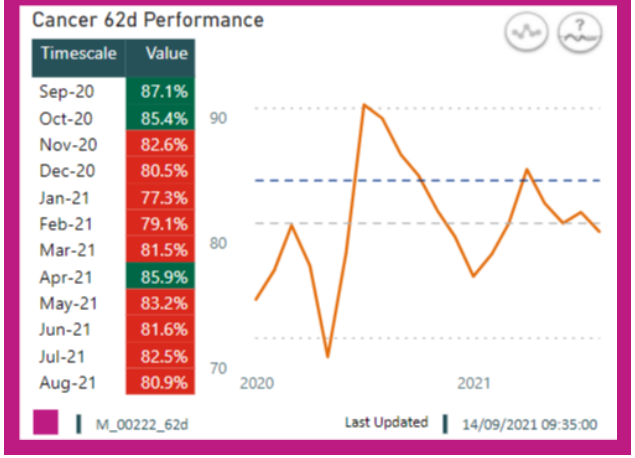


Sarah Shingler

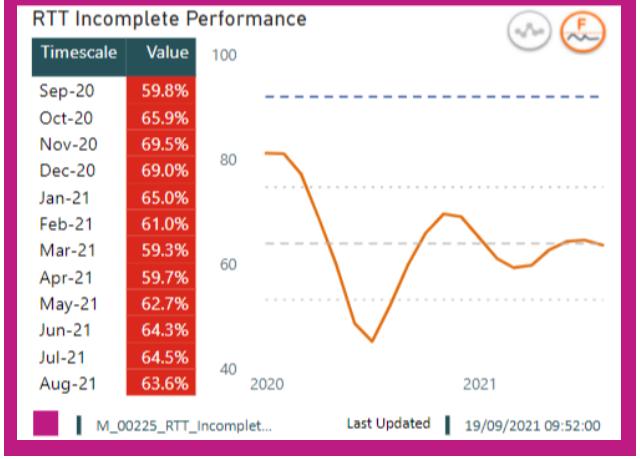
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

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.

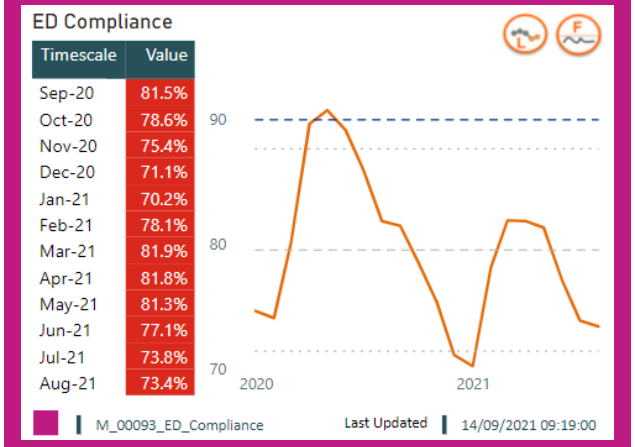
Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.



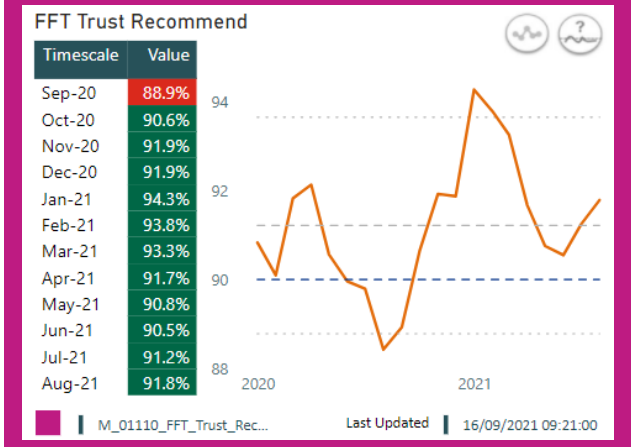
RTT: 18 Week Compliance
To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.



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



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



Executive Summary

East Kent Hospitals University NHS Foundation Trust

Our People

Andrea Ashman

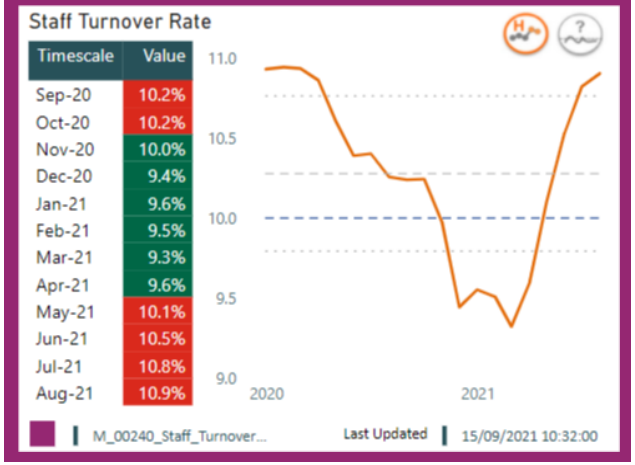
Staff Turnover (rate)
The annual turnover rate provides us with a high-level overview of Trust health.

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.

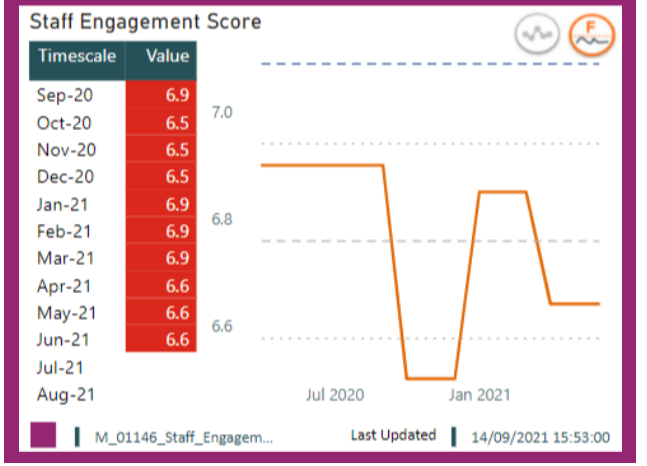
Staff Engagement (score)
Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention.

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



Executive Summary

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.

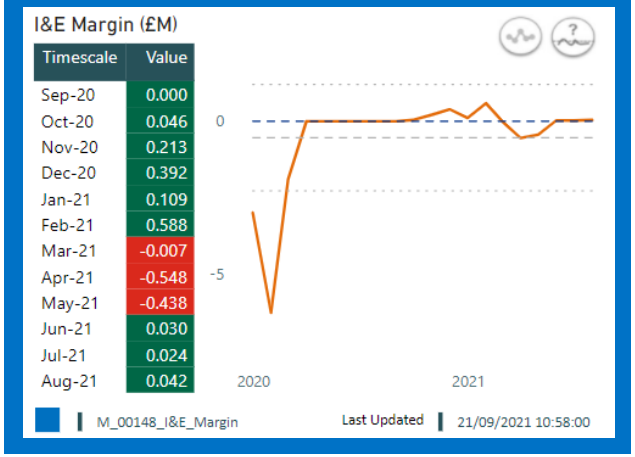
The Trust's carbon emissions are made up of:

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

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

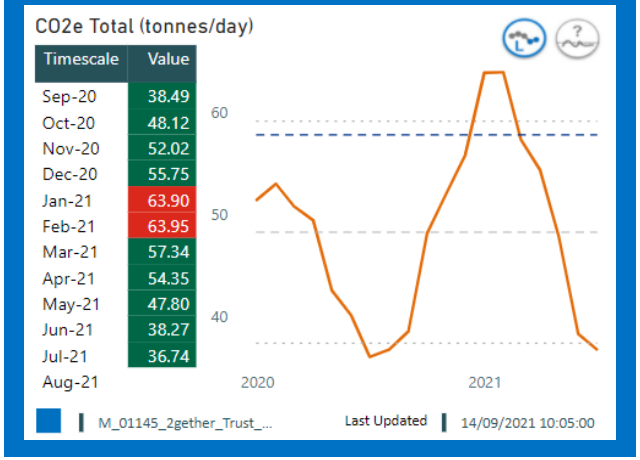
Financial Position

To achieve and sustain a break even financial position.



Carbon Footprint

To achieve an organisational carbon neutral footprint.



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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.

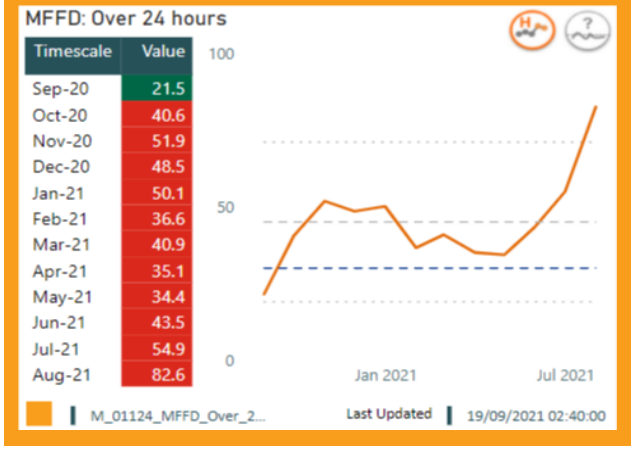
Unnecessary bed stays can negatively affect patient experience. In addition prolonged stays in hospital (especially for those who are frail or elderly) can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning.

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'.

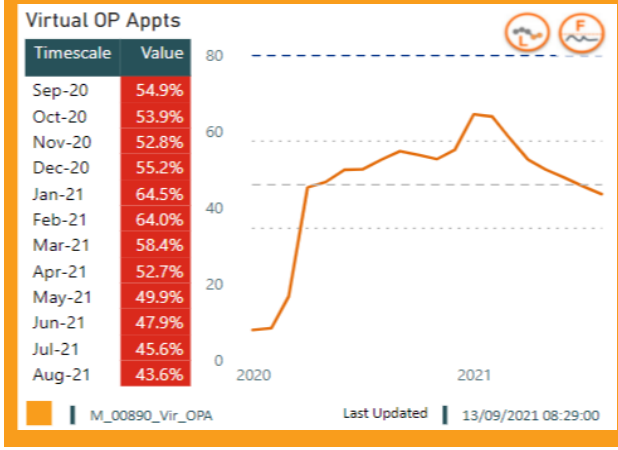
Innovation (Virtual OP Apps)
The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process.

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.



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



2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Falls

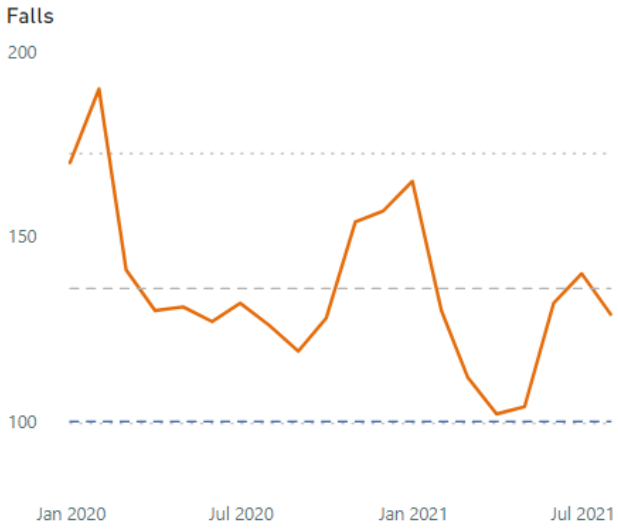
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
119	128	154	157	165	130	112	102	104	132	140	129

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

Driver is red for 2

Common cause (no significant change)

Variation indicates inconsistently passing and 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 | 14/09/2021 08:05:00

Performance

Current Performance: 129 falls recorded in August 2021. The majority of the current wards involved in We Care Falls, show a sustained improvement. 2 of the initial wards still have opportunity to improve, and are receiving additional support from the BO team. For example: AMU QEQM have made several changes which should show as significant reduction in numbers of falls in future: implementation of Falls risk packs and post fall packs; successful AMU recruitment of RMs and HCAs (with reduction in agency staffing); early identification of high risk patients (nurse in charge phone, green magnets on whiteboards); implementation of purple arm bands; In bay nursing ('No Cals in corridors'); Band 6's and HCA's now involved in investigating datixes (allowing learning to penetrate to shop floor).
Most wards now have falls link workers identified and training to support is being developed.
Key areas of focus for this breakthrough objective are:

- Improved ward level visibility/focus on falls reduction/ harm.
- Standardised reporting of falls on Datix across EKUHFT.

Key achievements include:

- Ward level A3 development with targeted RCA and focused actions.
- Shared learning/improvements at the Falls driver meetings.
- Falls dashboard co-design and development with accessible ward level data.
- MDT approach falls review: use of a falls decision tool; set up of a multi-professional falls/PU panel supporting the SI process.
- Development of self directed driver meetings and breakaway groups: SRO co-chairing with surgical/medical matrons.
- Improvements driven through PDSA cycles: e.g. Yellow blanket trial; Falls ward boxes

Risks

Risk of inability to bring new teams into the BO due to training capacity within the 'Centre of Excellence' team, and capacity for some wards to undertake We Care Falls work and training due to on-going commitment to other We Care projects and current intensity of Business as Usual.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Composite HSMR: Sepsis/Resp

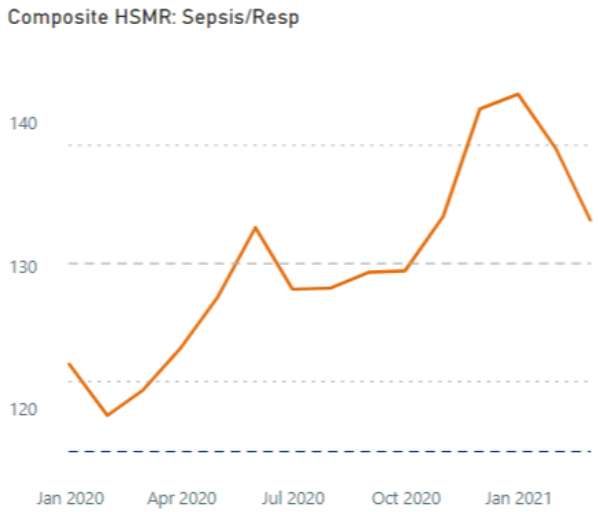
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
129.6	129.7	133.5	141.0	142.0	138.2	133.2					

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 | 14/09/2021 09:23:00

Performance

Due to delays experienced with our service provider, Dr Foster, the Trust has not received an updated HSMR for 3 consecutive months. This is being worked through and we hope to receive an update to months 1 & 2 in time for publication of the next IPR.

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

- Sepsis care bundle implemented on electronic patient record
- End of Life strategy in progress

Ambition for the next 30 days

- Focus on mortality in Surgery & Anaesthetics Care Group
- Confirm End of Life strategy
- Improve compliance with Treatment Escalation plans

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

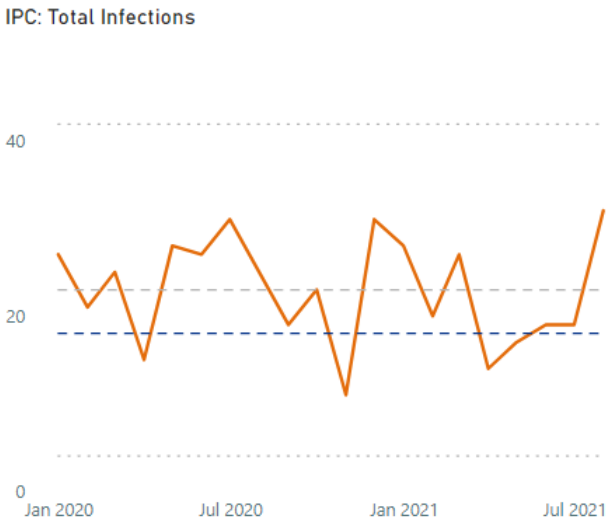
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
19	23	11	31	28	20	27	14	17	19	19	32

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

D2 Driver is red for 2

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 | 14/09/2021 17:16:00

Performance

Current Performance for total in-hospital infections is 32 in August, which is a significant in month deterioration across several of the organisms that make up the metric. August was a challenging month operationally and this may have had some impact. Performance has shown common cause variation over the last three months.

In the last month:

- All new front line teams (n = 6 additional) have been identified and recruited and are accessing We Care training.
    - QE – St Augustine's
    - WHH – Camb. J2 and L, Kings A2, B and C1
- AMS team have completed Gemba in ED and engaged with clinical team
- Identified where Co-Amoxiclav is used, focus on prepacks from majors – pilot study being developed with ED consultant for prescriber-led improvement project
- DIPC has visited all wards involved (new and existing) and conducted Gemba visits

Next month

- Training booked for 5/6 new front line teams (all during September 2021)
- Restart driver meetings from w/c 20/09/2021, IPC team to visit wards weekly (DIPC and others) to support engagement

Risks

The Pareto analysis suggests that the infections that contribute to the metric are distributed, rather than concentrated. This creates a risk that the (worthwhile and important) activities of the front line teams may have a limited impact on the metric unless there are considerably more front line teams engaged.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

ED - Aggregated Patient Delay

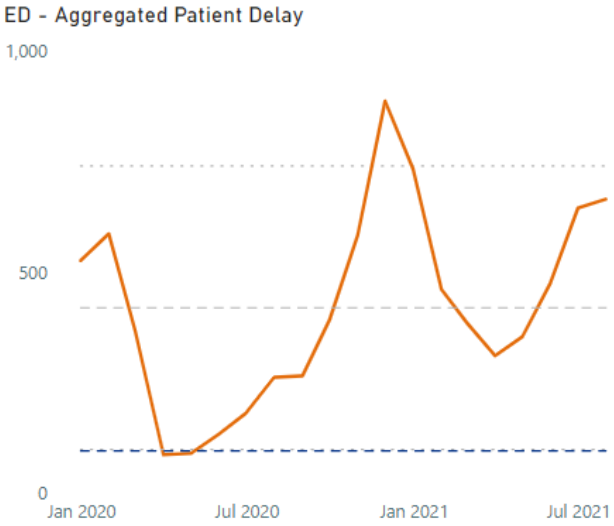
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
265	392	584	886	732	460	385	311	353	475	644	664

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

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

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 August is an aggregated delay of 664 hours. Performance improvement of this metric has fallen.

- Emergency demand remained high and in line with July levels at both WHH and QEQM.
- Simple discharges rose again in August, by 4.6% at WHH and 3.5% at QEQM. A drive to discharge patients earlier in the day has led to an overall Trust improvement of 1.1% for patients discharged before 10am.
- Complex discharges have reduced by 3.6% overall but with a significant reduction of 8.8% at WHH. QEQM has maintained previous months performance and K&C has seen a significant increase in the number of complex discharges.
- The numbers of stranded and super-stranded patients has increased in month to the highest levels seen in this financial year, 130 and 37 respectively.

Key areas of focus for this breakthrough objective are continued within the Emergency Patient Flow A3. Particular focus in relation to the present situation:

- Focus on streaming patients to UTC and SDEC pathways to decompress ED
- Protecting assessment space to ensure flow for non admitted patients
- Improvements in time of day for discharges both simple and complex
- Working with system partners and commissioners to reduce delay for patients ready to leave hospital through accessing current unused capacity and commissioning of pathway 1 resources

Risks

- Pathway 1 access for patients leaving hospital
- Staffing challenges in ED and in ward areas
- Continued issues with access to post-acute care capacity fails to meet demand.

... | M_00888_Agg_Delay

Last Updated | 14/09/2021 11:24:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

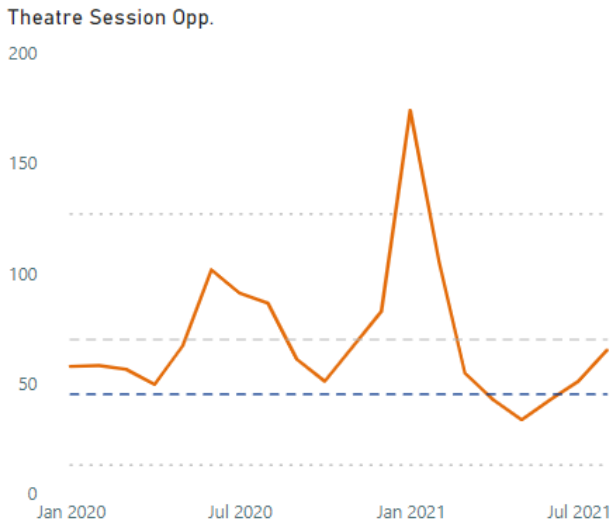
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
61	51	67	83	174	106	55	42	33	43	51	65

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

D2 Driver is red for 2

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 | 21/09/2021 09:20:00

Performance

Current Performance shows the equivalent of 65 sessions per week of theatre time unutilised for August 2021.. We had been displaying an improving performance however we have exceeded the threshold for July and August and this has been due to a number of factors including staff sickness in theatres, non elective demand for beds and annual leave. This months data has shown that the greatest opportunity is from cancelled sessions as a consequence of the factors highlighted above and nearly 43% of the opportunities are within the S&A care group (Trauma and Orthopaedics and General Surgery) . This is due to theatre staff being reallocated to support urgent and cancer theatre lists.

We are still not in a position to establish a robust 6-4-2 process, however we have an established forward booking/utilisation meeting. Channel Day Surgery staff have attended the KENT fundamentals training and are developing an A3 to support improving late starts.

Our focus for the next 3 months include:

- support ongoing recruitment into vacancies and manage current high levels of sickness
- Re establish the theatre driver meetings
- Interim theatre improvement lead to attend driver meetings and ensure alignment between We Care and Four Eyes Improvement Plan
- Focus on Ophthalmology booking and theatre utilisation as part of the Theatre Booking and Scheduling A3

Risks

Theatre staff recruitment has been challenging previously and remains a significant risk within the organisation. There is a national shortage/ increased demand for theatre staff to support elective recovery. This includes anaesthetic cover along with theatre personnel.

Winter pressures and demand on beds could impact the ability to maximise inpatient surgery.

Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	May-21	Jun-21	Jul-21	Aug-21
Harm Events			Nutrition Incidents	60	63	68	73	48
			VTE Assessment Compliance	90.0%	92.8%	91.4%	90.3%	89.1%
	W4		IP Spells with 3+ Ward Moves	500	521	539	554	505
	W4		Serious Incidents	18	19	27	41	28
			Maternity Serious Incidents	2	3	5	1	4

Performance

Serious Incidents

The number of SI's has decreased from last month, although the high shift vacancies and skills mix on wards will continue to impact the number of incidents the Trust experiences. Other metrics will play a role, as there was an increase in Falls, and there have been incidents declared for medication errors and issues resulting from the increased number of complex CAMHS patients. This month has also seen several missed diagnosis, delayed referrals or missed follow ups that have been declared, such as a missed diagnosis of a mass, delayed cataract assessment and missed Anti-D provisions. A small number of SI's have been declared due to the second review panel for SJRs now meeting regularly.

Maternity Serious Incidents

Maternity SIs increased in August. The 4 cases involved include an SI that occurred in July but uploaded on STEIS in August. The other 3 cases – key learning includes failure to escalate, CTG interpretation, delay in administration of Anti-D. Failure to review clinical notes and the themes to date continue as: poor escalation , poor documentation, failure to recognise deterioration eg. Foetal heart monitoring, All of the root causes and key issues are included within the Maternity Improvement plans.

Alerting Watch Metrics: Our Patients

True North Domain	Type	BO	KPI	Thres.	May-21	Jun-21	Jul-21	Aug-21
Cancer 62d	W4		Cancer 28d Performance	75.0%	73.6%	72.6%	72.1%	69.9%
RTT - 18 Weeks	W4		RTT 52w Breaches	2,586	4,521	4,270	4,317	4,430
			DM01 Compliance	75.0%	75.2%	75.2%	72.1%	70.3%
	W4		RTT 35w Undated	8,500	8,881	9,412	9,872	9,970
			RTT 1st OPA Booking Breaches	14,000	13,608	13,904	15,033	15,904
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	36.6%	35.2%	36.0%	34.0%
	W4		DTAs within 4hrs	600	1,467	1,210	1,102	985
	W4		ED Non-Admitted Compliance	90.0%	89.1%	85.4%	83.2%	82.4%
	W4		Super Stranded >21D	75	80	98	105	139
			Discharges by Midday	15.0%	17.4%	17.1%	16.8%	16.1%
FFT			FFT IP Response Rate	15.0%	16.1%	15.8%	16.1%	15.2%
			FFT ED Response Rate	12.0%	13.8%	13.3%	13.2%	13.7%
	W4		FFT Maternity Response Rate	18.0%	5.8%	4.8%	3.5%	4.8%
	W4		Complaint Response	90.0%	74.2%	71.7%	80.3%	70.7%

Performance

Cancer

Deterioration in Cancer 28d Performance is due to 2 main reasons; Patient choice breaches have risen to 12% from an avg of 5%. Referral numbers are now returning to spring '21 levels however it will take time to work through the backlog of high referrals during the summer months.

An increase in Urology breach numbers due to delays with MRI and LATP Biopsies in Q2 and consistently high 2ww referrals since January, peaking in July.

RTT 18 Weeks

Unfortunately we have seen a drop in RTT performance of 1% in August – 63.6%. This has been due predominantly due to staff shortages and annual leave and therefore a reduction in activity. We have seen a further increase in the number of patients waiting over 52 weeks , 4,430 , and this is due to limited theatre capacity and patient choice.

A weekly meeting is in place, chaired by the COO, to review all patients waiting over 100 weeks, to ensure there are robust plans in place for each patient. A trajectory is in place to ensure we have no 104 weeks waiting patients by December 2021.

Clinical and administrative validation of the waiting list continues.

ED Compliance

Both ED's have seen a continued increase in the acuity of patients attending. Although the number of attendances have decreased from 22,616 to 21,959 due to the pressures on beds and staffing clinical and operational staff have worked hard to maintain the level of performance. There have been days in August when there has been over 400 attendances to WHH and 350 to QEQMH.

'0' length of stay cases through SDEC (Same Day Emergency Care) continue to exponentially grow due to the levels of activity being treated through the Assessment Units as part of our improvement plans.

EKHUFT and community providers have reported an increased number of patients who no longer fit the 'Criteria to Reside' to stay in Hospital being delayed. The impact of this lack of capacity is patients staying as inpatients in acute beds and reduced patient flow through the Hospital for new emergency admissions.

Alerting Watch Metrics: Our People, Our Future & Our Sustainability

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	May-21	Jun-21	Jul-21	Aug-21
Staff Turnover Rate			Vacancy Rate	9.0%	8.5%	8.8%	8.8%	9.0%
	W4		Staff Turnover: Nursing	10.0%	12.0%	12.0%	12.1%	11.9%
Med. Fit for Disch.	W4		MFFD: Spot Purchase	5.0	10.4	9.3	12.9	19.1
	W4		MFFD: Community Hospital	5.0	5.6	9.6	7.0	8.4
	W4		MFFD: Home With Support	5.0	10.1	15.5	21.1	35.3
Innovation	W4		Virtual OP Appts - Follow Up	60.0%	53.1%	49.9%	48.5%	46.7%

Performance

Vacancy Rate

The staffing establishment has increased significantly in the last 2 years with further increases identified via business planning.

Recruitment is increasingly challenging demonstrated in metrics such as the extension in time to hire. Increased use of international recruitment adds further complexity incurring management of additional legal considerations. Accordingly, a business case has been developed for investment in Recruitment, which is progressing through the appropriate Trust committees for approval.

Staff Turnover

Average Total Turnover is now above the True North target (10%) at 10.9%. following an artificial position of low turnover during the pandemic. Specifically, nursing turnover stands at 11.9% and has been above the desired threshold (10%) for 11 of the last 12 months. Recent rises have plateaued, with comparable rates across each of the last 4 months and a promising, small reduction in August.

Premature turnover has improved significantly throughout the last 12 months and remains stable at the gold standard 20%.

Med Fit for Discharge

The number of MFFD patients has risen to the highest level since the start of Covid-19. The major contributing factors to delays are patients waiting for spot purchased placements; community hospital beds; and going home with support accounting for 75% of all delays. Home with support in particular is driving the most recent increases, growing from 10 in May to 35 patients in August. KCHFT has approx. 100 patients also awaiting home with support. The We Care methodology indicates an increase in efficiency or capacity in this pathway is urgently needed. The East Kent COOs are meeting in early October to discuss this deteriorating position and agree a way forward but particularly to discuss if this is the right metric to measure the strength of partnership working in the system.

Innovation

Virtual outpatient performance has reduced for the fifth consecutive month. This is due to the reintroduction of face to face clinics post wave two of the pandemic. A review of the biggest volume specialty areas is being undertaken to ensure where clinically appropriate virtual appointments are being maintained. It is recommended that the position is allowed to normalise in relation to the elective restart following which a threshold review will take place to ensure the position is being “watched” rather than “driven”.

Appendix 1
Non-Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	May-21	Jun-21	Jul-21	Aug-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Covid-19 HCAI	1	0	0	2	6
	W		Medication Errors; All	110	214	204	207	142
	W		Medication Errors; Severity C+	1	3	0	3	1
	W		Pressure Ulcers: Cat 2	32	24	29	32	24
	W		Pressure Ulcers: Cat 3 & 4	3	1	0	1	0
	W		Pressure Ulcers: DTI	10	6	6	7	12
	W		Pressure Ulcers: Unstageable	10	6	5	12	5
	W		IPC: Audits Composite	80.0%	87.2%	88.0%	87.5%	85.4%
	W		Safeguarding Incidents	20	12	21	15	31
	W		Clinical Incidents	2,500	1,695	1,859	1,781	1,562
	W		Never Events	0	1	0	0	0
Mortality	W		Extended Perinatal Mortality	6.35	5.09	5.87	7.63	6.21

Appendix 1
Non-Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	May-21	Jun-21	Jul-21	Aug-21
Cancer 62d	W		Cancer 2ww Performance	93.0%	98.1%	97.8%	98.1%	97.9%
	W		Cancer 31d Performance	96.0%	97.4%	98.6%	99.2%	97.4%
	W		Radiology Diags vs Plan	Traj.	16,637	15,929	16,8...	16,150
	W		Endoscopy vs Plan	Traj.	1,313	1,149	1,230	1,277
RTT - 18 Weeks	W		OPA vs Plan	Traj.	76,381	83,712	79,2...	72,480
	W		Elective Admissions vs Plan	Traj.	5,172	5,525	5,654	5,329
ED Compliance	W		Ref to Spec 2.5h	40.0%	43.4%	39.6%	39.2%	36.4%
	W		A&E Atts vs Plan	Traj.	22,958	23,247	22,6...	21,973
	W		Unplanned Re-attendance ED	10.0%	10.1%	10.0%	6.5%	9.5%
	W		NEL Admissions vs Plan	Traj.	7,378	7,095	7,121	6,573
	W		NEL Readmissions	15.0%	12.1%	11.6%	11.7%	11.5%
	W		Stroke Ward within 4 Hours	50.0%	38.8%	54.4%	45.0%	43.7%
FFT	W		FFT DC Response Rate	27.0%	27.8%	26.5%	26.0%	25.3%
	W		FFT OP Response Rate	17.0%	17.7%	17.1%	17.4%	17.0%
	W		Complaints	100	72	89	86	90
	W		PALS Enquiries	550	468	530	545	537

Appendix 1
Non-Alerting Watch Metrics: Our People, Future & Sustainability

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	May-21	Jun-21	Jul-21	Aug-21
Staff Turnover Rate	W		Staff Turnover: HCA	13.5%	11.6%	11.7%	12.1%	12.0%
	W		Premature Turnover Rate	25.0%	20.2%	20.2%	20.1%	20.1%
Staff Engagement	W		Sickness	5.0%	3.7%	3.7%	4.1%	
	W		Appraisals Compliance	73.0%	74.8%	74.0%	72.7%	72.6%
	W		Statutory Training	91.0%	92.1%	92.8%	92.4%	91.9%
	W		Safeguarding Children Training	85.0%	91.2%	92.3%	92.5%	91.6%
Financial Position	W		Total Pay	0.0%	-1.0%	0.5%	0.5%	0.3%
	W		Premium Pay	Traj.	7,396	5,768	7,134	7,351
	W		Non Pay	0.0%	3.8%	1.9%	3.3%	2.2%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.20	0.21	0.21	
	W		CO2e Gas (tonnes/day)	38.19	22.60	13.32	12.25	
	W		CO2e Electricity (tonnes/day)	18.00	14.41	15.16	16.28	
	W		CO2e Water (tonnes/day)	0.55	0.20	0.21	0.22	
	W		CO2e Steam (tonnes/day)	9.21	10.39	9.37	7.79	
Med. Fit for Disch.	W		MFFD: Assessment	5.0	1.7	1.8	1.6	2.0
Innovation	W		Virtual OP Appts - First	25.0%	42.4%	43.2%	38.9%	36.3%

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.