NHS
East Kent
Hospitals University
NHS Foundation Trust

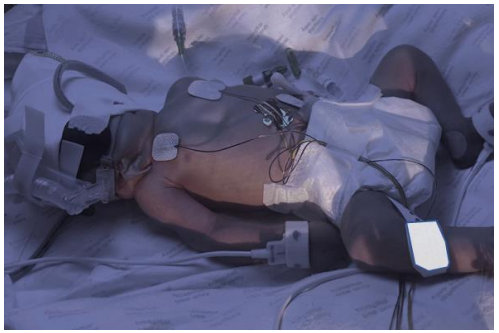
Integrated Performance Report

September 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.

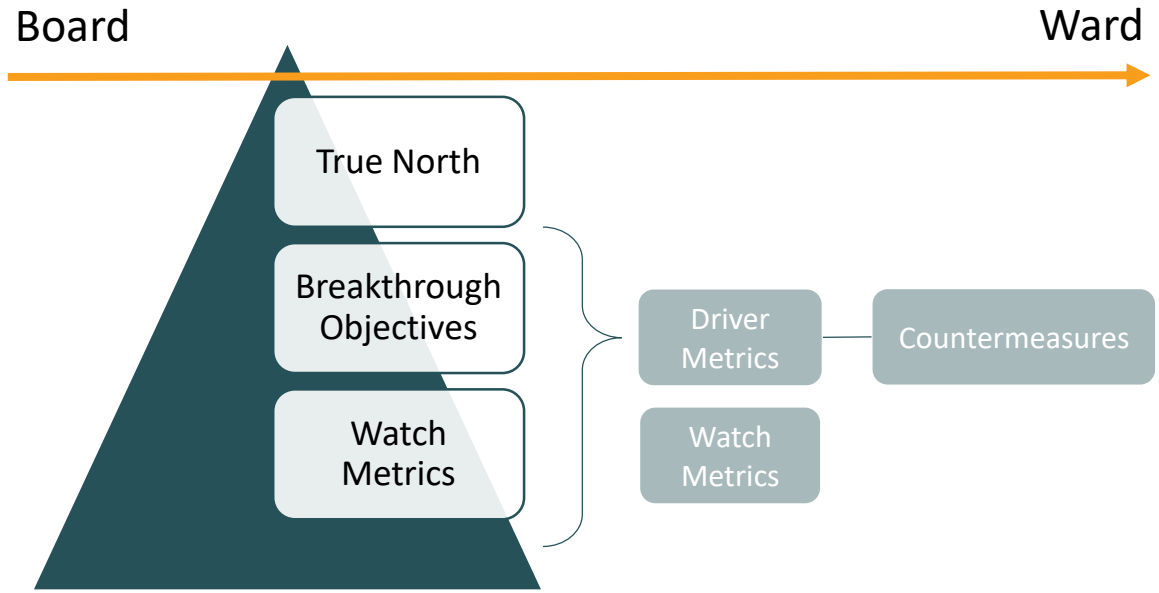
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

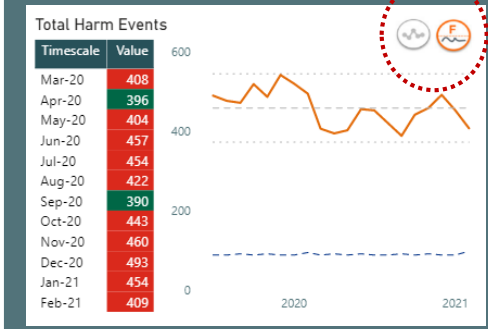
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

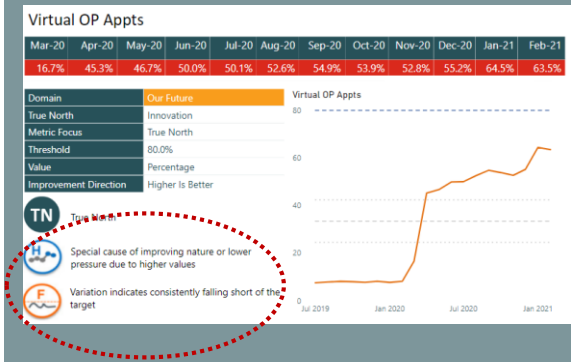
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them

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)

Executive Summary

East Kent Hospitals University NHS Foundation Trust

Our Quality & Safety

Rebecca Martin

Sarah Shingler

Neil Wigglesworth

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.

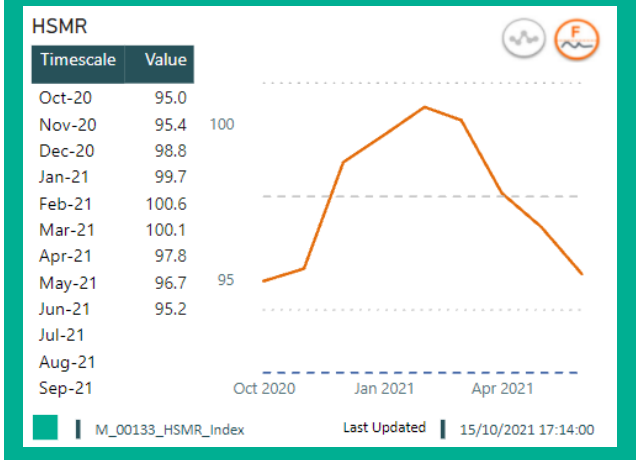
Our aim is to reduce mortality and be in the top 10% of all Trusts for the lowest mortality rates in 5 to 10 years.

Incidents Potentially Contributing to Harm
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;

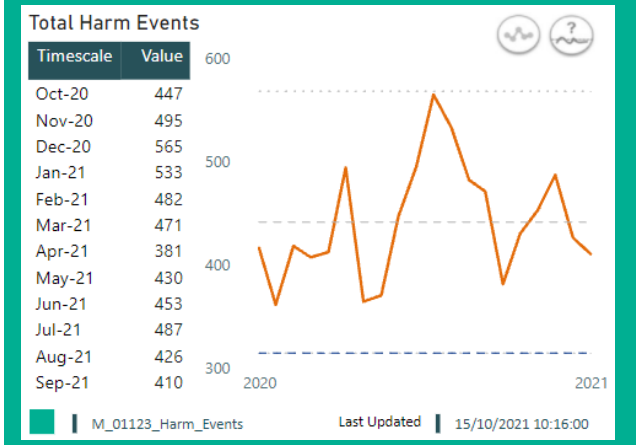
- Falls
- Pressure Ulcers
- C Difficile (in-hospital)
- E.Coli (in-hospital)
- Covid Infections (in-hospital)
- Nutrition Incidents
- Medication Errors

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.

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



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



2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Composite HSMR: Sepsis/Resp

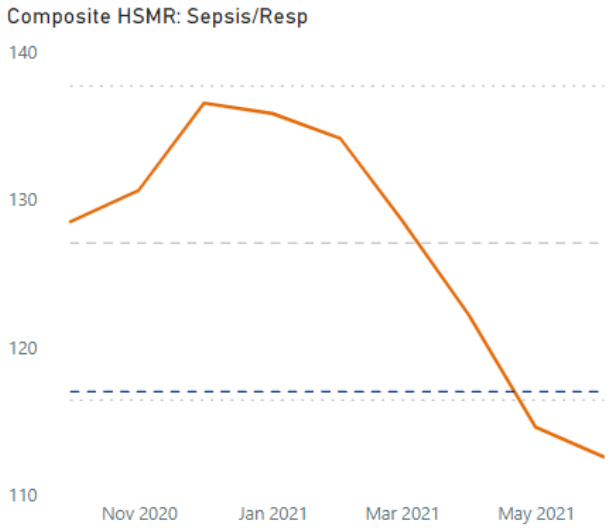
Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
128.5	130.6	136.6	135.8	134.2	128.6	122.1	114.6	112.6			

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

D1 Driver is green for

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

Variation indicates inconsistently passing and 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 | 15/10/2021 17:14:00

Performance

The Trust has now received data from Dr Foster which has brought the data up-to-date with an in-built 3 month lag. Data demonstrates that this metric is now at 112.6 below the threshold of 117.

Key areas for focus to achieve the overall goal

- Recognition, escalation and response to patients deteriorating from sepsis and respiratory failure by clinical teams
- Treatment escalation plans (as a proxy of sound clinical decision-making)
- Addressing excess mortality in patients with hip fractures
- Embedding learning from harm incidents

Achievements over the last 30 days

- Focused work with 2 frontline teams have achieved improvements in early stages of Plan-Do-Study-Act
- Clinical governance recommendations made to streamline Deteriorating Patient panel and Resuscitation Committee with the Breakthrough objective driver meeting; implementation strategy ready to proceed
- Mortality in hip fracture A3 completed with multi-disciplinary support

Ambition for the next 30 days

- Confirm the metrics to be included in data packs for frontline teams that will represent clinical representation of this breakthrough objective
- Implement the clinical governance changes to align expert groups with breakthrough objective

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

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Falls

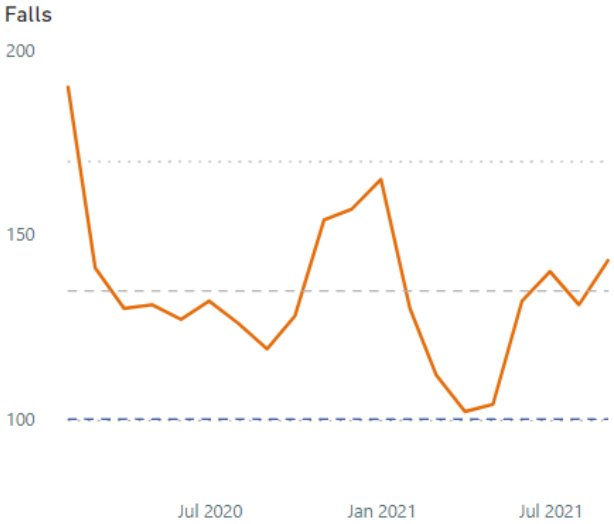
Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
128	154	157	165	130	112	102	104	132	140	131	143

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 | 14/10/2021 08:04:00

Performance

Current Performance: 143 falls recorded in September 2021. The majority of the current wards involved in We Care Falls, show a sustained improvement. Kings C2 has now moved falls to a watch metric having sustainably reduced falls according to the We Care business rules. An additional 6 areas have been identified from data as the current highest contributors to falls. These have been invited to join the driver group and are undertaking training.

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.

Key achievements include:

- development of A3s at ward level with targeted understanding of root 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.
- Several PDSA projects underway e.g. Yellow blanket trial; Falls ward boxes; Standardised High risk of falls Medication lists.

Risks

Risk of failure to make further improvements and reach threshold target without commitment and involvement of additional wards in the We Care Falls project.
Risk of lack of capacity for some wards to undertake We Care Falls work due to on-going commitment to other We Care projects. Mitigation is through escalation at We Care EMT discussions.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

IPC: Total Infections

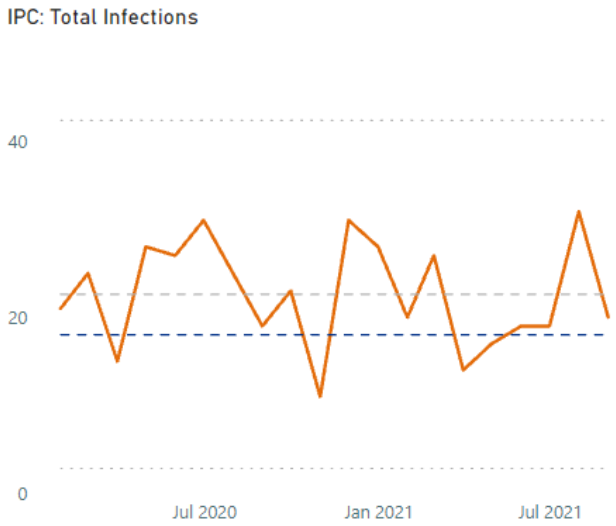
Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
23	11	31	28	20	27	14	17	19	19	32	20

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 | 14/10/2021 09:15:00

Performance

Current Performance for total in-hospital infections is 20 in September, an improvement compared with August and closer to the performance in previous months. Performance has shown common cause variation over the last three months.

In the last month:

- Driver meetings have continued and engagement with some existing front line teams has improved but limited A3 based work.
- St Margaret's Ward (QEQM) have demonstrated significant improvement across the range of IPC Audit measures
- The new teams at the William Harvey Hospital are being onboarded
- Cheerful Sparrows Male has dropped out of the roll out as it was converted to an ICU for Covid.
- The DIPC has responded to challenge from the Executive Management Team to re-evaluate the Breakthrough Objective and has brought forward recommendations for change – these have been agreed in principle (see below).

Next month

- Development of a proposal to refine the Breakthrough Objective or create a Trust Priority Improvement Project (TPIP) to replace it.

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 overall metric unless there are considerably more front line teams engaged.

Executive Summary

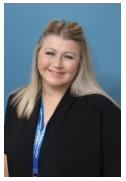
East Kent Hospitals University NHS Foundation Trust

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.



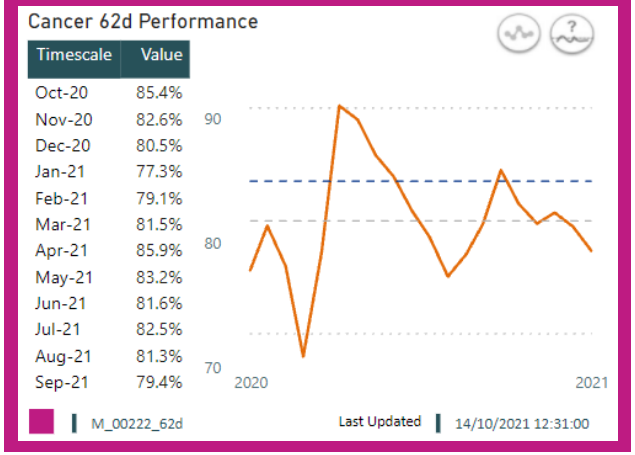
Sarah Shingler

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.

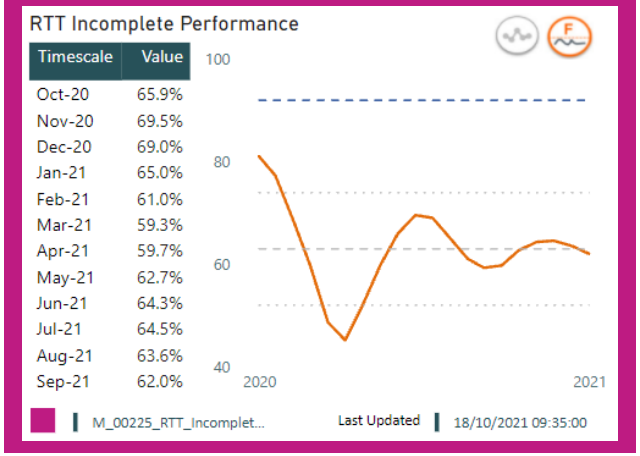
Cancer 62 Day

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



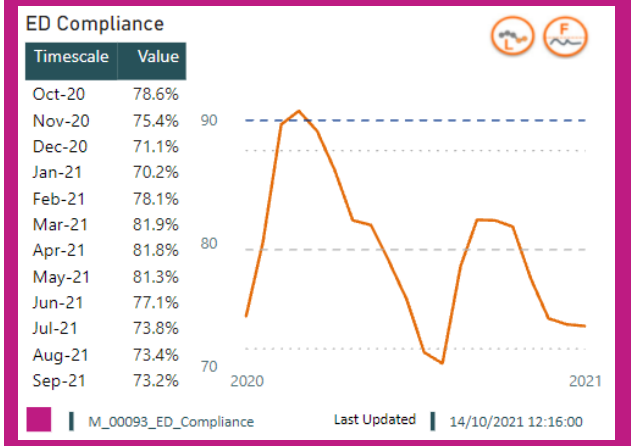
RTT: 18 Week Compliance

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



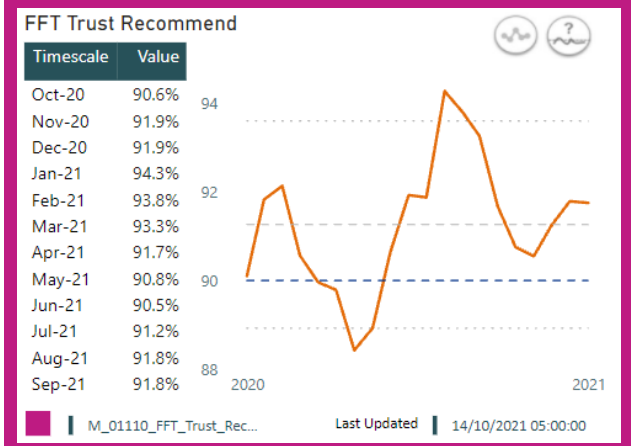
ED 4 Hour Compliance

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.



2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

ED - Aggregated Patient Delay

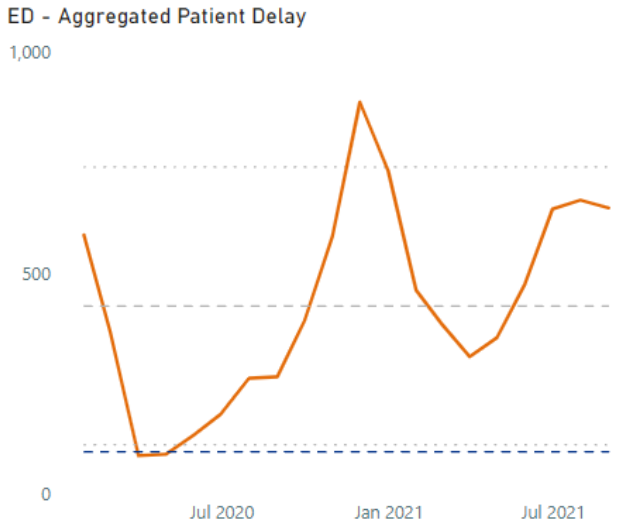
Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
392	584	886	732	460	385	311	353	475	644	664	647

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.

... | M_00888_Agg_Delay

Last Updated | 14/10/2021 11:24:00

Performance

Performance for September is an aggregated delay of 647 hours. Performance has improved against this metric..

- Emergency demand remained with WHH showing a 3.6% increase in attendances compared to August.
- Simple discharges dipped slightly in September by 4% at WHH and 6% at QEQM. QEQM improved on the good performance last month in terms of discharges before 10am but WHH deteriorated dropping back below their mean performance.
- Complex discharges have reduced by 9% overall with the biggest reduction seen at WHH (-11%). QEQM reduced slightly (3%) on the previous months performance. A continued lack of PW1 capacity is the key issue.
- The numbers of stranded and super-stranded patients have come down slightly in month to 373 and 129 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, including increasing the number of discharges before midday and increased use of the discharge lounge.
- 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 or additional spot purchase bed 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.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

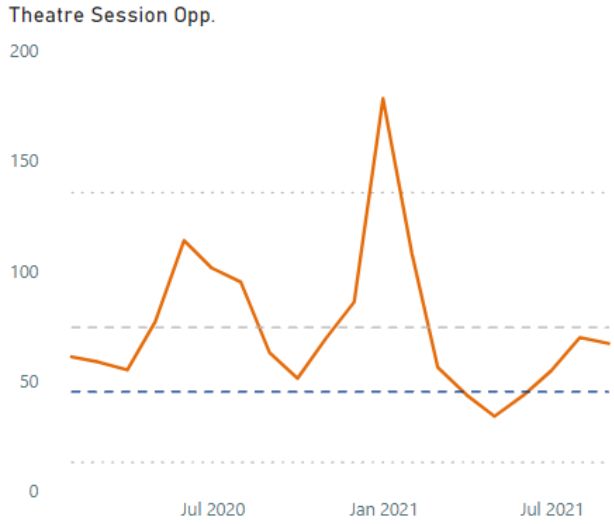
Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
51	69	86	178	108	56	44	34	43	55	70	67

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

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

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 | 18/10/2021 09:20:00

Performance

Current Performance shows the equivalent of 67 sessions unused i.e. opportunity for September 2021. We had been displaying an improving performance but this deteriorated in July. However we have seen a small improvement in September and work to improving this moving forward. This months data has shown that the greatest opportunity is from cancelled sessions, as per August and this is reflective of the sessions that have had to be cancelled due to staffing vacancies and sickness. However we have seen significant improvements in cancellations on the day across all 3 sites. Specific work around General Surgery and Orthopaedic pre op preparation continues to improve this further.

Work in progress for the next 3 months include:

- Increasing booked theatre utilisation to 92%
- Clear booking rules to support the delivery of a reduction in patients waiting over 52 weeks
- A3 – booking . This work is to include the booking rules of chronological booking.

This is alongside the following :

- support ongoing recruitment into vacancies and manage current high levels of sickness.
- Finalise the bed modelling – specifically the green bed base on the acute sites.
- Minimise any cancelled operations on the day
- Daily oversight of elective ITU demand
- Daily review of theatre staff and gaps – this includes senior oversight and decision making when lists have to be cancelled.

Risks

Ongoing non elective pressures resulting in lost bed capacity and leading to cancelled sessions.
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.

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.

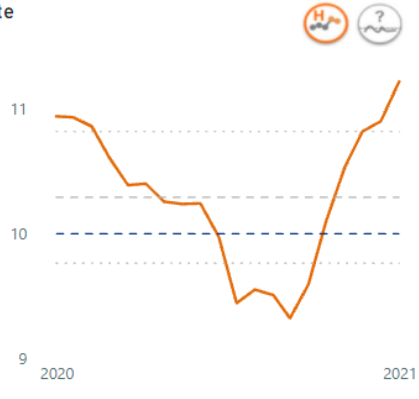
Staff Engagement (score)
Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention.

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
Oct-20	10.2%
Nov-20	10.0%
Dec-20	9.4%
Jan-21	9.6%
Feb-21	9.5%
Mar-21	9.3%
Apr-21	9.6%
May-21	10.1%
Jun-21	10.5%
Jul-21	10.8%
Aug-21	10.9%
Sep-21	11.2%



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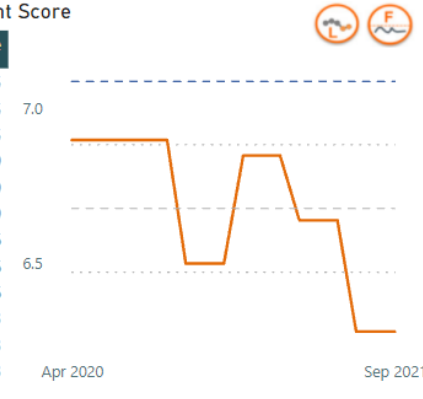
Staff Engagement
To improve our staff engagement score as demonstrated in the annual staff survey.

Staff Engagement Score

Timescale	Value
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	6.6
May-21	6.6
Jun-21	6.6
Jul-21	6.3
Aug-21	6.3
Sep-21	6.3



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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 term aim to maintain a breakeven position.

The impact of Covid-19 has paused the NHS business planning process nationally and has limited the ability of the Trust to hit its cost efficiency targets.

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.

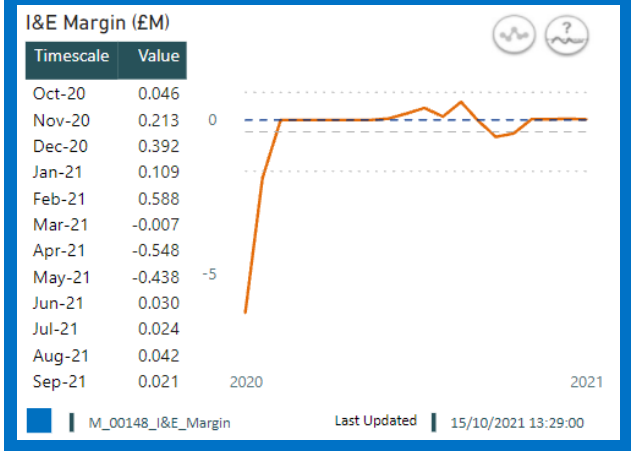
The Trust's carbon emissions are made up of:

- 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.

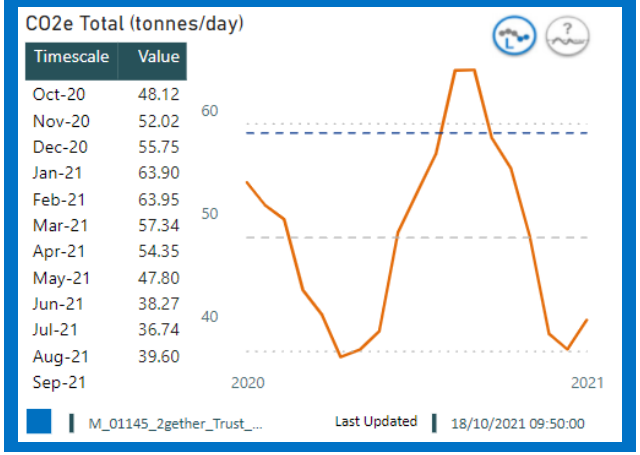
Financial Position

To achieve and sustain a break even financial position.



Carbon Footprint

To achieve an organisational carbon neutral footprint.



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.

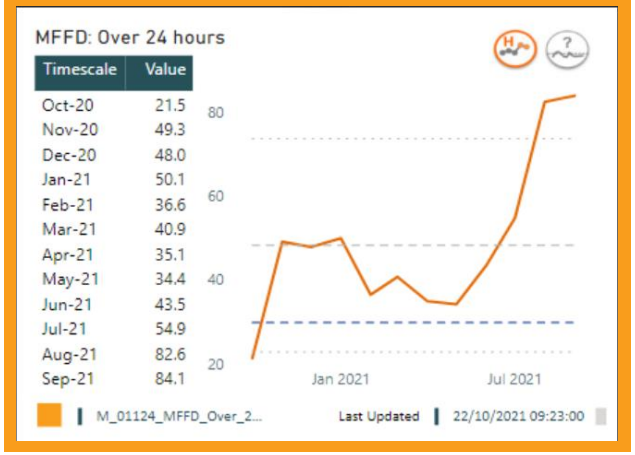
Unnecessary bed stays can negatively affect patient experience. In addition prolonged stays in hospital (especially for those who are frail or elderly) can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning.

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'.

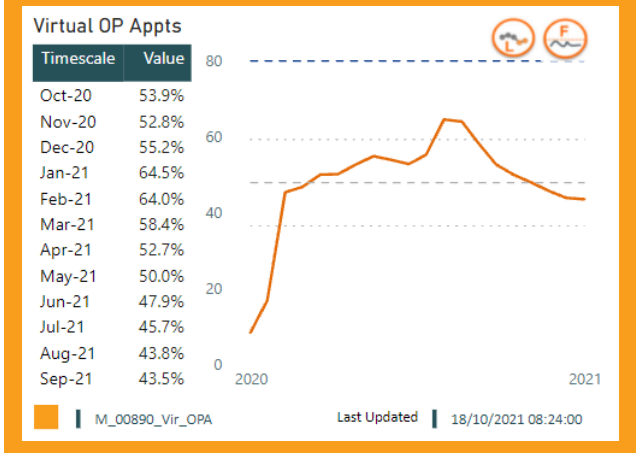
Innovation (Virtual OP Apps)
The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process.

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 virtually, where clinically appropriate, and to that end we have developed an enhanced engagement plan to encourage the shift from face to face to virtual mediums such as phone and telemedicine.

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 EK population.



Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jun-21	Jul-21	Aug-21	Sep-21
Harm Events			VTE Assessment Compliance	90.0%	91.3%	90.4%	89.2%	89.0%
			Safeguarding Incidents	20	21	17	13	41
	W4		Serious Incidents	18	27	40	28	28

Performance

VTE Assessment Compliance
Compliance with VTE Assessments has deteriorated slightly in September and is now breaching the lower confidence limit. Some anomalies have been identified in the data which are being validated. A Trust Priority Improvement Project (TPIP) is in development to deliver rapid improvement in this area.

Safeguarding Incidents
There has been an increase in safeguarding incidents reported in 2021. The incidents have all been individually reviewed and the main themes are poor discharge, falls, pressure sores and interaction with staff. All incidents have been appropriately reported and where indicated SIs completed. The safeguarding team have been linking in with the relevant 'we care' streams to develop and support action plans for improvement.

Serious Incidents
Serious incidents remain above threshold due to several factors. The SJR process has fully embedded to ensure cases identified for secondary review are processing through and this has resulted in declared incidents. It is probable that several other historical cases will impact SI numbers over the next few months while the backlog is addressed. The main factor for increased SIs is the impact of increased workload and decreased staffing, with contributory themes being documentation issues, escalation issues and some specific cases in maternity.

Alerting Watch Metrics: Our Patients

True North Domain	Type	BO	KPI	Thres.	Jun-21	Jul-21	Aug-21	Sep-21
Cancer 62d	W4		Cancer 28d Performance	75.0%	72.6%	72.3%	69.2%	68.8%
RTT - 18 Weeks	W4		RTT 52w Breaches	2,586	4,270	4,317	4,430	4,743
	W4		RTT 35w Undated	8,500	9,412	9,872	9,970	9,720
			RTT 1st OPA Booking Breaches	14,000	13,904	15,033	15,904	17,262
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	35.2%	36.0%	33.8%	34.1%
	W4		Super Stranded >21D	75	98	105	139	130
			Discharges by Midday	15.0%	17.1%	16.7%	16.1%	15.2%
FFT	W4		FFT DC Response Rate	27.0%	26.5%	26.0%	25.3%	25.5%
	W4		FFT Maternity Response Rate	18.0%	4.8%	3.5%	4.8%	4.0%
	W4		Complaint Response	90.0%	71.7%	80.3%	72.5%	33.3%

Performance

Cancer

Performance is 66.8% which is a decrease on previous month. There has been a significant increase in 2ww referrals which is putting pressure on all tumour sites and performance. The CCH Care Group is driving this metric in order to improve the position. At this time the threshold will remain in line with the national requirement.

RTT 18 Weeks

The trajectory for 52w waits is being revised as part of the H2 planning process, once complete the trajectory will be revised.

The number of 35wk patients undated has reduced for a second consecutive month, whilst this remains above the threshold it is not considered at this time to warrant driver status.

The volume of 1st OPA booking breaches has breached the upper confidence interval this month. Causes of this are being investigated and thresholds reviewed.

ED Compliance

Clinical Assessment within 1hr is a metric which indicates an efficient flow through our Emergency Department, with senior decision making early in the pathway. This metric is being driven by the UEC Care Group in order to improve performance. Consideration will be given prior to the next IPR as to whether the threshold here should be amended.

FFT

It is likely that the drop in response rate is due to women receiving an increased number of requests for feedback. Overall the number of responses received has increased significantly since the new text message system was introduced. Reducing the frequency of FFT texts has been discussed however it has been decided to continue as at present as some rich data is being collected. The Maternity Voices Partnership (MVP) will be undertaking a review with women to find out how they are finding the new method of gathering FFT feedback.

Complaints

The complaints response has fallen significantly in month due to the impacts of workload and staffing. Staff have been required to provide frontline care or support ward management resulting in a delay to complaint responses being completed.

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jun-21	Jul-21	Aug-21	Sep-21
Staff Turnover Rate	W4		Staff Turnover: Nursing	10.0%	12.0%	12.1%	11.9%	11.8%
Innovation	W4		Virtual OP Appts - Follow Up	60.0%	50.0%	48.6%	47.0%	46.4%

Performance

Staff Turnover

Total average turnover has risen for a fifth month in succession and is now above the True North target (10%) at 11.2% (September 21). This was anticipated post-pandemic following the exceptionally low turnover rates (5-8%) last summer which artificially suppressed the overall position.

Average Nursing turnover (11.8%) has reduced slightly for the second month in succession, with the actual in-month figure for September standing at 11.9%. This is almost 7% better than 6-months ago, with the overall figure beginning to plateau. Work is taking place against national and regional priorities to mitigate further rises. This includes focusing on; those considered a high 'flight-risk' (early & late career), international recruits, NHS People Promise areas (wellbeing, engagement & EDI) & around improving flexible working (which represents 20% of our leaver reasons).

Innovation

As the Trust moves through it's elective recovery phase, returning to more face to face appointments, the % of virtual appointments appears to be reducing. A clinical review is taking place to ensure the appropriateness of virtual appointments and understand where we can maximise the use of technology in this area to the benefit of our patients. Once complete the thresholds for this measure will be reviewed. It is however likely this clinical review will suggest a reduction in the threshold for virtual out patient appointments – follow up. It is therefore not suggested that at this time this 'watch' metric should move to a 'driver' metric.

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jun-21	Jul-21	Aug-21	Sep-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Covid-19 HCAI	1	0	2	6	5
	W		Medication Errors; All	110	204	210	175	146
	W		Medication Errors; Severity C+	1	0	3	1	0
	W		Pressure Ulcers: Cat 2	32	29	33	29	30
	W		Pressure Ulcers: Cat 3 & 4	3	0	1	3	1
	W		Pressure Ulcers: DTI	10	6	7	11	7
	W		Pressure Ulcers: Unstageable	10	5	12	4	8
	W		IPC: Audits Composite	80.0%	88.0%	87.5%	85.4%	87.0%
	W		Clinical Incidents	2,500	1,868	1,807	1,668	1,708
	W		Never Events	0	0	0	0	0
	W		Maternity Serious Incidents	2	6	2	4	1
Mortality	W		Extended Perinatal Mortality	6.35	5.87	7.63	6.21	6.15

Appendix 1
Non-Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jun-21	Jul-21	Aug-21	Sep-21
Cancer 62d	W		Cancer 2ww Performance	93.0%	97.8%	98.1%	97.9%	97.0%
	W		Cancer 31d Performance	96.0%	98.6%	99.2%	97.4%	98.5%
RTT - 18 Weeks	W		DM01 Compliance	75.0%	75.2%	72.1%	70.3%	73.1%
	W		OPA vs Plan	Traj.	83,712	79,2...	72,891	78,746
	W		Elective Admissions vs Plan	Traj.	5,525	5,654	5,338	5,375
ED Compliance	W		Ref to Spec 2.5h	40.0%	39.6%	39.2%	36.1%	40.2%
	W		A&E Atts vs Plan	Traj.	23,247	22,6...	21,999	22,582
	W		Unplanned Re-attendance ED	10.0%	10.0%	6.5%	9.3%	10.2%
	W		NEL Admissions vs Plan	Traj.	7,095	7,121	6,570	6,694
	W		NEL Readmissions	15.0%	11.6%	11.7%	11.5%	11.0%
	W		Stroke Ward within 4 Hours	50.0%	54.4%	45.0%	43.8%	54.4%
FFT	W		FFT OP Response Rate	17.0%	17.1%	17.4%	17.0%	17.6%
	W		Complaints	100	85	84	91	76
	W		PALS Enquiries	550	530	545	538	601

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jun-21	Jul-21	Aug-21	Sep-21
Staff Turnover Rate	W		Staff Turnover: HCA	13.5%	11.7%	12.1%	12.0%	12.9%
	W		Premature Turnover Rate	25.0%	20.2%	20.1%	20.1%	19.8%
Staff Engagement	W		Sickness	5.0%	3.7%	4.1%	4.1%	
	W		Appraisals Compliance	73.0%	74.0%	72.7%	73.3%	73.7%
	W		Statutory Training	91.0%	92.8%	92.4%	91.9%	91.6%
	W		Safeguarding Children Training	85.0%	92.3%	92.5%	91.6%	91.3%
Financial Position	W		Total Pay	0.0%	0.5%	0.5%	0.3%	-1.9%
	W		Premium Pay	Traj.	5,768	7,134	7,351	7,092
	W		Non Pay	0.0%	1.9%	3.3%	2.2%	1.2%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.21	0.21	0.20	
	W		CO2e Gas (tonnes/day)	38.19	13.32	12.25	14.42	
	W		CO2e Electricity (tonnes/day)	18.00	15.16	16.28	15.86	
	W		CO2e Water (tonnes/day)	0.55	0.21	0.22	0.19	
	W		CO2e Steam (tonnes/day)	9.21	9.37	7.79	8.93	
Criteria to Reside	W		Completeness	70.0%	79.1%	77.9%	74.0%	72.8%
Innovation	W		Virtual OP Appts - First	25.0%	43.2%	38.9%	36.3%	36.6%

Appendix 2
Trust Priority Improvement Projects

NHS
East Kent Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected completion
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	January 2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	January 2022
Accommodation Strategy	Phil Cave	To address the shortfall and enhance the functionality, experience and investment opportunities in office, residential and training facilities for staff and students.	May 2022
ED Expansion	Liz Shutler	Refurbished and expanded ED accommodation at QE and WH operational for patients to be admitted	December 2022
Job Planning (Trust wide)	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	TBC – scoping as new project
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	TBC – scoping with partner organisations
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	January 2021
End of Life Care	Sarah Shingler	Deteriorating patients who's death can be are recognised in a timely way enabling better care in the right place at the right time this will improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	TBC – scoping as new project
National & Local Clinical Audit	Rebecca Martin	Create a system so that all staff are able to participate in an effective way with clinical audit	April 2022
Identification and assessment of vulnerable person	Sarah Shingler	Assessment of Mental Health risk to determine the level of support required carried out for 100% of patients	December 2021
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	October 2021
✓ Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
✓ Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete

Appendix 2: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

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

Appendix 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.