NHS
East Kent
Hospitals University
NHS Foundation Trust

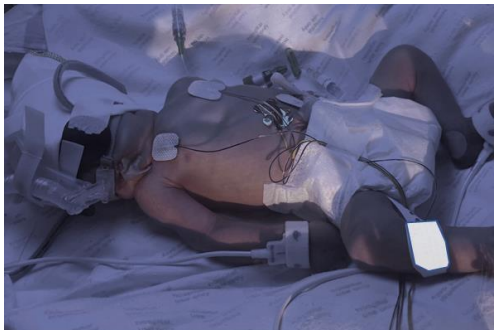
Integrated Performance Report

March 2022







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.

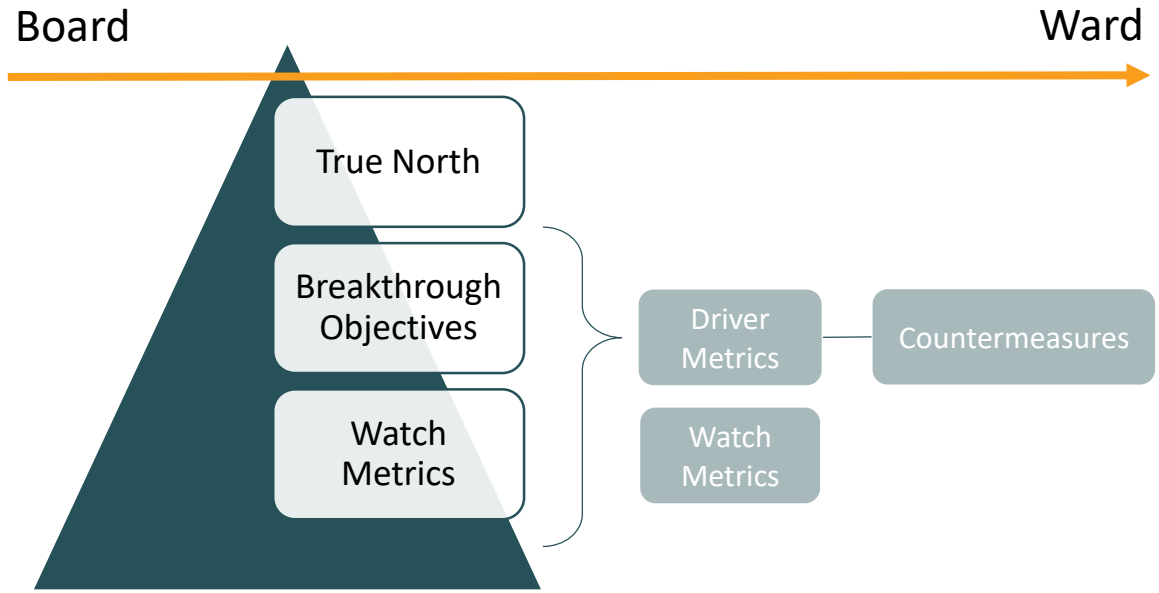
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

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)

Our quality and safety

Our quality and safety

Rebecca Martin

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 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
100.4	98.6	97.5	96.5	97.3	98.2	99.0	96.9	92.1			

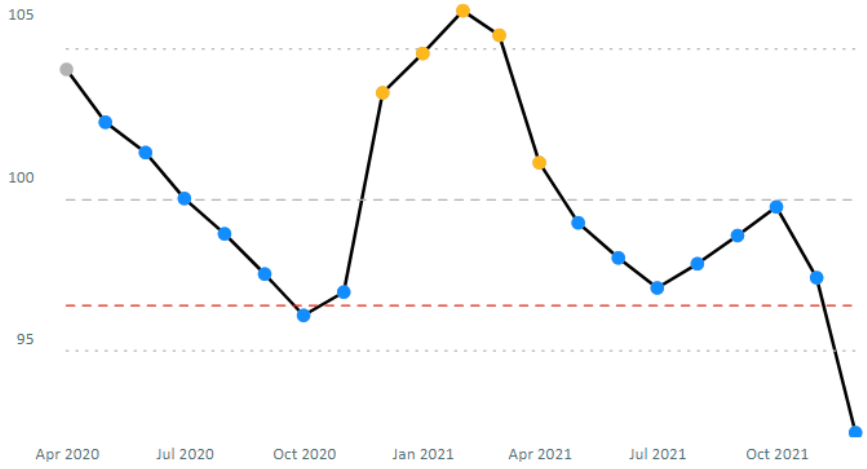
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group Astronomical Point

XMR Run Chart



What the chart tells us

The Trust HSMR has been improving since the end of the second Covid-19 wave in March 2021 and is now sitting below the lower control limit showing special cause variation of improving nature. The metric demonstrates a 12 month rolling position to December 2021 which is the last data release. There have been no new mortality alerts since the last report.

Nationally for all acute (non-specialist providers) we are 29 out of 124 on the Dr Foster (Telstra Health) platform and are in the statistically lower then expected group.

Intervention and Planned Impact

- The fracture Neck of Femur pathway is being revised to improve outcomes for this group of patients and time to theatre had been a driver metric for Surgery and Anaesthetic Care group. We have analysed the impact of reducing our current HSMR for fractured neck of femur from 118 to 100 on the overarching metric to give a reduction of 2 points on overarching HSMR. A Trust Priority Improvement Project (TPIP) is being developed for 2022/23 to support driving this at WHH and QEQM sites
- Current 12 month rolling HSMR for fractured neck of femur patients is improving but there are still key indicators within the National Hip Fracture database that merit further improvement or need to demonstrate improvements are sustained
- Mortality metrics continue to be reported and discussed at Mortality Surveillance Group and intelligence used to drive deep dives into pathways where indicated
- There were no new mortality alerts at the time of writing this report.

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk although the baseline appears to have settled which is sustained will give a clearer impact of improvement activity.

Our quality and safety

Sarah Shingler

Incidents with Harm

The True North target is to achieve zero incidents of moderate and above avoidable harm incidents within 5 years. We want to reduce harm caused to patients, to improve their experience and outcomes. Tissue Viability including pressure ulcer is the largest contributor (accounting for 37.3% of actual harm), however 76.8% of cases are admitted with this harm so have been removed from our numbers giving a monthly average of 28 incidents of total harms graded moderate and above. **Our target for the next 12 months is to reduce avoidable harm incidents of moderate harm and above to no more than 26 incidents per month by 26 by March 2023 (5% reduction).**

The breakthrough objective will be to reduce all harm incidents with a harm severity score of moderate and above, this will be achieved through the Fundamentals of Care and Patient Voice and Involvement workstreams.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
36	41	32	45	33	23	40	25	28	37	31	36

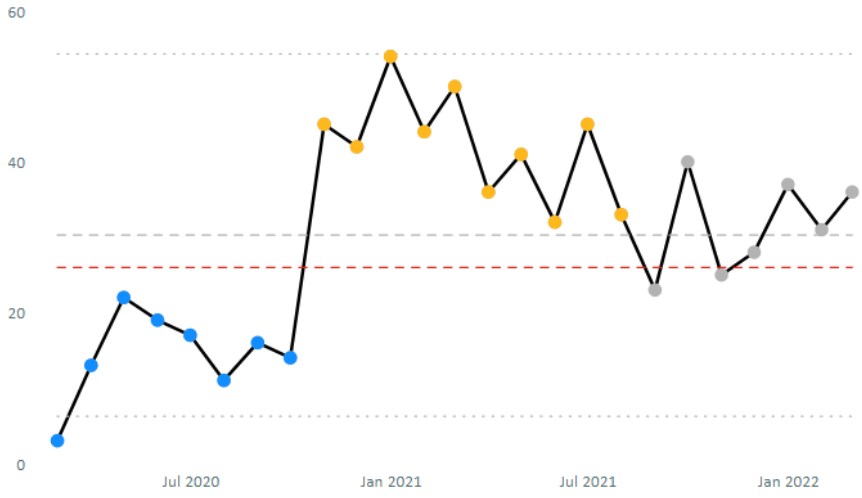
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart is showing the new metric which details all incidents with a harm severity score of moderate and above. **There were 36 incidents with a severity score of moderate and above in March.** The biggest contributor was Tissue Viability followed by Care/Treatment and then Operations / Procedures. There were 3 falls incidents in March which resulted in moderate harm or above.

Intervention and Planned Impact

Safe staffing is a major factor contributing to patient harms, we are now beginning to see a direct correlation between low staffing levels and harm. A business case has been approved and the ambition is for ward staffing to be right sized by December 22.

The speciality nursing teams are having an increased presence in both Emergency Departments to support both clinically and educationally. Associate Director Of Nursing for Quality and Fundamentals of Care commenced 11th April and will be the SRO for the True North harm breakthrough objective and chair weekly driver meetings with the frontline teams.

Oversight of progress is reported through the Fundamentals of Care Committee with exception reporting into Quality & Safety Committee (QSC). Ward accreditation scheme is being launched to coincide with wave four of 'we care'. A FoC audit is being piloted to provide assurance that risk assessments are being completed and staff are compliant with interventions to drive improvementsAn improvement plan is being finalised for nutrition, falls and pressure ulcer care linked to strategic objectives and RAG rated.

Risks/Mitigations

Wards with high number of moderate and above harm incidents will be invited to the weekly driver meetings. Temporary staffing strategies are in place to support QEQM ED and AMUs and other wards where staffing is significantly compromised and where enhanced care is required. Ward leaders and Matrons out on the floor supporting ward teams, increasing oversight that risk assessment and falls/pressure strategies are being used. Back to the Floor exercise taking place 5 May.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22
Harm Events	W4		Falls		100	152	164	148	145
	W4		Covid-19 HCAI		1	36	181	138	194
	W4		Nutrition Incidents		60	68	66	77	67
			Pressure Ulcers: Unstageable		10	10	7	11	15
			IP Spells with 3+ Ward Moves		500	474	497	541	571
			Maternity Serious Incidents		2	1	1	1	7

Falls
Due to increase in covid +ve patients and de-escalated patients, the need for contact bays/wards has increased, therefore patients are having an unprecedented number of ward moves.
Due to staff sickness and reduced temporary HCA staffing this has resulted in patients requiring enhanced observations not always receiving it. Covid has reduced the ability to provide co-horting bays for observation.

Nutrition Incidents
Staffing challenges result in lack of oversight for MUST scoring, dietetic requirements and dysphagia requirements.
Staffing levels on the wards have resulted in a reduced nurse presence at mealtime huddles and prioritising patients requiring assistance. The nutrition team are targeting and supporting these areas.
Increase in PICC line infections for parental nutrition due to poor line care. Nutrition team have already met with Infection control and IV access team to raise awareness and support high usage areas.

Pressure Ulcers: Unstageable
Increased pressure ulcer reporting in End of life patients after targeted education.
Prolonged duration patients are in ED in chairs or on a trolley.
Gaps in documentation regarding re positioning, likely to be caused by staffing challenges, all unstageable damage reported on buttocks except for the Medical device related damage.
Increase in moisture damage due to sheering, TV teams working collaboratively with moving and handling teams to target areas with poor slide sheet compliance.
Increased pressure damage in covid +ve patients

Maternity Serious Incidents
A new process has been implemented by the Care Group which has provided an increased rigour over the rapid review process when incidents occur of moderate or greater harm. The threshold for declaring an SI is low, to ensure lessons learnt are identified and immediate actions taken to address concerns. In addition there is an Executive SI panel where further challenge and scrutiny is given to each case declared.

Our patients

Our patients

Rebecca Carlton

Trust Access Standards: 18wk Referral to Treatment

The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the 'sustaining access' Strategic Initiative early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
59.7%	62.7%	64.3%	64.5%	63.6%	62.0%	61.4%	61.3%	59.8%	59.6%	59.5%	58.9%

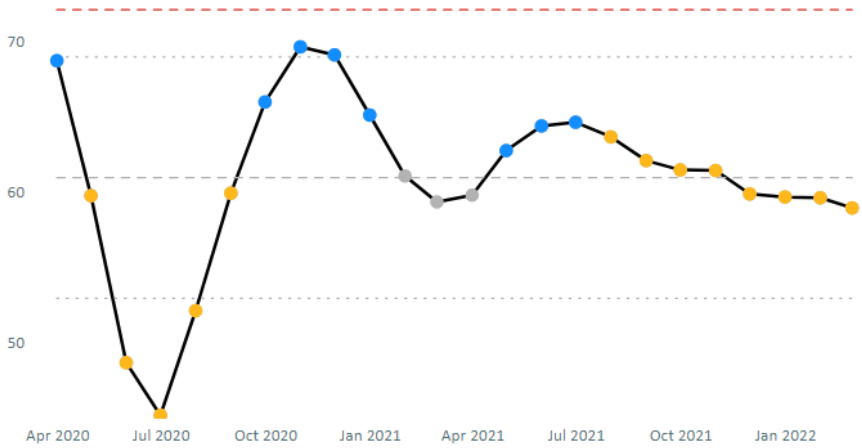
F — Variation indicates consistently falling short of the target

L — Special cause of concerning nature or higher pressure due to lower values

Flag Description

Descending Run Group

XMR Run Chart



What the chart tells us

Performance reduced rapidly at the beginning of the pandemic with the lowest performance occurring in July 2020. During the initial elective recovery phase in spring/summer 2020 performance improved, dipping to a lesser extent during waves two and three. Performance is demonstrating a special cause variation of a decreasing nature over the last 6 months with performance now below the mean for the period.

Intervention and Planned Impact

- Maximise theatre and outpatient capacity to treat more patients including returning red recovery areas back to theatres to provide more capacity .
- Theatre timetables being reset to ensure specialties have required access to theatre to treat urgent, cancer and long waiting patients.
- Continue to transfer patients to local IS and community providers.
- K&M system have offered to support with treating 2500 patients through the Shared PTL (West Kent IS providers) and a further 1200 at the newly built barn theatres.
- Continued validation of the waiting lists
- Re launch of the Access Policy (following approval at PAG) and training and support to ensure adherence.

Risks/Mitigations

- Patient choice on date of TCI
- Patients unwilling to move to another provider
- System unable to provide support for Shared PTL transfer of patients- particularly Otology
- Theatre estate and vulnerability

22/23 breakthrough objective

Theatre Session Opportunity

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.
It is imperative that elective surgery deferred during the global pandemic 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.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
26	17	23	38	51	48	39	38	52	54	60	39

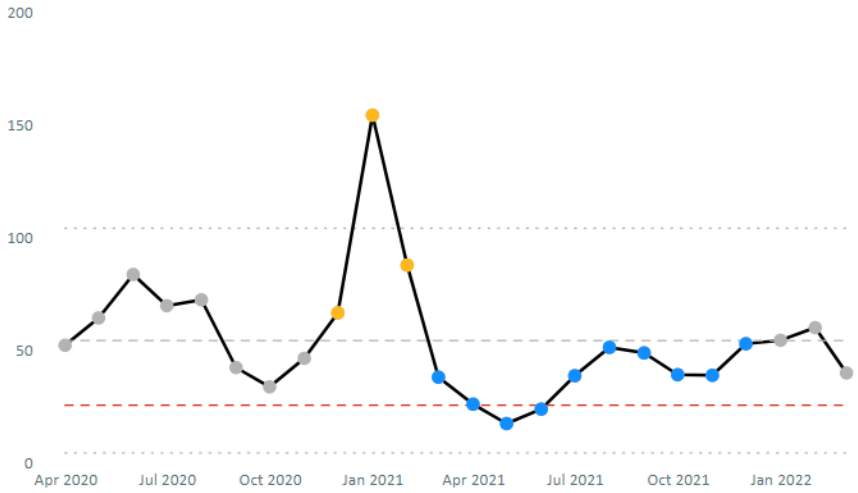
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Current performance shows an opportunity of 39 sessions of theatre capacity available which is a significant improvement on the previous month.
Review of the data identifies that the opportunity is made up of :14 cancelled sessions,12 sessions related to early finishes ,6 sessions related to turnaround times, 5 due to late starts and 2 due to cancellations on the day

Intervention and Planned Impact

- Validation of the data and recording continues and contributes to improved performance.
- 6-4-2 process being implemented to ensure timely offering out of vacant sessions and therefore a reduction in cancelled sessions.
- Continue to push for 95% booking of theatre lists to ensure maximum in session utilisation.
- On time starts continues to improve with theatre managers ensuring patients are sent for in a timely manner to prevent delays.
- Cancellations on the day are reducing and all potential cancellations are escalated before final sign off to ensure we have explored all options.
- Relaxation of IPC rules will support minimising loss of capacity due to short notice as it will be easier to backfill the lists. New pre operative testing SOP agreed.

Risks/Mitigations

- Breakdown / Replacement of essential theatre estates will reduce available capacity- where planned we are reallocating sessions where possible.
- Re instatement of IPC measures – Covid
- Further waves of Covid .
- Theatre staffing/ recruitment.

Our patients

Rebecca Carlton

Trust Access Standards: >12h total time in department

The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department where clinically appropriate. There is a nationally proposed new set of ED Access Standards which will focus on 12 hour Total Time in Department. This measures from arrival to either discharge, transfer or admission.

ED performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
2.3%	3.0%	4.4%	7.0%	6.7%	6.0%	8.5%	9.8%	9.6%	9.5%	9.2%	11.0%

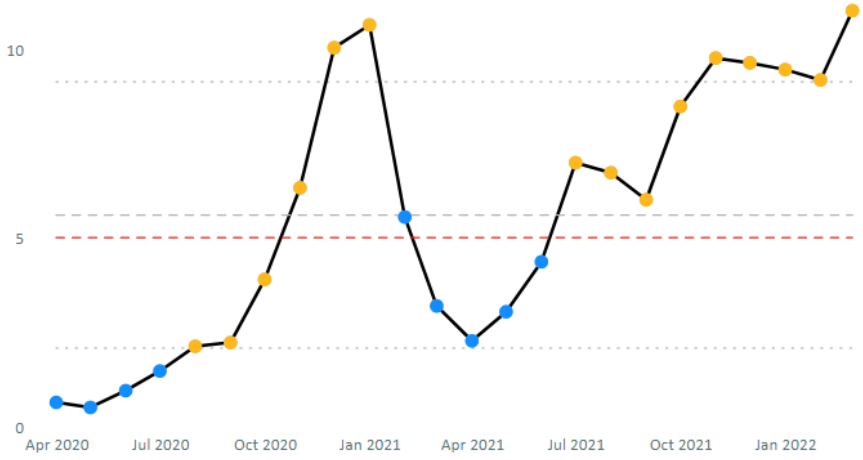
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The new national standard is for no more than 2% of patients to spend longer than a total of 12hrs in the emergency department, from arrival until being admitted, transferred or discharged. In April 2021 the Trust achieved 2.3%, since then as the Covid pandemic has receded and then intensified the Trust performance has deteriorated to approximately 9.5% since November. In March performance deteriorated to 11% which reflects increased Covid presentations, which have put the emergency pathway from ED through to admission and discharge under extreme pressure.

Intervention and Planned Impact

- Analysis has been completed to segregate Patients on a non admitted and admitted pathway to understand the delays and opportunities for improvement. Analysis has shown that 3.2% of patients are on a non-admitted pathway and there is opportunity to improve timeliness to diagnostics or via direct access pathways to SDEC.
- Internal meetings involving senior clinical leaders have been held in March which have identified improvements to the general medical rota, SDEC pathways and the current medical model which will positively impact on the time a patient has to wait in ED for a bed allocation.
- Refocus and commitment to increasing the number of discharges before 12 noon daily which will release bed capacity for those patients who have been admitted overnight.

Risks/Mitigations.

- Increasing number of patients with a LOS of >21 days due to insufficient PW1 (domiciliary care) and PW3 (residential/nursing home care) awaiting supported discharge. – mitigation continued via whole system working to escalate issues and commission appropriate capacity.
- Increased Covid presentations and delays in bed allocation due to IPC requirements – mitigation review IPC guidance in accordance with National Policy. Minimise patient moves to reduce cross infection.
- Increased patient acuity resulting in requirement for more complex diagnostics and senior clinical review - Ensure senior Consultants are available 7/7 to review patients in ED and on ward base.

22/23 breakthrough objective

Same Day Emergency Care (SDEC)

Ensuring patients are seen and treated in the right setting, at the right time and in the right way are key aspects of efficient and effective patient care. A number of patients currently accessing our Emergency Departments can be safely assessed, treated and discharged via a Same Day Emergency Care pathway, such as Emergency Ambulatory Care, Gynaecology, Surgery or Frailty). Access to an SDEC service may be following a direct referral by a GP or via the Emergency Department.

It is anticipated that an average of 2,600 patients each month can be safely seen and treated via a Same Day Emergency Care pathway, this is the ambition for 2022/23.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
1,507	2,115	2,078	1,996	1,752	1,800	1,933	1,669	1,845	2,144	1,942	2,290

F

Variation indicates consistently falling short of the target

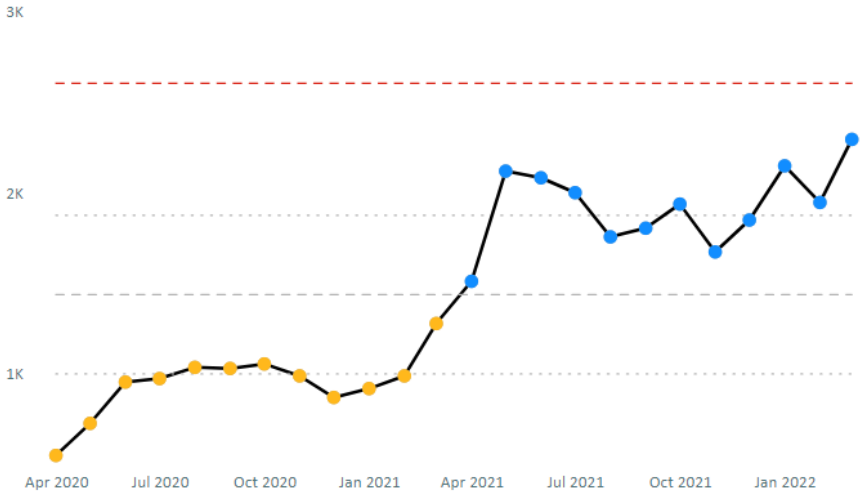
H

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

Flag Description

Above Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The number of patients accessing SDEC services has increased significantly since April 2020. There appears to have been a step change in April 2021 aligning with additional emergency care services coming on line. There has been some more recent growth since November 2022.

In March 2022, a total of 2,290 patients were treated via an SDEC pathway, this is the highest number in the last 24 months.

Intervention and Planned Impact

- This is a new area of focus (Breakthrough Objectives are reviewed annually), we are currently engaging key stakeholders and developing our improvement plan.
- A recent data collection exercise within the ED has helped to identify that there is potential to stream to existing SDEC pathways with a capacity being a challenge.
- In early May changes to the WHH estate will enable some moves to increase capacity in SEAU and FAU.
- Identify relevant staff to attend training and explore opportunities within their individual environment
- Weekly driver meetings focussing on the Emergency village are being restarted.

Risks/Mitigations

- Ongoing winter pressures may limit staff availability to attend training/driver meetings. **Mitigation:** Support from leadership teams to give staff the time and promote importance.

- IPC constraints**. Mitigation**: Using new capacity more flexibly to support different IPC needs

Our patients

Rebecca Carlton

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patients are seen, diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
86.7%	83.3%	82.2%	82.5%	80.7%	78.8%	79.3%	84.3%	78.0%	75.8%	71.7%	74.7%

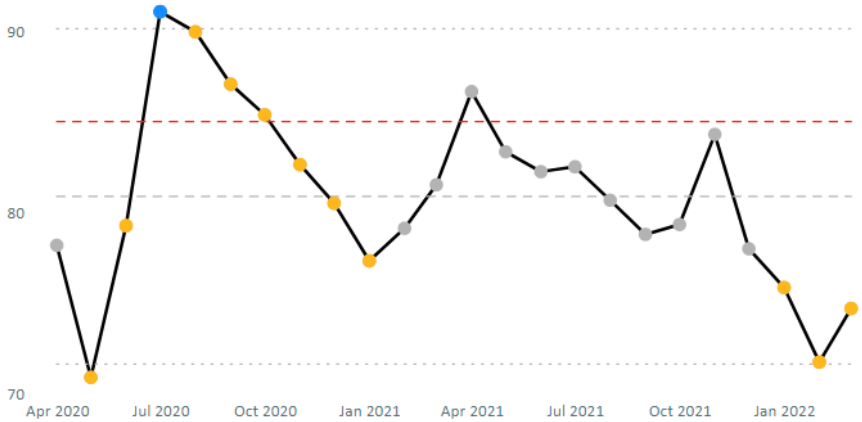
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Performance increased significantly following the prioritisation of Cancer pathways at the beginning of the pandemic achieving the standard for four consecutive months. With the exception of May 2020 all data points fall within control limits. Performance began to dip during the first recovery phase as demand into the Trust began to resume normal levels. The target has been met 5 times in the last 20 months and was narrowly missed, post validation, in November 21. Although the performance has deteriorated Kent and Medway Cancer Alliance continued to record the lowest back log of all cancer Alliances, East Kent Hospitals is the largest contributor to this. Performance has improved to 74.7% in March.

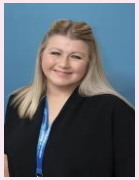
Intervention and Planned Impact

- Daily review and escalation to the Care Group for every patient ensuring an optimal plan is in place to progress patients pathway. This is supported by CNS clinical oversight and operational teams to progress diagnostics or review.
- Processes to highlight all breach dates to the relevant teams to ensure patients are booked within breach.
- Restore face to face out-patient appointments where appropriate and continue reviews of current clinic capacity and support provision to ensure consistency on each site where appropriate.
- Continue to prioritise Cancer referrals for Endoscopy and Radiology diagnostics.
- Weekly meetings established between Radiology and Cancer services to confirm demand and capacity required to achieve timely diagnostics.

Risks/Mitigations

- Availability of ring-fenced capacity for MRI and CT scans impacting the cancer pathway. This is being mitigated with support from the Cancer and Clinical Support Services Care Groups to progress the plan to continue to reduce diagnostic wait times.

Our patients



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.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
91.6%	90.7%	90.0%	90.5%	90.9%	90.9%	90.2%	91.0%	92.0%	92.5%	91.4%	92.3%

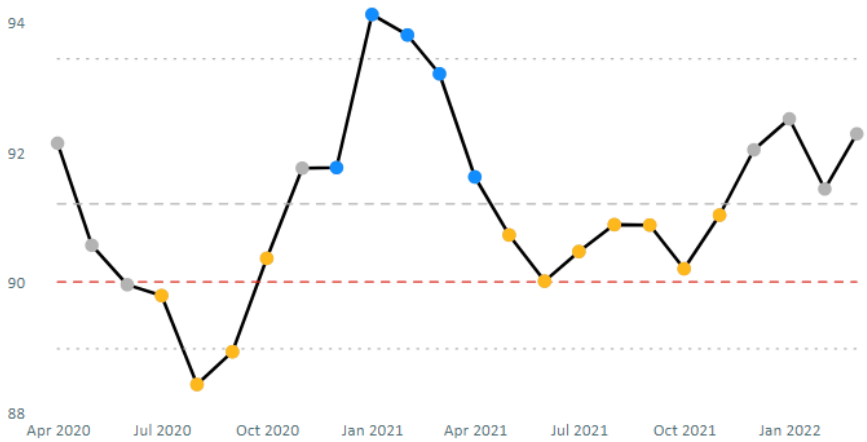
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The Trust has achieved the threshold target of 90% consistently since October '20 for patients who would recommend the Trust as a place for treatment. Performance peaked in Jan/Feb '21 outperforming the upper control limit for the period. However, recent performance shows that this improvement has not been sustained despite an improvement from the February position.

Intervention and Planned Impact

The True North for Our Patients has been recently reviewed; moving forwards in addition to FFT the breakthrough objective will focus on ten questions from the in-patient experience survey. Alongside this the ward accreditation project commences roll out in May 22. All in-patient adult wards will complete 50 in-patient surveys per month, with ward leaders and matrons having responsibility and oversight for addressing concerns and driving improvements. This will link into the We Care improvement work.

The Patient Voice and Involvement Strategy has been approved. A business case to resource the Patient Voice team has now been approved, with recruitment commencing.

Maternity patient experience project 'Your Voice is Heard' commences April 22, ambition to capture feedback from every woman who gives birth in one of our units (6000 births per year)

Risks/Mitigations

If culture and behaviours do not change there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 62d			Cancer 2ww Performance		93.0%	97.7%	96.6%	96.6%	97.4%
	W4		Cancer 28d Performance		75.0%	66.5%	62.5%	71.2%	67.2%
	W4		Radiology Diags vs Plan		Traj.	14,957	15,775	15,423	16,628
	W4		Endoscopy vs Plan		Traj.	1,044	1,262	1,424	1,383
RTT - 18 Weeks	W4		RTT 52w Breaches		Traj.	4,475	4,327	3,891	3,755
	W4		DM01 Compliance		75.0%	65.7%	62.3%	68.0%	67.2%
	W4		RTT 35w Waiters (w/o TCIs)		8,500	9,315	9,826	9,514	9,571
	W4		RTT OP Booking Breaches		14,000	19,440	19,193	19,696	20,245
	W4		Elective Admissions vs Plan		Traj.	5,275	5,192	5,779	6,265
ED Compliance	W4		ED Compliance		90.0%	70.3%	70.1%	72.0%	66.7%
	W4		Clinician First Seen within 1h		50.0%	38.6%	37.7%	36.0%	25.9%
	W4		Super Stranded >21D		75	151	186	172	193
	W4		Discharges by Midday		15.0%	14.4%	14.1%	14.8%	13.1%
	W4		NEL Admissions vs Plan		Traj.	6,265	6,493	6,150	6,643
FFT			FFT ED Response Rate		12.0%	12.4%	13.2%	14.8%	14.6%
	W4		FFT Maternity Response Rate		18.0%	3.9%	3.8%	10.4%	10.1%
	W4		Complaint Response		90.0%	25.0%	21.9%	13.8%	8.2%
			PALS Enquiries		550	526	677	748	889

Cancer

28 And 62 day performance has deteriorated in month due to delays in diagnostics, particularly radiology and the need for ringfenced Cancer diagnostic capacity. The CDC opened in October 21. Contrast started March 22. The expansion of the service to include contrast has had an immediate positive impact on Cancer diagnostic wait times. At the start of March the average wait for Cancer diagnostics was 28 days. As of 22nd April this has been reduced to 10 days.

RTT 18 Weeks

The number of patients waiting over 52 weeks continues to reduce as we treat long waiting patients. Patients waiting over 35weeks undated remains static but anticipate improvements as we improve theatre utilisation and capacity.

DMO1 remains a challenge due to the non elective demand for diagnostics but additional capacity is being explored across the system.

ED Compliance

As the Covid numbers have continued to increase, this has put additional pressure on the ED staff to manage patient flow within the IPC guidelines.

The Hospital Directors are proactively supporting the leadership in the Operational Control Rooms and working closely with the UEC, Surgery and GSM Care groups to increase the % of discharges before 12 noon.

For those contact patients who require supported discharge to a residential or nursing home this may delay their discharge further and has added to the complexity regarding bed management and increased number of patients who 'No Longer Meet the Criteria to Reside' in Hospital.

FFT

Maternity; The appropriate touch point times when the FFT questions will be asked during pregnancy have been agreed and the numerator and denominator has been adjusted to reflect the agreement. This was put in place early March therefore improvement is expected in April reporting. Although some improvement seen in month

EDs: both EDs were extremely challenged throughout March, with overcrowding and long waits. FFT data triangulates with PALS concerns and formal complaints received during this period.

Our people


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our people

Andrea Ashman

Staff Engagement (score)

Staff Engagement levels have remained below the national average throughout the last five years. The Staff Engagement Index itself (6.4) has been on a downward trend for three years and, as an organisation, we are one of the most challenged in the country, sitting in the bottom 20% nationally. Given the negative implications of reduced staff engagement, it is imperative that levels are significantly and consistently improved.

The National NHS Staff Survey (NSS) is used to give an indication of staff engagement, providing an overall Staff Engagement Index to the Trust. In order to monitor this more regularly, we are also measuring this at quarterly intervals through the National Quarterly Pulse Survey (NQPS). Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
6.6	6.6	6.6	6.3	6.3	6.3	6.4	6.4	6.4	6.4	6.4	6.4

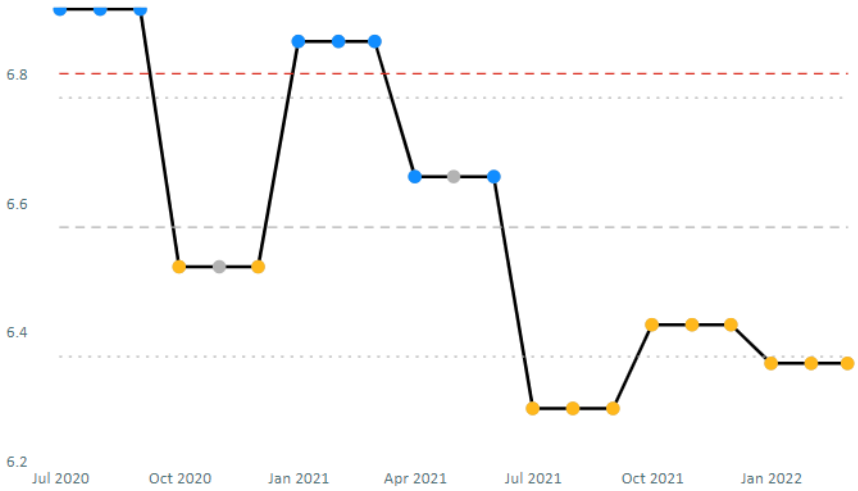
F — Variation indicates consistently falling short of the target

L — Special cause of concerning nature or higher pressure due to lower values

Flag Description

Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

Whilst there was an immediate 'bounce-back' following the NSS results in 2020, staff engagement levels have since fallen and have plateaued just above the lower control limit of the SPC chart. The most recent data indicates no significant change across the last 9 months. Staff engagement remains well below mean performance and is consistently missing the desired threshold.

Interventions and Planned Impact

A comprehensive programme of work has taken place to understand the 2021 National Staff Survey results and use this evidence-base to develop tailored action plans with each of our Care Groups. An industry-leading dashboard has been developed by the Staff Experience and Information Teams in order to relay the results in a more discoverable and accessible way. Using this tool, more robust analytics are helping drive concerted and consistent action, and should give confidence that the organisation is able to identify key areas of challenge and act in a timely manner on concerns raised.

The NHS measures staff engagement by considering three key domains; motivation, involvement and advocacy. We perform poorest nationally against the involvement domain. It also represents the most heavily weighted aspect of engagement and significantly influences advocacy and motivation. As a result, a breakthrough objective has been established for involvement. This will ensure improvement is driven in those areas where this will have the greatest impact.

Levels of motivation have also fallen throughout the last year and contribute to the overall reduction in staff engagement. This is a national phenomenon and has been attributed to burnout. As a result, a comprehensive package of proactive wellbeing support is now available and easily accessible through a variety of vehicles across the organisation.

Risks/Mitigations

The National Quarterly Pulse Survey (NQPS) data for Q4 shows a consistent position since October 2021. The NQPS for Q1 (2022/23) is currently taking place and will close on 31st April. Data will be available in May 2022 to determine the latest position. A True North for staff engagement is now supported by a breakthrough objective on Involvement. An accessible and discoverable dashboard is enabling robust analytics and action plans are being developed locally to drive improvement.

22/23 breakthrough objective

Staff Involvement Score

The Trust's staff involvement score of 6.2 (out of 10) is lower than the national average for acute trusts (6.7). Staff involvement is one of the 3 components that contributes to staff engagement – the We Care People True North. Of the three components, staff involvement is more heavily weighted, it can be tangibly impacted and also influences the other two components - staff motivation and advocacy. Our aim is to improve staff involvement, as a core aspect of improving the overall staff engagement score.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
6.4	6.4	6.4	6.1	6.1	6.1	6.4	6.4	6.4	6.2	6.2	6.2

F

Variation indicates consistently falling short of the target

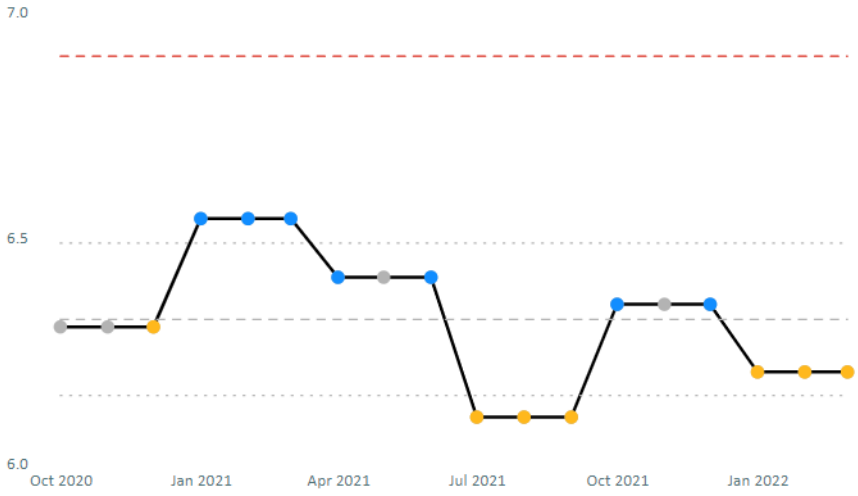
L

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The chart shows that the staff involvement score has dropped to 6.2 (measured as part of the quarterly pulse check). Staff involvement measured by 3 questions in the staff survey and quarterly pulse check:

- opportunities to show initiative frequently in my role
- able to make suggestions to improve the work of my team/dept
- able to make improvements happen in my area of work

Intervention and Planned Impact

- This is a new area of focus (Breakthrough Objectives are reviewed annually), we are currently engaging key stakeholders and developing our improvement plan
- Staff survey data has been reviewed and 10 priority areas have been identified (worst scores for involvement). An initial cohort will be identified from these 10 areas
- These priority areas will lead to the identification of relevant staff to attend training and explore opportunities for staff involvement within their individual environment

Risks/Mitigations

- Nationally, levels of staff involvement in the NHS have been on a downward trend for the last 3-4 years
- Pressure from regulators requiring immediate action, which may work against involving staff
- The A3 plan is still in development which will highlight key actions and potential further risks

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22
Staff Turnover Rate	W4		Staff Turnover Rate		10.0%	12.2%	12.3%	12.6%	12.9%
	W4		Vacancy Rate		9.0%	9.9%	9.3%	12.7%	12.7%
	W4		Staff Turnover: HCA		13.5%	13.5%	14.3%	14.1%	14.2%
	W4		Staff Turnover: Nursing		10.0%	11.7%	11.7%	11.8%	11.8%

Staff Turnover

Total turnover, when measured as a rolling 12-month average, has risen for a twelfth month in succession and remains above the True North target (10%) at **12.9%** (March 2022).

Real-time turnover, however, has been steadily improving for five months, fell as low as 11.27% in February and compares favourably against the South East turnover average of 14.3%.

However this has inflected sharply upwards in March to **15.53%**. This rise is the result of **100 leavers**, 20-30 more than in any previous month of the year. Almost 25% of this turnover is comprised of nurses, spread primarily across GSM, S&A and UEC.

It is worth contextualising that **42%** of these 100 leavers have retired, and that the timing of this is in-line with the end of the financial year. Whilst more challenging to mitigate against, the Trust has tried to alleviate this, where possible, by engaging with a specialist partner to encourage colleagues to understand the wider benefits of continuing to work through pre-retirement workshops. Since their inception at the end of last year **111 colleagues** have attended these and a further 51 are booked to attend in the next month.

The end of year position identifies that there have been 1,492 joiners and 976 leavers throughout 2021/22, giving a growth of **516 WTE**.

Vacancy Rate

Reflects the impact of increased establishment

Our sustainability

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 last two financial years a breakeven position or better was delivered. This metric will measure us against our long term aim to maintain a breakeven position.

For 2021/22 the impact of Covid-19 paused the NHS business planning process nationally and had limited the ability of the Trust to hit its cost efficiency targets. In 2022/23 there is a return to a more traditional planning process and an efficiency target of £30m, in additional to Covid spending reductions of £9m and elective recovery fund income of £18m. The current plan is a deficit of £22m and will be reported against next month.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
-0.548	-0.438	0.030	0.024	0.042	0.021	-1.494	-0.996	-0.941	-0.090	1.307	0.076

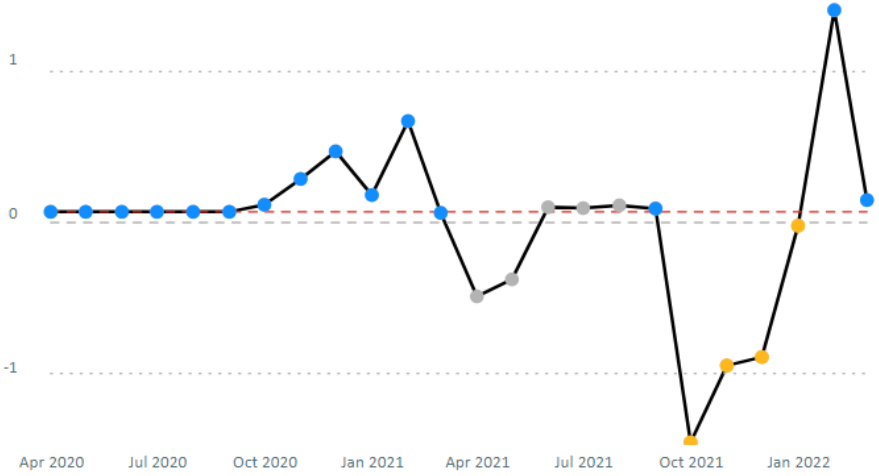
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Outside Moving Range Limit

XMR Run Chart



What the chart tells us

Since April 2020 the Trust's I&E margin has been broadly achieving a breakeven position. During the second half of the year the Trust started to post a small deficit driven by uncertainty in income flows, as these were firmed up the Trust reported a surplus by year end.

Interventions and Planned Impact

The Trust has a surplus position which is driven by less than expected service development costs and increased winter pressure funding from the CCG.

The Trust worked with the regional Kent & Medway system partners and NHSEI to ensure we were appropriately reimbursed for any unavoidable costs and additional funding has been agreed for the increase in patients seen through the emergency department.

The Trust delivered a small surplus in 2021/22.

Risks/Mitigations

For 2021/22 the accounts are being audited and will be subject to review until mid-June 2022.
For 2022/23 the key risk and mitigations are:

- Efficiency target of £30m, PMO team working with care groups and exec directors
- Covid-19 spend reductions £9m, DIPC working with finance to release costs
- ERF delivery £19m, 104% of 19/20 activity to be delivered, care groups have plans and weekly oversight by COO.
- Non-pay inflation. Currently inflation in plan is at 2.7% whereas ONS has it at 6.1% creating circa a £6.5m gap Procurement are working closely with NHS E procurement and supply chain to minimise impact.

22/23 breakthrough objective

Premium Pay Spend

Premium pay spend consists of agency (circa £36m per annum), bank (circa £32m per annum) and overtime/ locums (circa £19m per annum) across the Trust. The total value is around £87m per annum (18% of total pay bill). These costs are amongst those that can be most influenced by the management of the organisation and therefore a good area for a breakthrough objective that will positively impact the finances of the Trust.

The objective is to reduce the spend by 10% or £8.7m in 2022/23 but maybe refined once the full project plan is developed.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
7,829	7,396	5,768	7,134	7,351	7,092	6,783	7,255	6,441	7,168	7,403	9,148

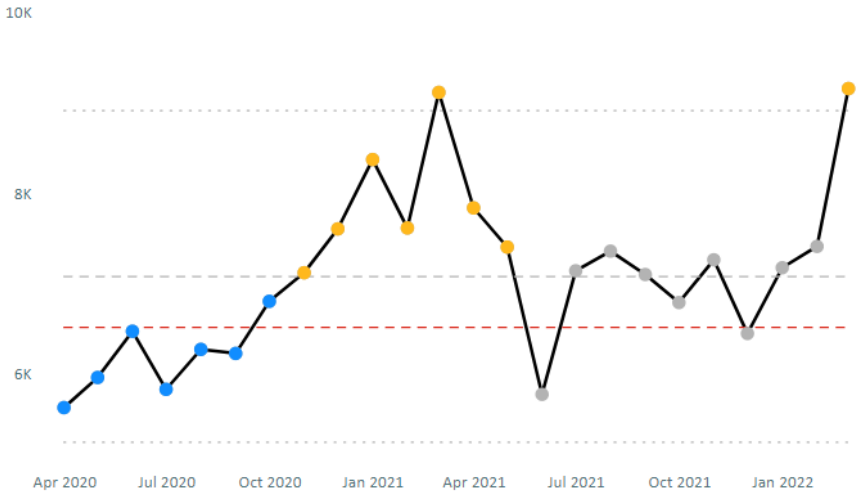
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point

XMR Run Chart



What the chart tells us

The chart tracks premium pay spend in £'000 across the last two years. There are two points in March 2021 and March 2022 where a spike is seen above the usual control limits, historically this is caused by the Trust ensuring that all costs for that financial year are captured and will include unpaid claims that are due in year.

This information is the baseline for which we will measure improvement over 2022/23.

Intervention and Planned Impact

- The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all care groups to help deliver.
- The working up of an A3 project plan is still in progress and will be reported through EMT and PRMs and subsequently Board each month.
- Key Interventions include:
  - Formalising and strengthening the weekly premium pay meeting.
  - Recruiting to the temporary staffing team.
  - Converting medical agency to direct engagement model.
  - Review of bank, agency and overtime rates across all staff groups.
  - Ensure improved sign off processes and governance across the Trust.
  - Recruitment to key clinical posts to reduce the need for temporary staffing.

Risks/Mitigations

- The temporary staffing team is not fully established but posts are out to advert.
- The A3 plan is still in development which will highlight key actions and potential further risks.
- The Covid-19 pandemic comes in waves which drives increased sickness and potentially a negative effect on bank and agency.

Our sustainability

Liz Shutler

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North. The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. It is these areas we will be focussing on improving over the coming five to ten years. We also plan to add in other measures such medicines waste, NHS fleet and leased vehicles and staff travel, as we develop these metrics in the future. Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

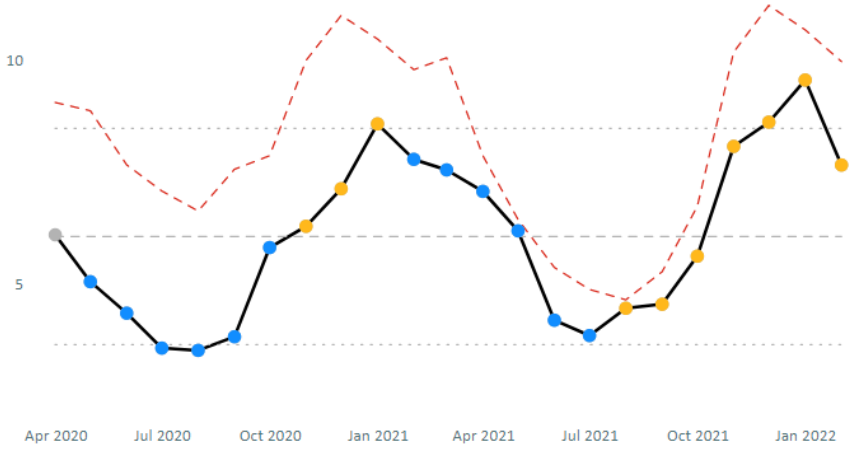
Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
7.06	6.17	4.18	3.83	4.44	4.53	5.61	8.06	8.60	9.55	7.65	

P — Variation indicates consistently passing the target

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

Flag Description: Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's Carbon Footprint as demonstrated in the chart. The position remains below the trajectory in all months. The February net position is below the monthly trajectory of 9.96 at 7.65 kgC02e per m2 and is slightly below the same period last year.

It should be noted that the Trust has adapted the currency of measurement for February 2022 from C02e tonnes per day to net kgC02e per m2. In addition, the trajectory has changed from comparing performance against historical data to a trajectory of systematic carbon reduction in line with the NHSE/I Delivering a Net Zero NHS. This allows the measurement of carbon used to be proportionate to the size of the Trust's i.e. the commissioning of the Elective Orthopaedic Centre at Kent and Canterbury Hospital has increased our site footprint and as a consequence has increased the use of carbon, therefore the new metric allows for appropriate contextualisation.

Interventions and Planned Impact

The Trust is working with Breathe Energy to recommend opportunities for a continuing programme of carbon reduction and to bid, on the Trust's behalf, for central money to enable long term carbon reduction as part of the Public Sector Decarbonisation Scheme. Schemes are currently being developed, focusing on carbon reduction, rather than financial savings.

Electric vehicle charging points have been installed at QEQM and implementation is planned at WHH and K&C in 2022. A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions. This Group will drive the strategic improvements required to reduce the carbon footprint, in line with our agreed trajectory.

Risks/Mitigations

- Appropriate funding to trigger significant change is not available.
- Potentially lack of behaviour change and culture in the organisation negates the opportunity to promote carbon reduction.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.
- The installation of combined heating and power (CHP) programme reduces the use of green electricity but increases the use of gas.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22
Financial Position	W4		Total Pay		0.0%	-1.2%	-1.2%	-1.3%	-2.0%
	W4		Non Pay		0.0%	-0.2%	-0.2%	-0.5%	-6.0%

Total Pay

The pay position is adverse to plan due to higher than planned usage of temporary staffing primarily to backfill staff who were either sick or isolating due to Covid-19 Omicron variant. It is proposed that the pay metric is not promoted to a driver metric at this time as the financial plan and pay expenditure budget will be reset in April due to the start of the new financial year. Additionally, the Trust Board has approved a breakthrough objective in 2022/23 of agency expenditure which will monitor this position.

Non Pay

The non-pay variance in M12 is skewed by an impairment of our asset values as part of the annual accounts process. This is an allowable adjustment under NHS E accounting rules against our target. The non-pay plan will be reset in April 2022. Overall the Trust produced a small surplus in year.

Our future


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our future

Rebecca Carlton

Not fit to reside (pats/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. As such this allows us to easily identify the ongoing support and care patients need to facilitate discharge.

Patients are delayed in hospital awaiting a supported discharge which may be Domiciliary care such as a Care Package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works closely with local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
220.2	223.2	297.1	309.9	299.6	303.0	299.5	332.0	346.2	314.3	320.4	336.2

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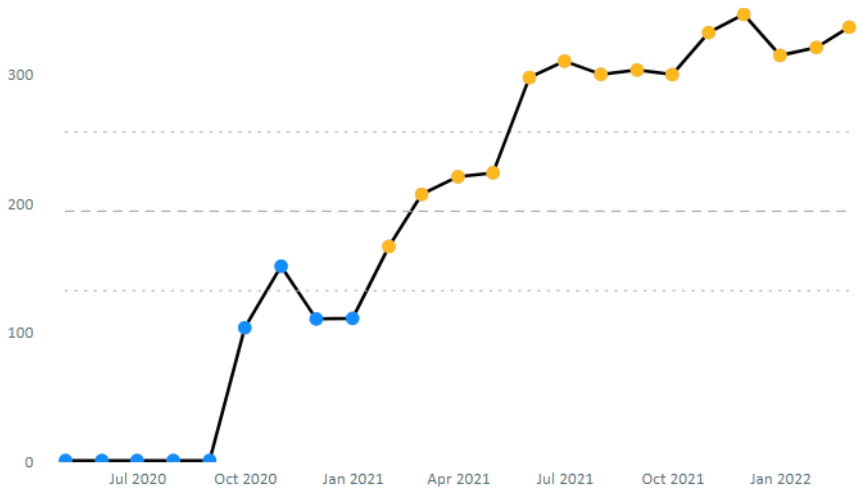
Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The number of patients who no longer meet the criteria to reside (C2R) in hospital has been increasing over the past year and although the number peaked at 346 in December with a reduction in January 2022, the number of patients delayed has increased through February and March to 336. This reflects the increase in the number of patients being admitted with Covid and also the lack of external capacity to enable patients to be discharged on the correct pathway immediately they do not meet the Criteria to Reside.

Intervention and Planned Impact

- Continuing to work very closely with the local health economy (LHE), meeting 3 times p/w, inclusive of KCHFT, KCC, CCG, Hospice and Mental Health Trust colleagues to confirm and challenge that appropriate capacity is available externally to meet the discharge needs of our local population.
- Weekly MDT meeting to review all patients with a LOS >7d and planned MADE prior to Bank Holidays or at times of continued pressure to reduce risk of internal and external delays.
- Daily board rounds include documentation of the C2R category, reported daily within Trust &LHE.
- ECIST support to launch and embed 'Modern Ward Round'. Launched at WHH in April and QE in May, including March refocus of patient PTL and recording of C2R categories on board rounds.
- Relaunch identifying 'golden' discharges to increase % of discharges before midday.

Risks/Mitigations

- Insufficient external capacity, particularly in PW1, PW2 and PW3 to meet patients needs; Mitigation is to work through the LHE and Regional meetings to highlight capacity to be commissioned.
- Patients and their families refuse to be discharged into an alternative discharge pathway; Mitigation is to provide every patient with a letter from the CMO and CNO confirming discharge arrangements and also to ensure that Matrons or Hospital Director team are involved in discussions with families to provide support.

Our future

Liz Shutler

Recruitment to Clinical Trials

In order to deliver outstanding care for patients, we need to provide and promote access to clinical trials and innovative practice for all our local population. Research, education and innovation are not yet embedded in our organisation at the heart of everything we do. We need to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence. The preferred measurement of success is the number of staff participating actively in research and innovation. However, at present the total number of staff involved in research and innovation is unclear and work is being undertaken to enable this metric to be measured and used going forward. Data does, however, enable us identify the number of patients recruited to trials within the Trust and this metric will be used initially.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
164	197	205	267	176	161	208	303	198	116	91	199

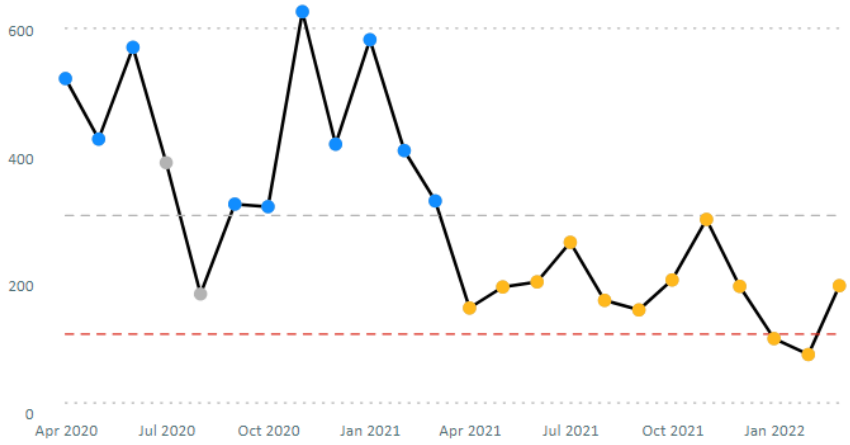
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

In 2020/21, 5,132 patients were recruited into trials. This number is significantly higher than usual as it included 3,000 Covid patients. In 2021/22, the Trust recruited 2,285 patients (including 240 Covid patients) across 22 specialities. By specialty, the number of patients recruited ranges from 1 (ENT) to 742 (Reproductive Health and Childbirth). The stratified data identifies key areas of potential growth as Cardiology, Anaesthetics, Surgery and Haematology. The March position of 199 patients recruited to trials is above the threshold of 123 (positive).

Intervention and Planned Impact

- Additional studies are being selected with the clinical teams in Cardiology, Anaesthetics, Surgery and Haematology.
- Focus is being put on interventional studies which will support nurses being more patient facing.
- The four key growth areas of focus are being targeted.
- The Clinical Trials Unit at QEQM opens on 1st June 2022, which will increase capacity and space for trials.
- Four additional research fellow posts are being reviewed for joint funding with the Care Groups in the four selected areas, to support increased trial activity.
- Further work is being undertaken to enable staff numbers across all healthcare professionals to be captured. This is likely to be via the new research database that is expected to be available in Summer of 2022.

Risks/Mitigations

- Lack of outpatient space to facilitate follow up. This is currently being absorbed but will become more challenging, over time, as trials increase.
- Lack of recurrent funding to support the additional research fellow posts. Discussions are underway with the relevant Care Groups.
- If the new research database is delayed, this will delay the Trust's ability to identify accurately the number of staff involved in research and the current metric will need to continue.

East Kent Hospitals University NHS Foundation Trust

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

There are no alerting watch metrics for this domain.

Appendix 1
Non-Alerting Watch Metrics

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True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22
Harm Events	W		IPC: Total Infections		18	29	21	22	18
	W		Reported Medication Errors		110	192	203	207	181
	W		Medication Errors; Severity C+		1	0	1	2	0
	W		Pressure Ulcers: Cat 2		32	33	32	27	31
	W		Pressure Ulcers: Cat 3 & 4		3	1	2	1	2
	W		Pressure Ulcers: DTI		10	5	8	11	7
	W		IPC: Audits Composite		80.0%	87.4%	87.6%	87.7%	88.3%
	W		VTE Assessment Compliance		90.0%	91.8%	90.7%	91.5%	92.1%
	W		Safeguarding Incidents		20	7	14	11	17
	W		Clinical Incidents		2,500	2,005	2,310	2,036	2,047
	W		Serious Incidents		18	23	17	14	23
	W		Never Events		0	0	0	0	1
Mortality	W		Extended Perinatal Mortality		6.32	5.47	4.63	4.77	4.92

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 62d	W		Cancer 31d Performance		96.0%	97.9%	96.9%	97.8%	98.9%
RTT - 18 Weeks	W		OPA vs Plan		Traj.	54,196	56,126	56,103	60,636
ED Compliance	W		A&E Atts vs Plan		Traj.	19,760	20,260	19,626	23,021
	W		NEL Readmissions		15.0%	11.2%	11.5%	10.4%	10.9%
	W		Stroke Ward within 4 Hours		50.0%	73.3%	58.7%	62.5%	70.8%
FFT	W		FFT IP Response Rate		15.0%	17.2%	16.5%	18.1%	18.4%
	W		FFT DC Response Rate		27.0%	26.6%	28.3%	30.1%	30.2%
	W		FFT OP Response Rate		17.0%	17.8%	18.5%	18.4%	19.7%
	W		Complaints		100	59	72	86	93
	W		Mixed Sex Breaches		500	69	129	126	48

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-21	Jan-22	Feb-22	Mar-22
Staff Turnover Rate	W		Premature Turnover Rate		25.0%	19.3%	19.9%	19.6%	19.2%
Staff Engagement	W		Sickness		5.0%	5.4%	6.0%	5.4%	
	W		Appraisals Compliance		73.0%	76.9%	77.1%	77.8%	77.9%
	W		Statutory Training		91.0%	91.6%	91.9%	91.6%	91.3%
	W		Safeguarding Children Training		85.0%	91.2%	91.3%	91.3%	92.3%
Carbon Footprint	W		CO2e Electricity (tCO2e)		Traj.	414.7	410.2	397.4	
	W		CO2e Water (tCO2e)		Traj.	4.15	6.96	8.92	
	W		CO2e Anaesthetic Gases (tCO2e)		Traj.	12.32	7.64	9.86	

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
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	• Training Hub facility secured at East Kent College and proposal put forward for central management. • Integrated Education Strategy proposal presented to Integrated Education Board. • Project Lead and Team identified to take forward next stage of space utilisation review. • Demand modelling being reviewed to support the need for additional residential accommodation	• Implement Project Team to progress space utilisation review. • Continue to explore options for education and training space to complement EKC model. Progress the central management team proposal. • Progress review of demand modelling to secure additional residential accommodation.
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	• First Job Planning workshop launched with good attendance. • Admin support for CMO team now in place. • Comms strategy to address staff that have not engaged with job planning in the past 12 months commenced. • Care group structure/reporting on e-Jobplan now aligned to accurately represent current Trust structure. • User-journey for CMO webpage update agreed.	• Complete content for new pages agreed for CMO webpage. • Develop FAQ list with answers following Job planning workshops. • Provide requested flowchart regarding new Job Planning policy to LNC. • Confirm contract details of current e-Jobplan system to prepare for system review. • Process feedback from the Job planning workshops
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	May 2022	• Mr Shah (Consultant Surgeon) has shared his teams progress on Kings B ward, and the benefits timely EDN completion is having • Five wards prioritised to support improvement (CoE team coaching provided).	• Share learning from Mr Shah's team. • Clinician engagement and ownership will be the focus , as progress and improvement will be limited otherwise

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
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022 New date Sept 2022	• MicroGuide confirmed as the ongoing host for clinical guidelines for foreseeable future • Draft policy updated and shared, feedback being collated • Permanent Band 6 post identified and funded within Quality Governance Directorate	• Advertise and appoint to Clinical Guidelines Manager post • Collate feedback on policy and present final version to QSC and PAG
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	• Collect and collate the data for analysis and discussion • Engaging Care group stakeholders • RCA and top contributors identified	• Continue to engage stakeholders and implement countermeasures as per A3 • Core group meeting 25th April
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	• There is currently no SRO attached to this TPIP, therefore progress is limited. • Clinical Audit team continue to work with Care Groups regarding their compliance	• Clinical Audit team continue to work with Care Groups regarding their compliance

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
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
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Safeguarding	Sarah Shingler	Timely assessment of patients with mental health &/or cognitive impairment risks, to determine the level of support required carried out for 100% of patients. Provision of individualised treatment plan to optimise support and care to maintain safety.	Mar 2022 - BAU
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 3: 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 3: 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 3: Glossary of Terms

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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.