NHS
East Kent
Hospitals University
NHS Foundation Trust

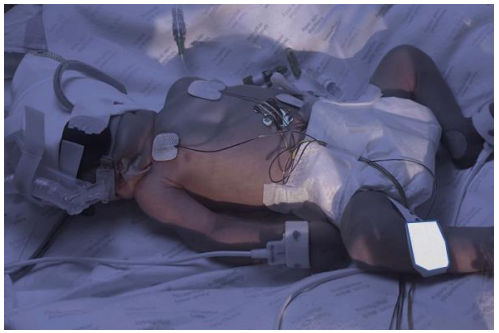
Integrated Performance Report

December 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.

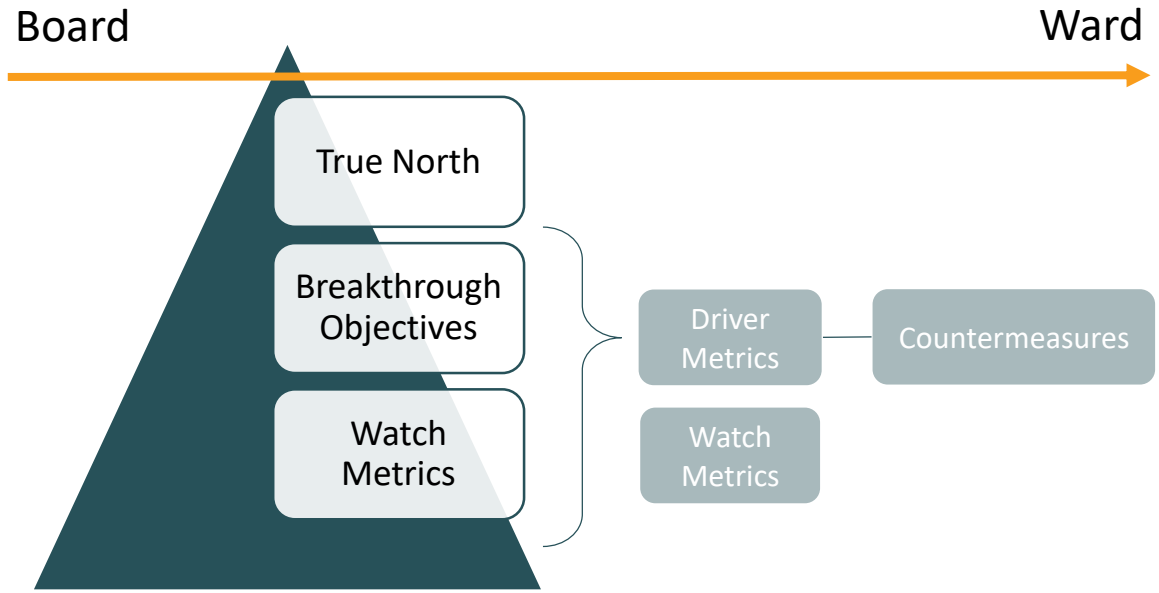
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

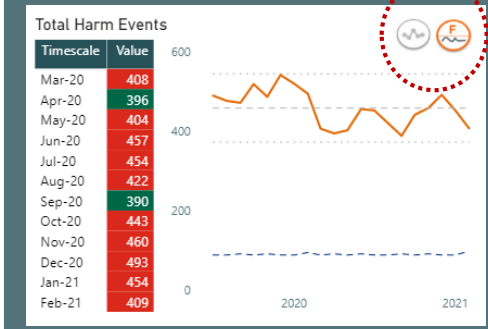
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

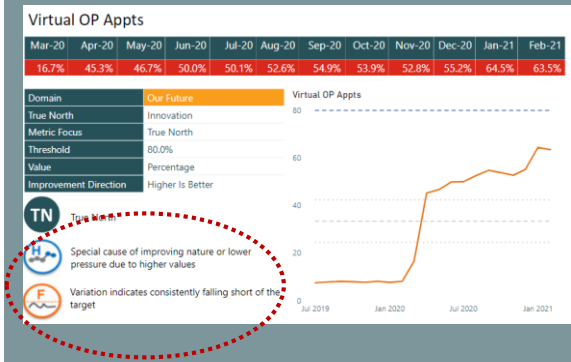
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

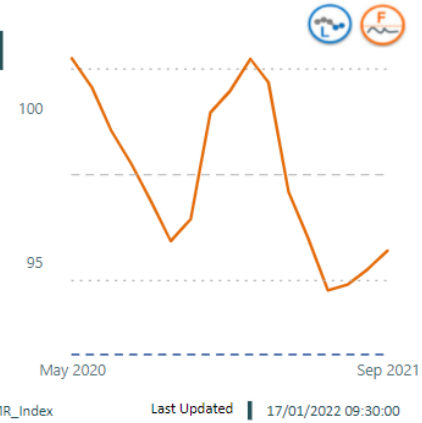
- Falls
- Pressure Ulcers
- C Difficile (in-hospital)
- E.Coli (in-hospital)
- Covid Infections (in-hospital)
- Nutrition Incidents
- Medication Errors

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.

HSMR

Timescale	Value
Jan-21	100.6
Feb-21	101.6
Mar-21	100.9
Apr-21	97.3
May-21	95.8
Jun-21	94.1
Jul-21	94.3
Aug-21	94.8
Sep-21	95.4
Oct-21	
Nov-21	
Dec-21	

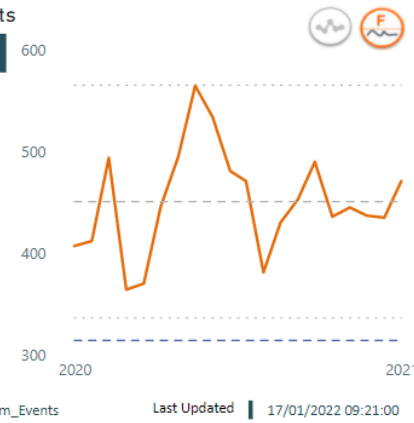


M_00133_HSMR_Index Last Updated 17/01/2022 09:30:00

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

Total Harm Events

Timescale	Value
Jan-21	534
Feb-21	481
Mar-21	471
Apr-21	381
May-21	430
Jun-21	453
Jul-21	490
Aug-21	436
Sep-21	445
Oct-21	437
Nov-21	435
Dec-21	471



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2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Composite HSMR: Sepsis/Resp

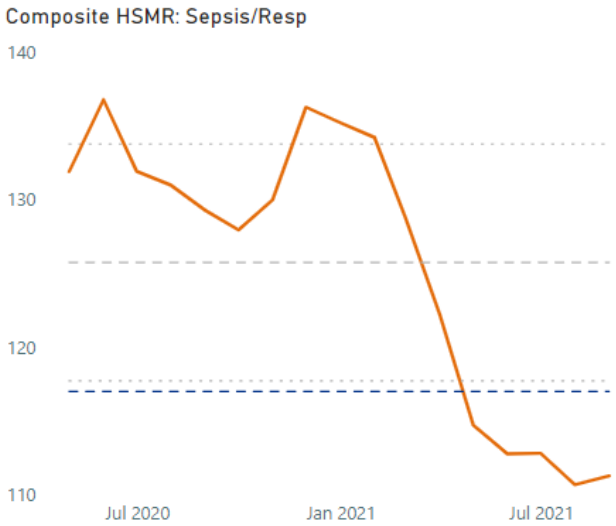
Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
135.2	134.2	128.7	122.2	114.7	112.8	112.8	110.7	111.3			

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 consistently falling short of the target



Performance

Performance in September 2021 shows a rolling 12-month composite Hospital Standardised Mortality Ratio (HSMR) for respiratory failure and sepsis of 111.3 with a positive trend.

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 planning
- Embedding learning from harm incidents
- Hip fracture outcomes and mortality

Achievements over the last 30 days:

- System-wide plan for advance care planning now clearly shared for individual Trusts to implement
- Case note reviews for healthcare-associated Covid infections have commenced

Ambition for the next 30 days:

- Complete case note reviews for healthcare-associated Covid infections
- Re-establish Seabathing ward as nominated hip fracture area

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.

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.

... | M_00133_Deteriorating_Patient

Last Updated | 17/01/2022 09:30:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Falls

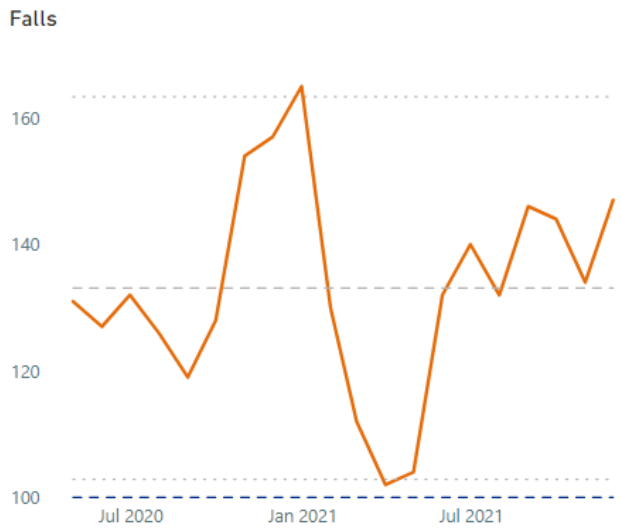
Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
165	130	112	102	104	132	140	132	146	144	134	147

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)

F 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.

Performance

147 falls were recorded in December. 102 were unwitnessed. The majority were low harm with 4 moderate and 1 death.

Due to site pressures the driver meetings have not been attended by the ward teams, but additional wards (Kings B, St Augustine, Camb M2, K and L), have completed training and commenced their A3s. They will be joining the fortnightly Falls Driver meetings.

The UEC care group continue to have the highest levels of falls across the trust.

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.
- A review and embedding of AMU Board rounds at WHH.

The Falls team have implemented a new FRAP that aims to prompt the reassessment of patients transferred from ED to the wards.

The yellow falls kits are now being procured and will be rolled out in UEC at WHH and QEQM, supported by the new deputy HoN at WHH and new QEQM falls team members.

Risks

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

... | M_00320_Falls

Last Updated | 17/01/2022 08:04:00

Executive Summary

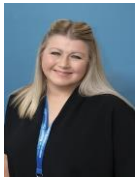
East Kent Hospitals University NHS Foundation Trust

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.

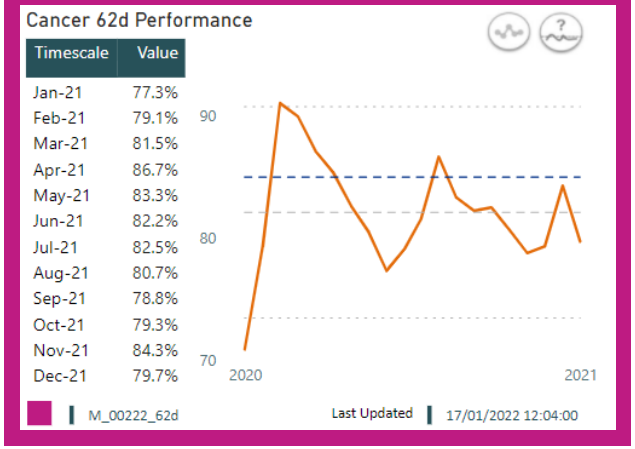


Sarah Shingler

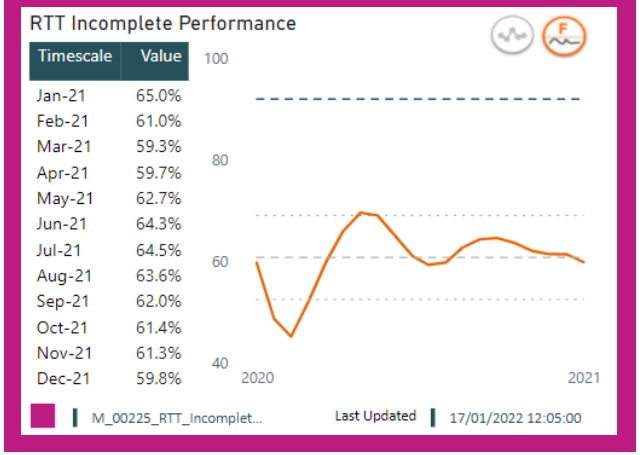
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

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.

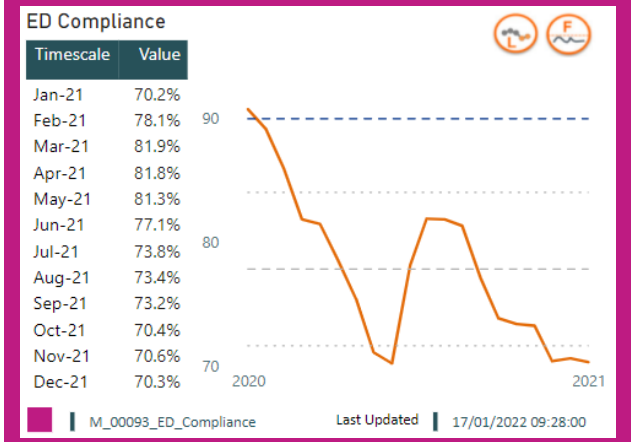
Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.



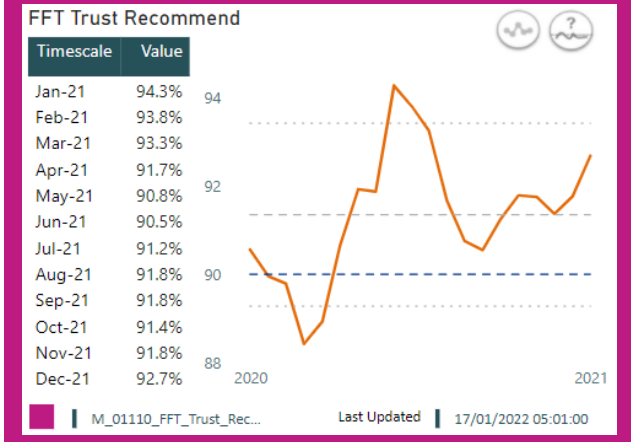
RTT: 18 Week Compliance
To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.



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

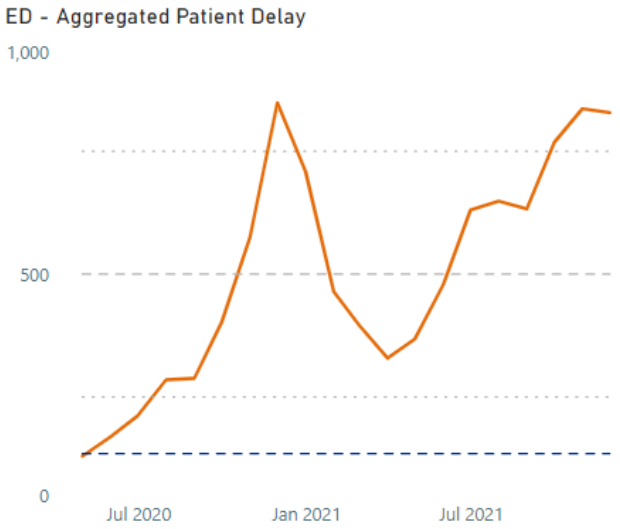
Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
732	460	385	311	353	475	644	664	647	797	873	864

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

D2 Driver is red for 2

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

Variation indicates consistently falling short of the target



Understand the data

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

We are driving this measure because....

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

We are making this an area of clinical and operational focus to drive down the wait times, improve flow and the standard of care for our patients.

Performance

Performance for December is an aggregated delay of 864 hours, which is a slight improvement against this metric.

The numbers of patients attending in December was above plan, with variation across the month due to the Christmas bank holidays and a peak in the last week in December. The increase in covid presentations also put pressure on to the emergency pathway and resulted in extended delays in ED whilst the appropriate ward environment was allocated.

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

The number of patients who have a DTA and are in the ED at 08:00 has decreased with a notable improvement week commencing 20 December, which reflects the huge efforts from within the Trust and local health economy to achieve 85% bed occupancy.

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

- Continued focus on streaming to UTC and SDEC pathways.
- Protecting SDEC capacity to maximise activity flow.
- 30% of discharges before midday.
- Increased use of discharge lounges.
- Reducing LOS on AMU to below 48 hours.
- Finalising the development of the 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.

... | M_00888_Agg_Delay

Last Updated | 17/01/2022 11:24:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

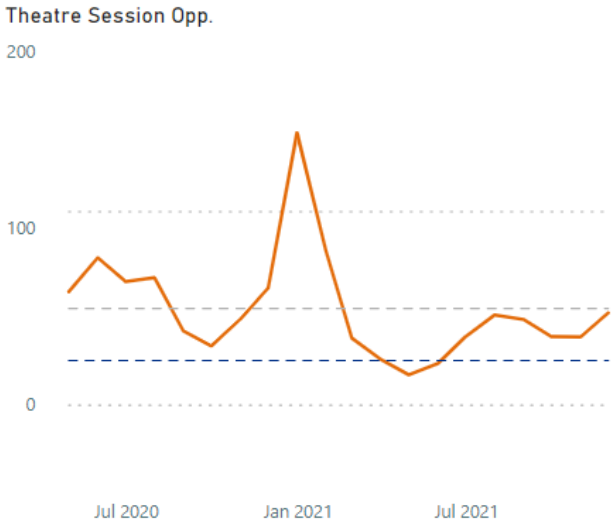
Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
154	87	38	26	17	23	39	51	48	39	38	52

Domain	Our Patients
True North	RTT - 18 Weeks
Metric Focus	Driver
Threshold	25
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 | 17/01/2022 09:36:00

Performance

Current Performance shows the equivalent of 52 sessions unused opportunity for December 2021, this is due in part to the number of cancelled sessions and patient availability during the Christmas and New Year period.

This has also been compounded by the Covid surge and limited availability of green beds at the WHH and QEQM, leading to cancelled surgery on the day. As such we have reviewed the theatre timetables and plans are in place to move colorectal surgery to Kent and Canterbury in the new Year for a period of 4 weeks.

The third wave of Covid has also led to the need to prioritise access to theatres at Kent and Canterbury and plans are in place to move colorectal cancer surgery

Cancellations remain an area of focus and we have seen the following cancellations in December :

Clinical Cancellations – 97

Non Clinical Cancellations -42

Patient Cancellations – 31

Following the communication of the 13th December re declaration of a level 4 national incident and internal non elective pressures we have agreed to only operate on priority level 1, 2 and Cancer cases and cancel all other activity. This has been agreed until the 7th February with a review at Gold each week . Therefore our focus moving forward is to :

- Ensure that our waiting lists are validated and available for surgery when we restart
- Increasing the pre operative pool
- Review of allocation to theatres.

Risks

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

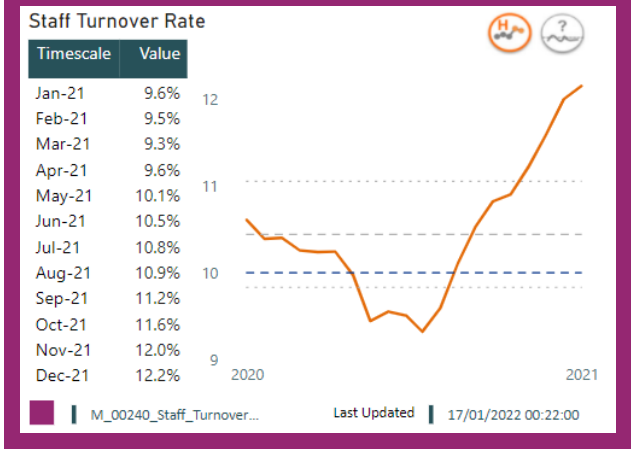
Staff Turnover (rate)
The annual turnover rate provides us with a high-level overview of Trust health.

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

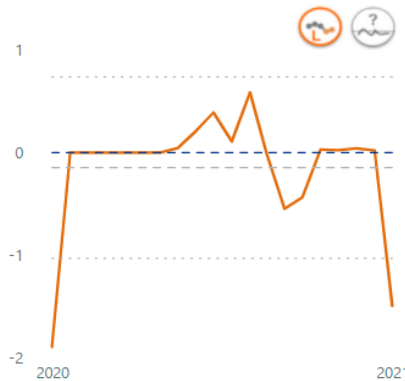
It is these areas we will be focussing on improving over the coming five to ten years.

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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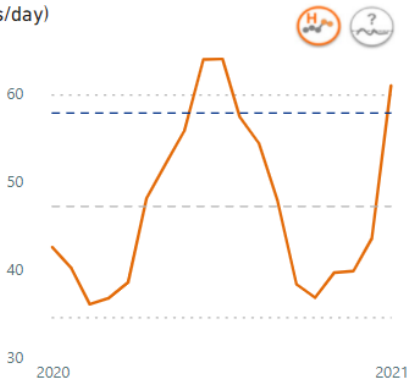
Carbon Footprint

To achieve an organisational carbon neutral footprint.

CO2e Total (tonnes/day)

Timescale	Value
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	43.52
Nov-21	60.90
Dec-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 through 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'.

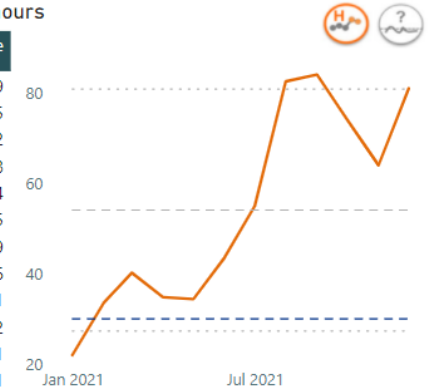
Innovation (Virtual OP Apps)
The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process.

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
Jan-21	21.9
Feb-21	33.5
Mar-21	40.2
Apr-21	34.8
May-21	34.4
Jun-21	43.5
Jul-21	54.9
Aug-21	82.6
Sep-21	84.1
Oct-21	74.2
Nov-21	64.1
Dec-21	81.1



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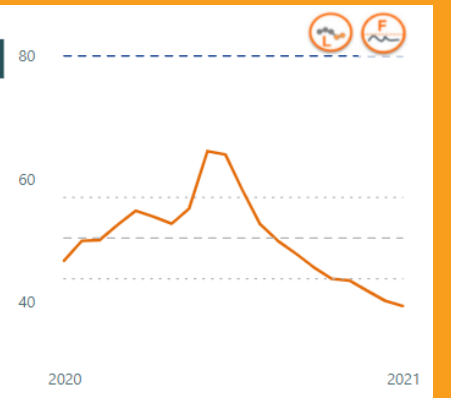
Innovation
To increase the use of technology and innovation in the delivery of high quality care for the EK population.

Virtual OP Appts

Timescale	Value
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	41.9%
Nov-21	40.2%
Dec-21	39.4%



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Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Sep-21	Oct-21	Nov-21	Dec-21
Harm Events	W4		Covid-19 HCAI	1	4	14	15	35
	W4		VTE Assessment Compliance	90.0%	89.2%	89.2%	89.5%	89.9%
	W4		Serious Incidents	18	26	24	35	24

Performance

Covid-19 HCAI

The Covid-19 HCAI cases for December are associated with the Omicron surge which has led to many unexpected cases across all pathways and specialties (many as incidental findings). These have led to secondary HCAI cases in greater numbers and outbreaks and have been very challenging to manage. This has been the experience of all facilities dealing with Omicron. This figure will be higher in January before dropping as the Omicron surge peaks.

VTE Assessment Compliance

The stratified data showing underperformance being driven by number of spells across GSM specialties and general surgery without VTE risk assessment. This is being addressed with the relevant clinical directors supported by the thrombosis group.

Serious Incidents

The number of SIs is consistent over recent months. The staffing levels continue to be reflected in root causes of incidents, either due to skills mix or number of staff. Other themes were missed/omitted/delayed diagnostics or medication administration, as well as falls and pressure ulcers.

Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Sep-21	Oct-21	Nov-21	Dec-21
Cancer 62d	W4		Cancer 28d Performance	75.0%	70.1%	72.2%	69.9%	65.6%
RTT - 18 Weeks	W4		DM01 Compliance	75.0%	73.1%	74.2%	73.3%	65.7%
	W4		RTT 35w Undated	8,500	9,720	9,434	8,894	9,315
	W4		RTT 1st OPA Booking Breaches	14,000	17,262	17,779	17,976	19,440
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	34.0%	34.7%	38.6%	39.2%
	W4		Super Stranded >21D	75	130	127	139	151
FFT	W4		FFT DC Response Rate	27.0%	25.5%	24.9%	25.9%	26.3%
	W4		FFT Maternity Response Rate	18.0%	4.0%	4.2%	4.3%	3.9%
	W4		Complaint Response	90.0%	36.1%	33.3%	19.7%	27.3%

Performance

Cancer

28 day performance has shown some deterioration and again this is due to the Covid surge, patient cancellations and the bank holidays. Focussed work is being undertaken in January and February to improve the position and provide, where possible more access to diagnostics and theatre capacity.

RTT 18 Weeks

The number of 35wk patients undated has increased in response to the national directive to prioritise P1,P2, Urgent and cancer patients who are often the shortest waiting patients. Whilst we continue to use the Independent Sector, Insourcing and other providers these have all been impacted by the Covid surge and the shut down of capacity over the Christmas and New Year period.

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. Streaming processes with senior nurses assessing patients upon arrival are improving our ability to assess patients within the hour.

FFT

Maternity; In consultation with MVP number of touch points reviewed and reduced down to 4 – changes will be in place from end of January with the numerator and denominator adjusted to reflect the agreement. Patient Experience TN being reviewed currently suggested changes to be presented to Board in February.

Complaints

Recent months have seen an increase in complaints received by the Trust, during a time when the Impacts of workload and staffing resulted in ward managers and matrons supporting frontline operations. This has resulted in significant delay to responding to complaints. A review of the complaints process is currently underway

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Sep-21	Oct-21	Nov-21	Dec-21
Staff Turnover Rate	W4		Staff Turnover: Nursing	10.0%	11.8%	11.7%	12.0%	11.7%
Financial Position	W4		Total Pay	0.0%	-1.9%	-1.9%	-1.5%	-1.2%

Performance

Staff Turnover

Total turnover has risen for a ninth month in succession and is above the True North target (10%) at 12.6%. However when measured in month it has improved for the third month in succession and by 3.7% September – December and stands at 11.45% down from 15.20%. The trend of improvement has continued with a clear downward trend across each of the last five months.

HCA turnover still presents a challenge and we experience peaks and troughs in the distribution throughout the year still. Interventions are having some effect to reduce the rate, but it remains a continual focus of local activity . Premature turnover continues to improve and sits within our gold-standard (20%) at 19.62%. This has been sustained for four months in succession and 6 out of the last nine months.

Financial Position

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 is supporting the Trust with a desk top review of temporary staffing.

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Sep-21	Oct-21	Nov-21	Dec-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Medication Errors; All	110	177	169	172	154
	W		Medication Errors; Severity C+	1	0	1	2	1
	W		Nutrition Incidents	60	58	54	61	67
	W		Pressure Ulcers: Cat 2	32	32	31	28	35
	W		Pressure Ulcers: Cat 3 & 4	3	1	1	0	0
	W		Pressure Ulcers: DTI	10	7	6	6	6
	W		Pressure Ulcers: Unstageable	10	8	7	5	9
	W		IPC: Audits Composite	80.0%	87.0%	88.0%	87.5%	87.4%
	W		Safeguarding Incidents	20	27	12	19	20
	W		IP Spells with 3+ Ward Moves	500	470	516	505	473
	W		Clinical Incidents	2,500	3,431	2,039	1,932	1,759
	W		Never Events	0	0	0	0	0
Mortality	W		Extended Perinatal Mortality	6.32	7.27	7.08	5.47	5.47

Appendix 1
Non-Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Sep-21	Oct-21	Nov-21	Dec-21
Cancer 62d	W		Cancer 2ww Performance	93.0%	97.0%	98.2%	98.0%	97.7%
	W		Cancer 31d Performance	96.0%	98.8%	98.6%	97.9%	98.3%
ED Compliance	W		Unplanned Re-attendance ED	10.0%	9.8%	9.7%	9.0%	10.6%
	W		Discharges by Midday	15.0%	15.2%	15.9%	16.5%	16.6%
	W		NEL Readmissions	15.0%	11.0%	10.6%	10.0%	11.1%
	W		Stroke Ward within 4 Hours	50.0%	50.0%	50.0%	55.8%	71.8%
FFT	W		FFT IP Response Rate	15.0%	16.4%	16.3%	16.8%	16.9%
	W		FFT OP Response Rate	17.0%	17.6%	16.9%	15.8%	17.7%
	W		Complaints	100	78	96	107	60
	W		PALS Enquiries	550	600	607	619	527
	W		Mixed Sex Breaches	500		272	289	69

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

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Sep-21	Oct-21	Nov-21	Dec-21
Staff Turnover Rate	W		Staff Turnover: HCA	13.5%	12.9%	12.9%	13.6%	13.5%
	W		Premature Turnover Rate	25.0%	19.8%	19.6%	19.3%	19.3%
Staff Engagement	W		Sickness	5.0%	4.5%	4.8%	4.8%	
	W		Appraisals Compliance	73.0%	73.7%	76.6%	78.1%	76.9%
	W		Statutory Training	91.0%	91.6%	90.1%	90.3%	91.6%
	W		Safeguarding Children Training	85.0%	91.3%	90.6%	90.6%	91.2%
Financial Position	W		Premium Pay	Traj.	7,092	6,783	7,255	6,441
	W		Non Pay	0.0%	1.2%	0.8%	0.1%	-0.2%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.21	0.22	0.21	
	W		CO2e Electricity (tonnes/day)	18.00	14.29	13.04	15.42	
	W		CO2e Water (tonnes/day)	0.55	0.22	0.20	0.23	
	W		CO2e Steam (tonnes/day)	9.21	7.31	8.38	11.08	

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
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	• Building works nearing completion • Detailed implementation plan for clinical move of patients in place	• 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	• Data to run at specialty level with names • Agreed to do info graphics to Drs every month to allow comparison • Job plan policy will be presented at next meeting • Review of Job plans of 10 or less PAs	• Data cleanse • Draft Infographic report • JP policy is going to committee on the for approval • Presenting Job Plan TPIP at clinical leadership meeting • 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 and costs	• 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.