NHS
East Kent
Hospitals University
NHS Foundation Trust

Integrated Performance Report

October 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.

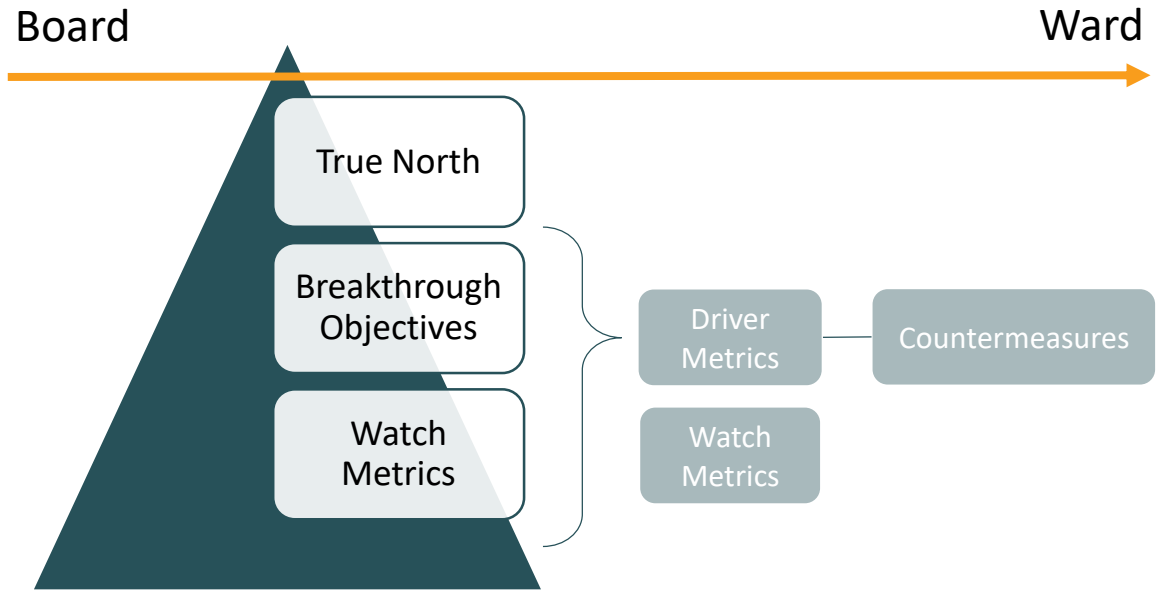
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

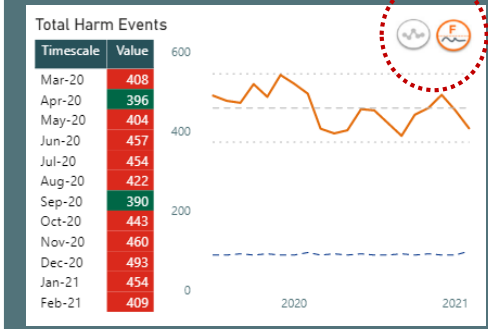
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

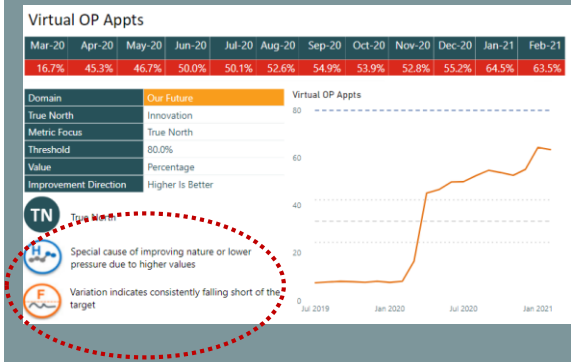
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

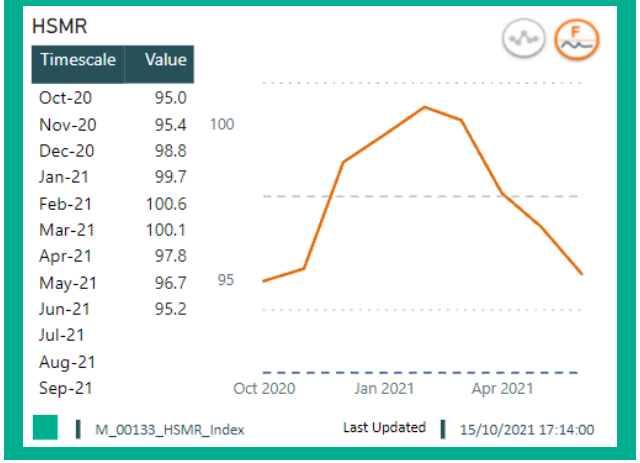
Our aim is to reduce mortality and be in the top 10% of all Trusts for the lowest mortality rates in 5 to 10 years.

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;

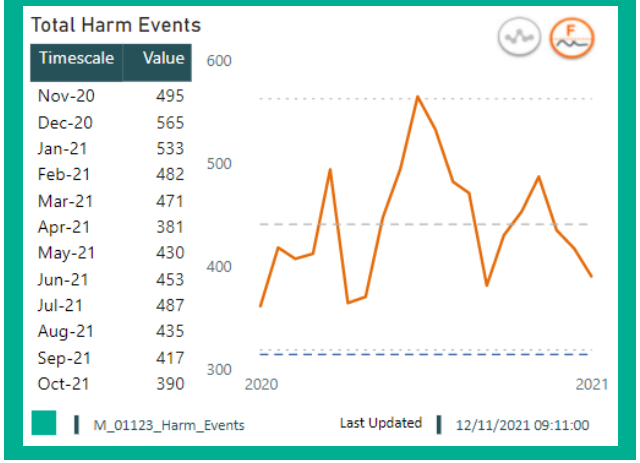
- Falls
- Pressure Ulcers
- C Difficile (in-hospital)
- E.Coli (in-hospital)
- Covid Infections (in-hospital)
- Nutrition Incidents
- Medication Errors

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

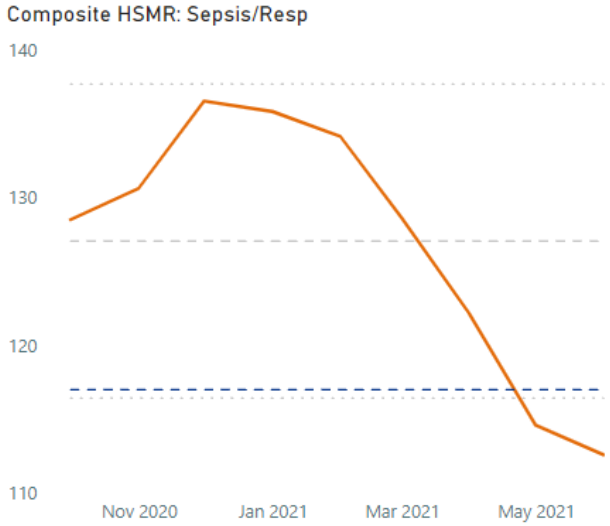
Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
128.5	130.6	136.6	135.8	134.2	128.6	122.1	114.6	112.6			

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

Performance in June 2021 shows a rolling 12-month composite Hospital Standardised Mortality Ratio (HSMR) for respiratory failure and sepsis of 112.8 with a positive trend. More recent mortality data was not available at the time of publication.

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:

- Engagement with the Kent & Medway working group to support an alternative, evidence-based advance care planning tool
- In order to deliver care to hip fracture patients in line with best practice, Seabathing ward has been identified and socialised as the nominated ward for hip fracture patients.
- Learning from deaths team has delivered training and supported Stroke and ITU team at QE to deliver Morbidity & Mortality meetings that allow clinicians to learn and reflect on clinical practice

Ambition for the next 30 days:

- Embedded learning meetings for Trauma & Orthopaedic teams at QE, Vascular team at K&CH
- Co-ordinate trust-wide approach to healthcare-associated infections of Covid-19 with learning from harm/deaths process
- Review the compliance with antibiotic use in septic patients with the 7 frontline teams

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

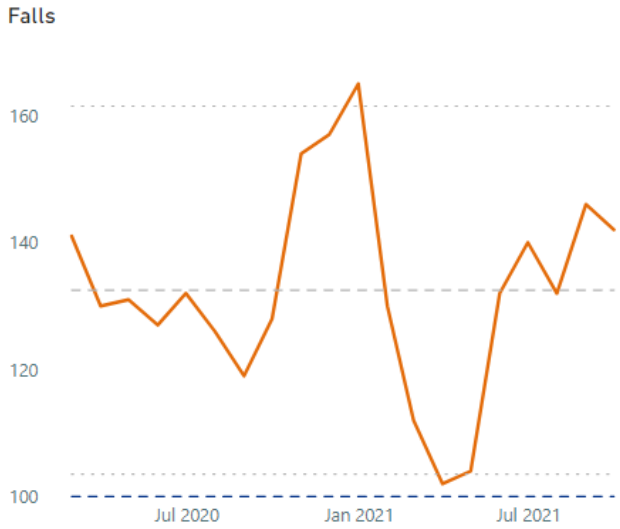
Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
154	157	165	130	112	102	104	132	140	132	146	142

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

D2 Driver is red for 2

Common cause (no significant change)

Variation indicates consistently falling short of the target



Understand the data

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

We are driving this measure because...

The Quality & Safety True North target is to achieve zero avoidable harm within 5-10 years. Our analysis shows that currently falls are the greatest contributor (40%) to harm events. Currently 45% of falls are reported as not resulting in harm and 54% of falls are reported as resulting in low harm. The assessment of falls is not currently standardised across the Trust.

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

... | M_00320_Falls

Last Updated | 12/11/2021 08:03:00

Performance

142 falls were recorded in October. 100 were unwitnessed. The majority were low harm with 8 moderate or severe harm.

The original six wards continue to share learning in the driver meetings: Kings A2, and Kings D having made a sustainable change with Falls now a 'Watch metric.' Harbledown have made significant improvements: 7 falls in Aug, 3 in Sept, and 2 in October. WHH AMU have reduced falls overall by 32%.

Additional wards (Kings B, St Augustine, Camb M2, K and L), have completed training and commenced their A3s. They are joining the fortnightly Falls Driver meetings.

WHH AMU falls increased in October associated with an increase in bed base to include 12 beds within SDEC (54 beds in total). The additional areas require support from staff from other areas/agency, unfamiliar with the area and the type of patients falling (younger, often with MH concerns, not the frailty associated trend within traditional AMU).

Counter measures being developed to support include:

- Regular review of safe staffing on AMU/SDEC.
- Developing a familiarisation guide for transferred/ agency staff.
- Staff allocation lists and staff rotation for cohorting or 1:1 nursing.
- Regular falls team reviews and sharing of cohort nursing guides.

Cambridge L had an increase in falls in October (10): Reflecting the patient cohort (confused/ dementia/ wandering). A3 is in development.

Falls team update:

- The 222 Falls response will 'Go Live' 29/11/21.
- ED Yellow kit PDSA: WHH complete, in progress at QEQM.
- A ward competencies and equipment review is underway.
- A new FRAP aims to prompt the reassessment of patients transferred from ED to the wards.

The 1st six wards have collectively reduced falls sustainably across EKUHFT by 14% over 10 months. The next wave of wards are predicted to achieve an additional 13% reduction over the next 6 months.

Risks

Risk of failure to make further improvements and reach threshold target until additional wards deliver sustainable change.

Executive Summary

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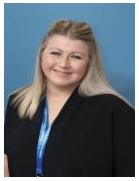
Our Patients

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.

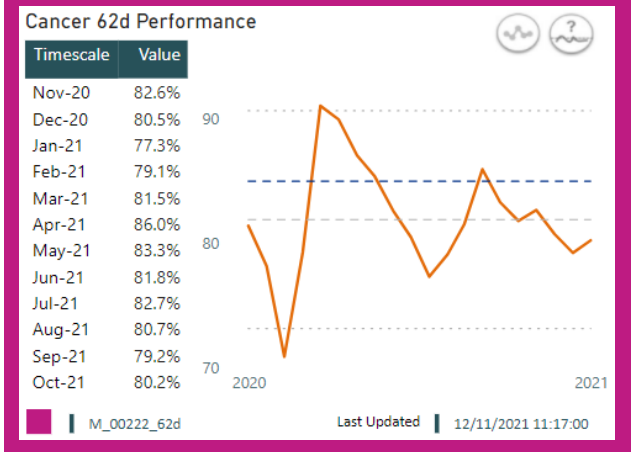


Sarah Shingler

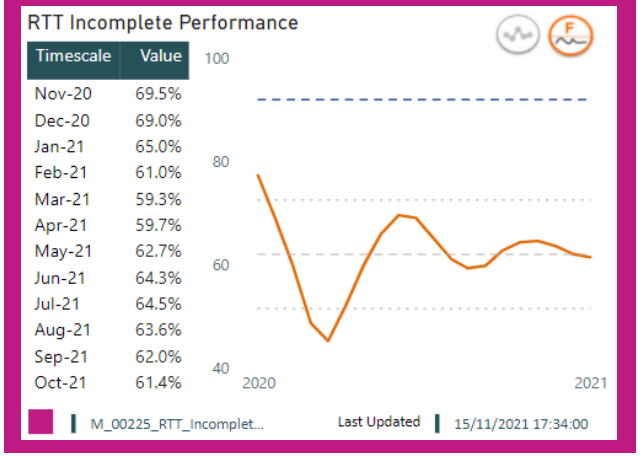
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

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.

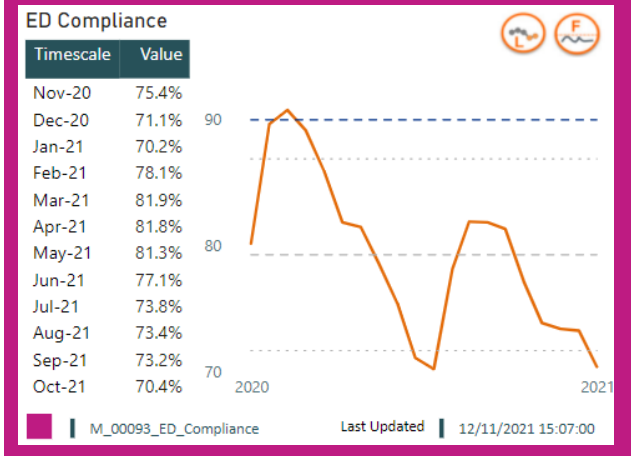
Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.



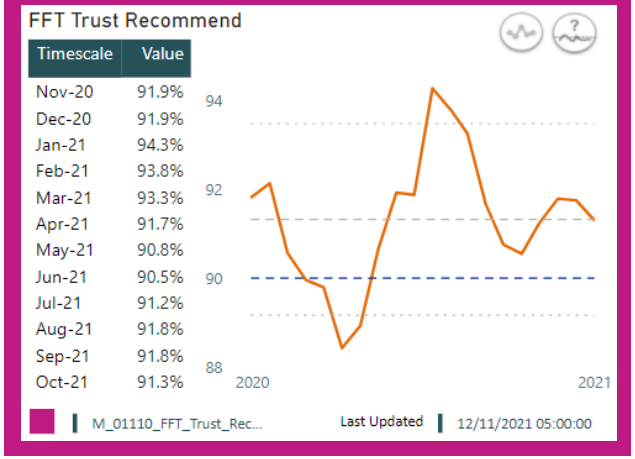
RTT: 18 Week Compliance
To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.



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.



2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

ED - Aggregated Patient Delay

Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
584	886	732	460	385	311	353	475	644	664	647	807

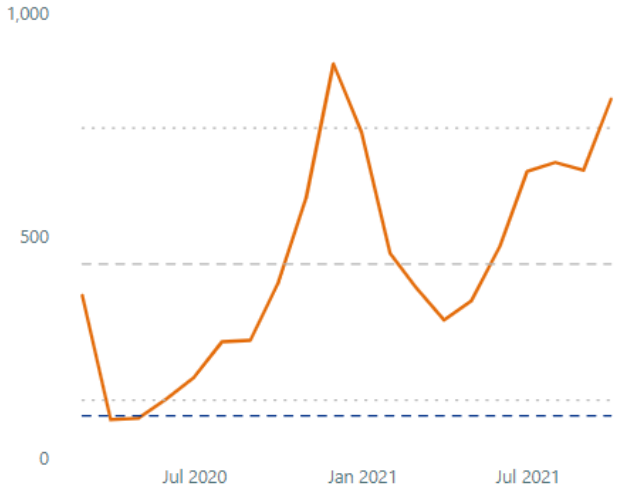
Domain	Our Patients
True North	ED Compliance
Metric Focus	Driver
Threshold	95
Value	Number
Improvement Direction	Lower is Better

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

ED - Aggregated Patient Delay



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 | 15/11/2021 17:47:00

Performance

Performance for October is an aggregated delay of 807 hours, which is a deterioration against this metric.

The numbers of patients attending in October continued to be within the upper control limits, with peaks which were significantly above control limits. The number of patients able to be streamed to the UTC pathway dropped by 10% due to an increasing acuity, which is evidenced by the VB11Z code group of patients, indicating that they were discharged without diagnostics or treatment. The Charlson Score, which is an internationally recognised indicator of patient complexity. We admit more patients with a significantly high CCI (18.5% -v- 13.8% nationally.

The total time in ED for non admitted patients has remained at 3.3 – 3.4 which is positive.

The ED building works have had an impact on the WHH, with a step change in the total time in ED and increase in 12 hour Trolley Wait Breaches from 15 October.

Key areas of focus for this breakthrough objective are continued within the Emergency Patient Flow A3 are:

- Continued focus on streaming to UTC.
- Protecting SDEC capacity to maximise activity flow.
- 30% of discharges before midday.
- Increased use of discharge lounges.
- Gaining agreement to develop a whole system A3 to improve discharge processes.

Risks

- Access to external capacity for complex patients leaving hospital
- Staffing challenges in ED and in ward areas
- Increased acuity resulting in high admission profile.
- Impact of building work on ED flow.

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

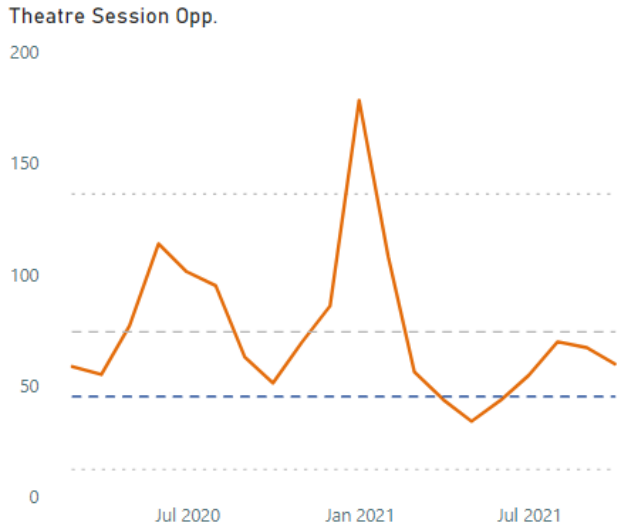
Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
69	86	178	108	56	44	34	43	55	70	67	60

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 | 15/11/2021 09:24:00

Performance

Current Performance shows the equivalent of 60 sessions unused i.e. opportunity for October 2021. Performance is improving with reduced opportunities identified. The greatest opportunity this month has been identified as underutilised endoscopy sessions followed by cancelled sessions. Review of endoscopy utilisation is progressed through separate driver meetings and as such there is a proposal to remove this opportunity from this breakthrough object and focus all the opportunity available from theatres. October was a particularly challenged month with a number of cancelled sessions due to consultant unavailability. S & A had the greatest opportunity from cancelled sessions and this was predominantly within Trauma and Orthopaedics. Followed by Ophthalmology within SHNB.
October saw an increase in clinical (97) and patient (34) cancellations on the day with Urology reporting 28 clinical cancellations on the day, the highest number reported over the last 2 years. The care group is undertaking a deep dive into the reasons for the cancellations.

Our focus for the next 3 months include:

- Ensuring lists booked to 92%
- Increasing our pre assessment pool , to support backfilling short notice cancellations
- Deep dive into cancellations before the day
- Identifying activity that can be transferred to Canterbury to reduce cancellations on the other sites.
- Support the theatre staffing review and recruitment.
- Involvement with the FEI / NHSEI work on maximising elective capacity and ring fenced beds , focussing on the EOC.

Risks

Winter pressures impacting on availability of beds and the capacity to continue with elective work.

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

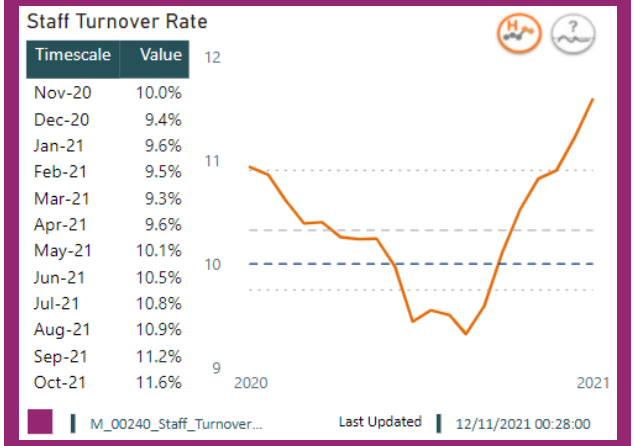
Staff Turnover (rate)
The annual turnover rate provides us with a high-level overview of Trust health.

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.

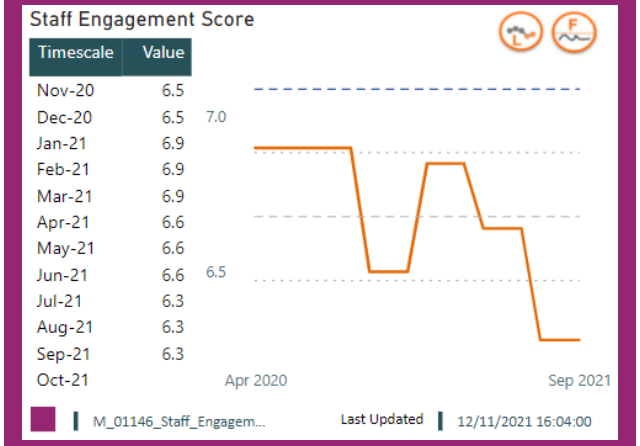
Staff Engagement (score)
Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention.

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



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

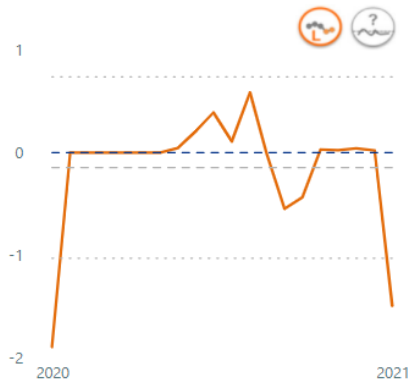
It is these areas we will be focussing on improving over the coming five to ten years.

Financial Position

To achieve and sustain a break even financial position.

I&E Margin (£M)

Timescale	Value
Nov-20	0.213
Dec-20	0.392
Jan-21	0.109
Feb-21	0.588
Mar-21	-0.007
Apr-21	-0.548
May-21	-0.438
Jun-21	0.030
Jul-21	0.024
Aug-21	0.042
Sep-21	0.021
Oct-21	-1.494



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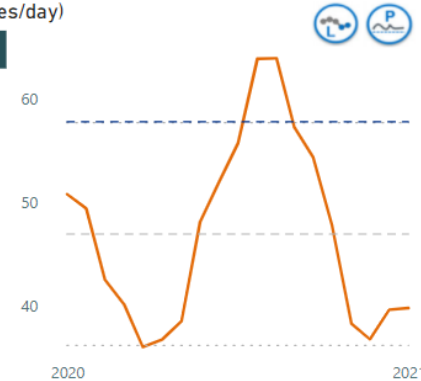
Carbon Footprint

To achieve an organisational carbon neutral footprint.

CO2e Total (tonnes/day)

Timescale	Value
Nov-20	52.02
Dec-20	55.75
Jan-21	63.90
Feb-21	63.95
Mar-21	57.34
Apr-21	54.35
May-21	47.80
Jun-21	38.27
Jul-21	36.74
Aug-21	39.60
Sep-21	39.77
Oct-21	



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East Kent Hospitals University NHS Foundation Trust

Our Future

Liz Shutler

Rebecca Carlton

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'.

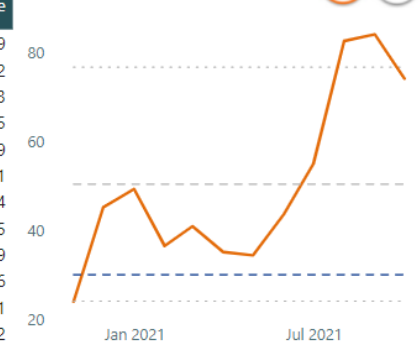
Innovation (Virtual OP Apps)
The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process.

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.

MFFD: Over 24 hours

Timescale	Value
Nov-20	23.9
Dec-20	45.2
Jan-21	49.3
Feb-21	36.5
Mar-21	40.9
Apr-21	35.1
May-21	34.4
Jun-21	43.5
Jul-21	54.9
Aug-21	82.6
Sep-21	84.1
Oct-21	74.2



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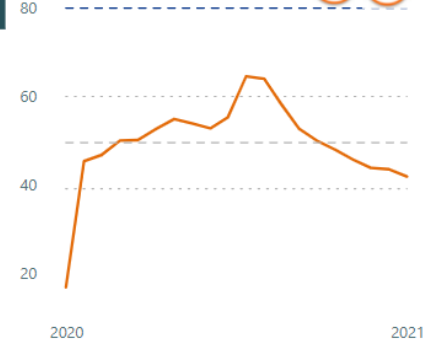
Innovation
To increase the use of technology and innovation in the delivery of high quality care for the EK population.

Virtual OP Appts

Timescale	Value
Nov-20	52.8%
Dec-20	55.2%
Jan-21	64.5%
Feb-21	64.0%
Mar-21	58.4%
Apr-21	52.7%
May-21	50.0%
Jun-21	47.9%
Jul-21	45.7%
Aug-21	43.8%
Sep-21	43.5%
Oct-21	41.8%



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Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jul-21	Aug-21	Sep-21	Oct-21
Harm Events	W4		Covid-19 HCAI	1	2	6	5	16
			VTE Assessment Compliance	90.0%	90.4%	89.2%	89.0%	89.0%
	W4		Serious Incidents	18	40	28	27	24
Mortality	W4		Extended Perinatal Mortality	6.32	6.68	6.78	7.27	7.08

Performance

Covid-19 HCAI

The Covid-19 HCAI cases are associated with an increased community incidence leading to unexpected community acquired cases that create in-hospital contacts and HCAI cases (as defined nationally). Where there are two or more cases this is defined as an outbreak and small numbers of outbreaks have been identified and managed during this period. Metric will remain above the threshold for November but shows early signs of reduction.

VTE Assessment Compliance

The stratified data showing underperformance being driven by number of spells across GSM specialties and general surgery without VTE risk assessment. An A3 is being developed as part of a trust priority improvement project to agree countermeasures to reverse the trend.

Serious Incidents

The number of SIs remain above the threshold, although it has stabilised over the past 3 months and fallen from the peak of 40 during July. Below adequate staffing levels have resulted in patient harm leading to incidents being declared. Several incidents are related to gaps in assessment or referral, such as completing the correct scan or referral at the optimum time.

Extended Perinatal Mortality

The increase in perinatal mortality rate is largely due to the increase in stillbirths over the past 12 months. Whilst the still birth rate, 5.47 is higher than the threshold 4.4, the neonatal death rate is much lower at 1.62 (threshold 2.19). This measure is a 12 month rolling rate, it is anticipated that next month the rate will reduce to below the threshold.

Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jul-21	Aug-21	Sep-21	Oct-21
Cancer 62d	W4		Cancer 28d Performance	75.0%	72.3%	69.2%	70.1%	71.5%
	W4		DM01 Compliance	75.0%	72.1%	70.3%	73.1%	74.2%
	W4		RTT 35w Undated	8,500	9,872	9,970	9,720	9,434
	W4		RTT 1st OPA Booking Breaches	14,000	15,033	15,904	17,262	17,779
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	36.0%	33.8%	34.0%	34.8%
	W4		Super Stranded >21D	75	105	139	130	127
FFT	W4		FFT DC Response Rate	27.0%	26.0%	25.3%	25.5%	24.9%
	W4		FFT Maternity Response Rate	18.0%	3.5%	4.8%	4.0%	4.2%
	W4		Complaint Response	90.0%	80.0%	73.2%	36.4%	32.0%

Performance

Cancer

28 day performance is improving month on month and the 62 day performance also increased.

RTT 18 Weeks

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. Insourcing contracts will impact positively on this metric with an aim to book up to 70 additional >35wk waiting patients by the end of November.

The volume of 1st OPA booking breaches has breached the upper confidence interval this month. CSSD who manage outpatients will be asked to drive this at their monthly performance meeting.

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 is a driver for the UEC Care Group in order to improve performance. Building work and the opening of the new reception and streaming area will improve our ability to assess patients within the hour.

FFT

Maternity; Women are now beginning to complain about the high number of times that they are being asked to complete FFT responses, we understand the response rate is particularly low related to midwifery compared to Obstetrics. The appropriate touch point times when the FFT questions will be asked during pregnancy are currently being agreed, once complete the numerator and denominator will be adjusted to reflect the agreement.

Complaints

Impacts of workload and staffing continue with ward managers and matrons being pulled back to the frontline. This is resulting in a delay to complaint responses being completed. DQG and CNO are currently scoping a review of current complaint review process

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jul-21	Aug-21	Sep-21	Oct-21
Staff Turnover Rate	W4		Staff Turnover: Nursing	10.0%	12.1%	11.9%	11.8%	11.7%
Staff Engagement	W1		Statutory Training	91.0%	92.4%	91.9%	91.6%	90.1%
Financial Position	W4		Premium Pay	Traj.	7,134	7,351	7,092	6,783

Performance

Staff Turnover

Total turnover has risen for a seventh month in succession and is above the True North target (10%) at 11.6%. However it is important to note that total turnover, measured in-month, actually reduced by 1.21% between September and October. Turnover has improved across all four measures; total (↓1.21%), nursing (↓3.58%), HCA (↓10.21%) and premature (↓0.52%).

The increase seen in the 12-month rolling average, despite a reduction in-month, was anticipated because of the loss of some exceptionally low turnover rates (5-8%) seen last year which artificially suppressed the overall position.

The primary contributors to turnover remain nurse and HCA turnover. Nurse turnover however has improved for the third month in succession, standing at just 7.61% in-month, and HCA turnover reduced dramatically, stabilising the position following a sharp rise in September. Premature turnover continues to improve and sits within our gold-standard (20%) at 19.62%. Work continues with our regional colleagues to ensure this is sustained.

Financial Position (Prem Pay)

Premium pay has been higher than plan due to pressure on the Trust in relation to Covid and emergency activity. The thresholds are being reviewed for 22/23. NHSE are supporting the Trust with a desk top review of temporary staffing.

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

NHS
East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jul-21	Aug-21	Sep-21	Oct-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Medication Errors; All	110	210	185	150	124
	W		Medication Errors; Severity C+	1	3	2	0	1
	W		Nutrition Incidents	60	73	48	58	54
	W		Pressure Ulcers: Cat 2	32	33	29	30	30
	W		Pressure Ulcers: Cat 3 & 4	3	1	2	1	1
	W		Pressure Ulcers: DTI	10	7	11	7	6
	W		Pressure Ulcers: Unstageable	10	12	4	8	6
	W		IPC: Audits Composite	80.0%	87.5%	85.4%	87.0%	88.0%
	W		Safeguarding Incidents	20	18	11	40	23
	W		IP Spells with 3+ Ward Moves	500	554	504	470	517
	W		Clinical Incidents	2,500	1,981	1,730	1,860	1,807
	W		Never Events	0	0	0	0	0

Appendix 1
Non-Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jul-21	Aug-21	Sep-21	Oct-21
Cancer 62d	W		Cancer 2ww Performance	93.0%	98.0%	97.9%	97.1%	98.1%
	W		Cancer 31d Performance	96.0%	99.3%	98.0%	98.6%	98.9%
	W		Radiology Diags vs Plan	Traj.	16,825	16,152	15,957	16,431
	W		Endoscopy vs Plan	Traj.	1,230	1,276	1,128	1,400
RTT - 18 Weeks	W		OPA vs Plan	Traj.	79,233	73,239	82,661	76,134
	W		Elective Admissions vs Plan	Traj.	5,654	5,373	5,468	5,893
ED Compliance	W		Time in Dept over 12 hrs	6.0%	6.9%	6.6%	6.0%	8.3%
	W		A&E Atts vs Plan	Traj.	22,616	21,997	22,664	22,900
	W		Unplanned Re-attendance ED	10.0%	6.5%	9.3%	9.8%	10.3%
	W		Discharges by Midday	15.0%	16.7%	16.1%	15.2%	15.9%
	W		NEL Admissions vs Plan	Traj.	7,121	6,568	6,707	6,524
	W		NEL Readmissions	15.0%	11.7%	11.5%	11.0%	10.5%
	W		Stroke Ward within 4 Hours	50.0%	45.0%	44.4%	50.0%	53.9%
FFT	W		FFT IP Response Rate	15.0%	16.1%	15.2%	16.4%	16.3%
	W		FFT ED Response Rate	12.0%	13.2%	13.7%	13.1%	12.5%
	W		FFT OP Response Rate	17.0%	17.4%	17.0%	17.6%	16.9%
	W		Complaints	100	83	91	77	95
	W		PALS Enquiries	550	545	538	600	605
	W		Mixed Sex Breaches	500				272

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Jul-21	Aug-21	Sep-21	Oct-21
Staff Turnover Rate	W		Vacancy Rate	9.0%	8.8%	9.0%	7.9%	8.8%
	W		Staff Turnover: HCA	13.5%	12.1%	12.0%	12.9%	12.9%
	W		Premature Turnover Rate	25.0%	20.1%	20.1%	19.8%	19.6%
Staff Engagement	W		Sickness	5.0%	4.1%	4.1%	4.5%	
	W		Appraisals Compliance	73.0%	72.7%	73.3%	73.7%	76.6%
	W		Safeguarding Children Training	85.0%	92.5%	91.6%	91.3%	90.6%
Financial Position	W		Total Pay	0.0%	0.5%	0.3%	-1.9%	-1.9%
	W		Non Pay	0.0%	3.3%	2.2%	1.2%	0.8%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.21	0.20	0.21	
	W		CO2e Gas (tonnes/day)	38.19	12.25	14.42	17.74	
	W		CO2e Electricity (tonnes/day)	18.00	16.28	15.86	14.29	
	W		CO2e Water (tonnes/day)	0.55	0.22	0.19	0.22	
	W		CO2e Steam (tonnes/day)	9.21	7.79	8.93	7.31	
Innovation	W		Virtual OP Appts - First	25.0%	38.9%	36.3%	36.6%	33.2%
	W		Virtual OP Appts - Follow Up	25.0%	48.6%	47.0%	46.4%	45.6%

Appendix 2
Trust Priority Improvement Projects

NHS
East Kent Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022	• Clinical consultation • OU stakeholder and change management progressing • Development & Environmental Build underway	• Development Environment ready • Configuration options and scanning strategy to be reviewed as part of clinical consultation process • HL7 testing started in October 2021 • Go Live planned for Q3 2021/2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022	• There have been delays in getting supplies as well as recruiting work force. New date for opening is 13th Dec	• Continue to build schedule
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	May 2022	• Delay due to growth in scope of project to cover the accommodation strategy, office space and medical education.	• A3 to be reviewed along with delivery plan
ED Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Dec 2022	• Simulation of a trauma call / cardiac arrest being planned while building work progresses.	• Continue to build schedule
Job Planning (Trust wide)	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	April 2022	• Asked for data to be run at specialty level with names • Plan to do info graphics to drs every month to get positive friendly competition going • JP policy will be presented at next meeting end of Oct. Also looking at JP of 10 or less PAs	• Data cleanse being undertaken • Draft Infographic report being developed • JP policy is now with CMO going to committee on the 3rd Dec for approval • Presenting JP TPIP at clinical leadership meeting on 25th Nov • A business case is in progress for more admin support
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	May 2022	• Fortnightly meetings with 5 Jnr doctors contributing • Draft SOP for completing an EDN to share at next meeting • Included in the Oct new registrars induction	• Agreed to trial SOP on two wards CJ1 & Seabathing • WW will visit Sea bathing to provide support • Meeting with CCG regarding complaints & Datix's

Appendix 2
Trust Priority Improvement Projects

NHS
East Kent
Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022	• Met with Medical & Clinical Directors to ascertain their views. • Looking at other Trust practices • Looking at systems used in the Trust Micro guide –Pathology cost £4000, ED App £2000 and if the micro guide system is update it will cost the Trust £19,500 per annum	• Job description completed and in circulation for comments • Clinical Guidelines draft policy completed and in circulation for comments. • No decision made on either upgrade of micro-guide or to look at another software solution
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	TBC Scoping as new project	• First draft of problem statement developed and shared with core team • Starting to collect data	• Collect and collate the data for analysis and discussion
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	April 2022	• Writing a job description for all audit leads • ED are to write a recovery plan	• Share vision statement at an away day booked for 15th Nov • Alison D has revised the monthly exception report to show trends by CG to be presented at Nov meeting • Reporting schedule now in place 1st CGs to participate C&YP and Women's health. For Nov will be UEC & GSM
Safeguarding	Sarah Shingler	Assessment of Mental Health risk to determine the level of support required carried out for 100% of patients	Dec 2021	• Produced first dashboard report to raise awareness of changes around safeguarding • PTL live including vulnerable patients • Incorporate paediatric data into A3	• Communicate changes to Enhanced Observation tools and audits • Communicate roles and responsibilities around safeguarding • Produce first dashboard report on Information Portal • Focussed work at QEQM to reduce KASAFs

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete

Appendix 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

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.