East Kent Hospitals University NHS Foundation Trust

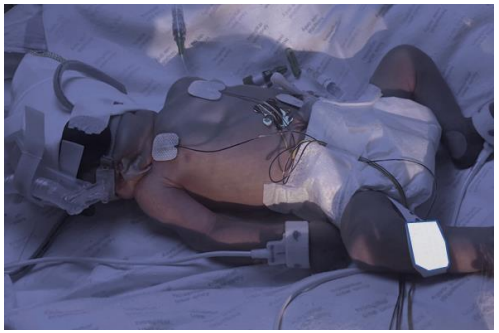
Integrated Performance Report

May 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 Patient Safety Incidents resulting in harm
- Reducing time spent in our ED Departments
- Improving theatre capacity
- Improving our Staff Involvement Score
- Reducing Premium Pay Spend

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.

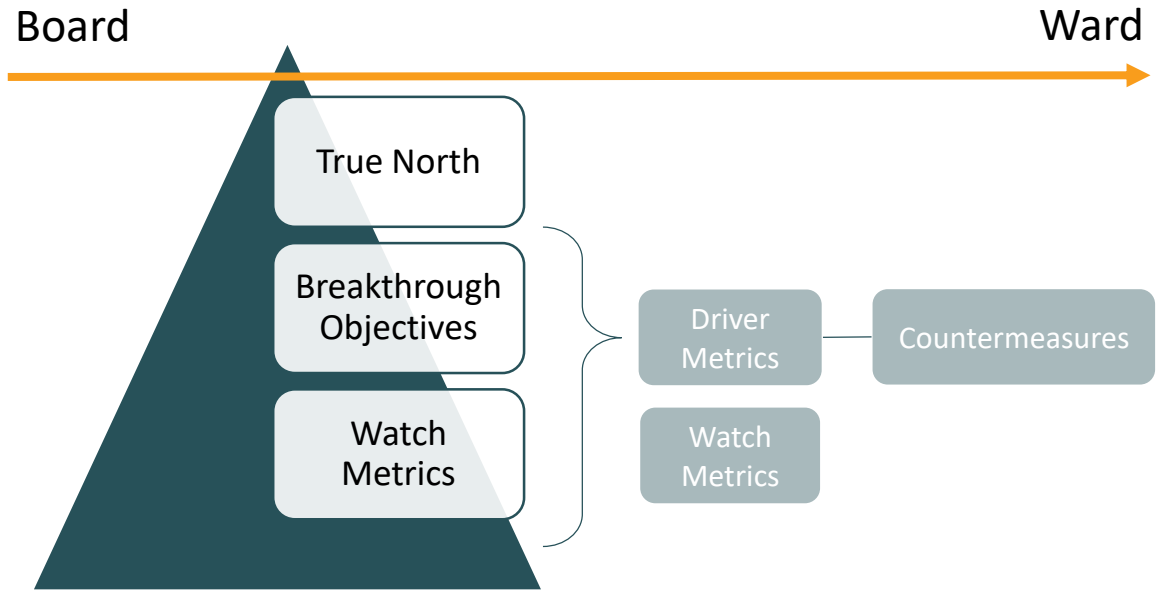
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our 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 2022/23. 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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
97.5	96.6	97.4	98.4	99.2	96.9	91.7	88.7	86.8			

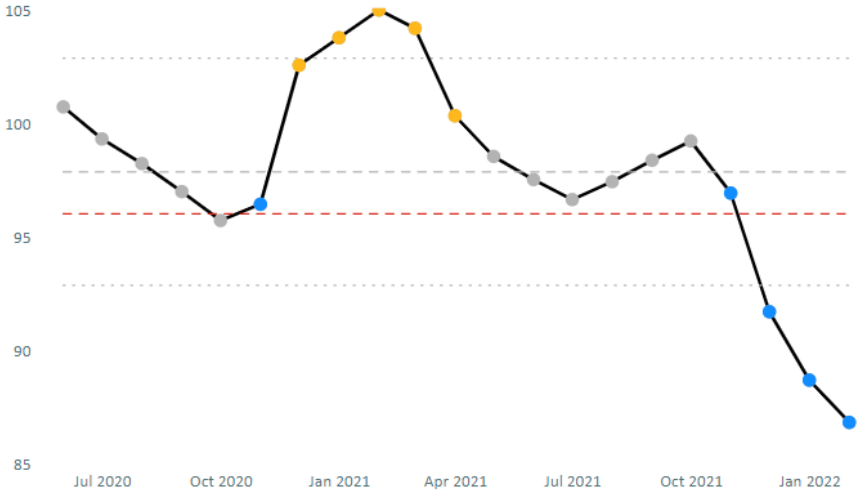
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The Trust HSMR continues it improvement trajectory, now sitting below the lower control limit showing 'special cause variation of improving nature'. The metric demonstrates a 12 month rolling position to February 2022 which is the last data release.

Nationally for all acute (non-specialist providers) we are 29th out of 124 on the Dr Foster (Telstra Health) platform and are in the statistically lower then expected group. The position is likely to fluctuate with each data release as the values above and below us are close together.

Intervention and Planned Impact

- The fracture Neck of Femur pathway is our focus for 2022/23 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 HSMR for fractured neck of femur from 118 in December to 100 by end of the year on the overarching metric to give us a reduction of 2 points on the overarching HSMR. A Trust Priority Improvement Project (TPIP) is underway 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 (80.6 to February 2022) 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 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 if 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 patient safety incidents of moderate and above avoidable harm within 5 years. We want to reduce harm caused to patients, to improve their experience and outcomes. **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 March 2023 (5% reduction).**

The breakthrough objective will be to reduce all patient safety 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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
30	36	22	22	44	15	32	31	31	30	27	24

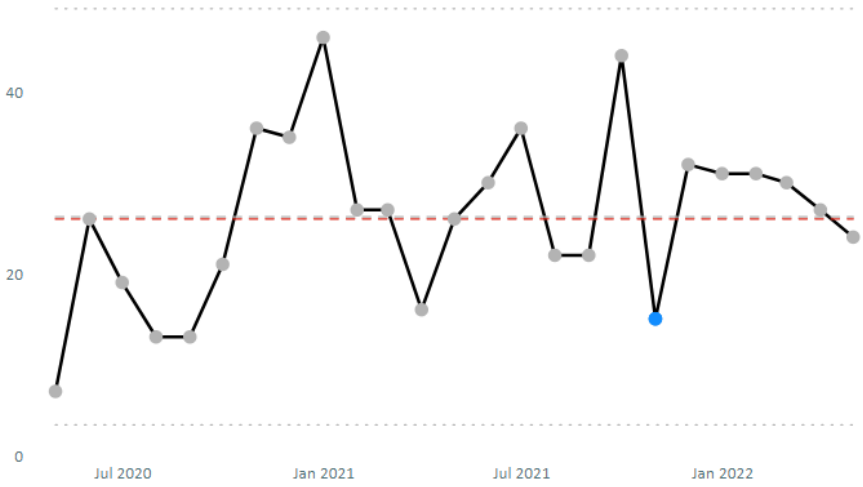
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 24 incidents with a severity score of moderate and above in May which is below the threshold set for 22/23. Delay/failure being the highest contributor this has changed from the previous month when care/treatment was the highest contributor.

Intervention and Planned Impact

Safe staffing is a major factor contributing to patient harms, we are now seeing a direct correlation between low staffing levels and harm specifically on the QEQM site. QEQM is prioritised within the recruitment pipeline and safer staffing process continues to be followed.

The speciality nursing teams continue to have an increased presence in both Emergency Departments to support both clinically and educationally. Improvement plans now developed for nutrition, falls and pressure ulcer care linked to strategic objectives and progress will be reported into the Fundamentals of Care Committee (FoC). There were no moderate or above harm incidents related to pressure ulcers or nutrition related incidents and work is ongoing to ensure this position is sustained. Falls increased to 175 in May, however we continue to see a reduction in the number of moderate harm and above harm incidents with 2 moderate harm incidents reported in May. Falls in ED at the QEQM increased to 15 from 6 in April with this being linked to an increase in mental health patients with challenging needs and an increase in intoxicated patients.

Risks/Mitigations

Wards with high number of moderate and above harm incidents now attend weekly driver meetings where a key focus is reviewing the root cause of the top contributors to harm incidents. 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. GSM/UEC/S&A care groups developing driver A3s for the Harm TN.

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.	Feb-22	Mar-22	Apr-22	May-22
Harm Events	W4		Covid-19 HCAI		1	138	186	133	34
			Nutrition Incidents		60	80	67	50	60
	W4		IP Spells with 3+ Ward Moves		500	541	571	523	545
	W4		Serious Incidents Breached		0	103	88	102	114

Covid-19 HCAI

Number of HCAI cases of Covid-19 peaked in March 2022 coinciding with the peak of the BA.2 Omicron sub variant in early April. Cases have been falling since, will continue to fall and are expected to be close to zero by June 2022.

IP Spells with 3+ Ward Moves

The number of times a patient transfers ward within their inpatient stay was identified as a key workstream from the Emergency Care summit which took place earlier this year. A number of actions are in place to understand the reasons for transfer and explore how systems already in place can help to limit non-clinical transfers and flag patients who for safety reasons should not be moved. We will continue to watch this metric and hope to see a reduction as a consequence of this workstream.

Serious Incidents Breached

Declared Serious Incidents (SIs) must be investigated and closed within 60 days, to ensure timely understanding of issues, address gaps and provide learning to avoid repeated incidents. The Trust commenced this financial year with a backlog of outstanding cases, and are working to close the backlog and prevent any new breaches. The majority of breached SIs are within GSM (41), with UEC (27) and S&A (25) also holding a significant number. A thematic approach to investigate and close a large proportion of the SIs has been agreed with the CCG, and a recruitment process is underway for additional resource to support the review.

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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
64.3%	64.5%	63.6%	62.0%	61.4%	61.3%	59.8%	59.6%	59.5%	58.9%	58.4%	60.7%

F

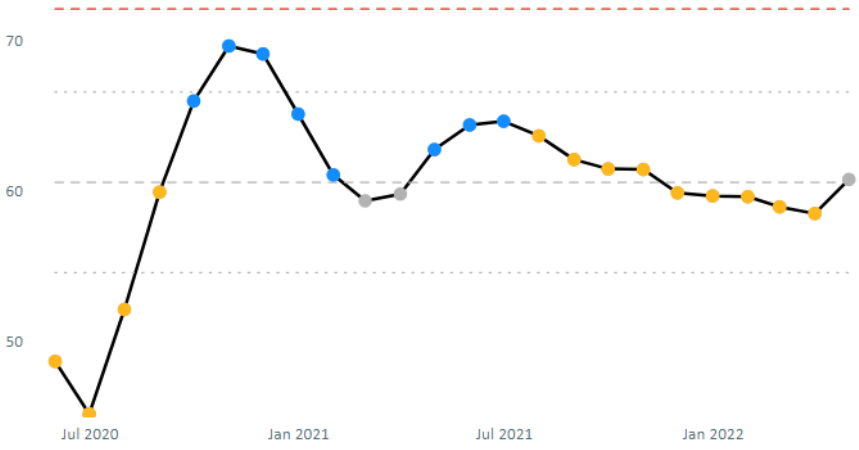
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Performance has improved in May 22. During the initial elective recovery phase in spring/summer 2020 performance improved, dipping to a lesser extent during waves two and three. Whilst Covid is still present the IPC restrictions governing elective operating have been relaxed and this has supported an improvement in activity. Non-Admitted waiting lists have grown significantly over the last two years, this is contributing to the reduced compliance in this metric.

Intervention and Planned Impact

- Maximise theatre and outpatient capacity to treat more patients, actual utilisation has improved to 80%.
- Theatre timetables being reset to ensure specialties have required access to theatre to treat urgent, cancer and long waiting patients and aligning this to consultant job plans.
- Continue to transfer patients to local IS and community providers. We have procured whole pathway capacity which will support the non-admitted element of the RTT pathway, as referenced above this part of the pathway has significant growth.
- Refresh all access PTL meetings across every specialty setting to ensure adherence to the national patient tracking list (PTL) management guidance.
- We are starting a piece of work to understand the data supporting health inequalities across our elective pathways.
- Our longest waiting patients remain on track to be seen by the end of June, the focus will then turn to 78w at a patient level.
- Our harm review process is now focussed on reviewing patients on the waiting list every 3 months. Systems are being put in place to ensure this is recorded appropriately.

Risks/Mitigations

- K&M plans to develop theatre capacity in the region are not yet confirmed, this will constitute a risk to delivery of the 52w reduction trajectory.
- Theatre estate and vulnerability, this is planned to complete by 16th August.

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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
23	38	51	48	39	38	52	54	60	39	36	32

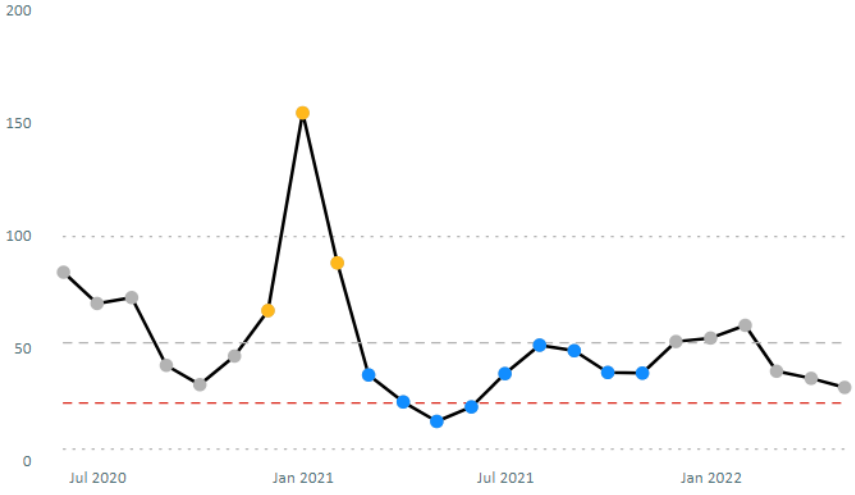
Variation indicates inconsistently passing and falling short of the target

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 32 sessions available which is a continued improving position. Pareto analysis of the May data shows; 16 cancelled sessions, 7 sessions related to early finishes, 5 sessions related to turnaround times, 3 due to late starts and 1 due to cancellations on the day.
Surgery Head & Neck constitutes the largest opportunity of the care groups. In May Ophthalmology reported a total of 29 cancelled sessions of which 25 were due to consultant unavailability due to leave. A further 9 sessions were cancelled within Orthopaedics for the same reason. If these sessions had not been cancelled then the threshold of 25 would have been achieved.

Intervention and Planned Impact

Maximising theatre capacity will enable us to treat more patients and reduce waiting times for patients waiting for surgery. To facilitate this there are a number of measures that have been implemented and this includes:

- Validation of the data and recording continues and contributes to improved performance.
- Continue drive to deliver 95% booked utilisation of theatre lists to ensure maximum in session utilisation – May performance 88.2%.
- On time starts continues to improve with theatre managers ensuring patients are sent for in a timely manner to prevent delays. May performance 53.3%
- Work with SHNB to improve/ reduce the opportunity within Ophthalmology – noted that booked utilisation is at 88.3% against an actual utilisation of 72.5% .
- Work includes rationalisation of allocation of theatre lists
- Average cases per lists remains at 2.3 and we anticipate that this will continue whilst we clear the backlog and focus on dating long waiting patients.

Risks/Mitigations

- Breakdown / Replacement of essential theatre estates will reduce available capacity- where planned we are reallocating sessions where possible.
- Breakdown and replacement of key theatre equipment.
- Theatre staffing/ recruitment.

Our patients

Rebecca Carlton

ED 12h Total Time in Department

There is a nationally proposed new set of Emergency Department 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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
4.4%	7.0%	6.7%	6.0%	8.5%	9.8%	9.6%	9.5%	9.2%	10.5%	10.4%	8.7%

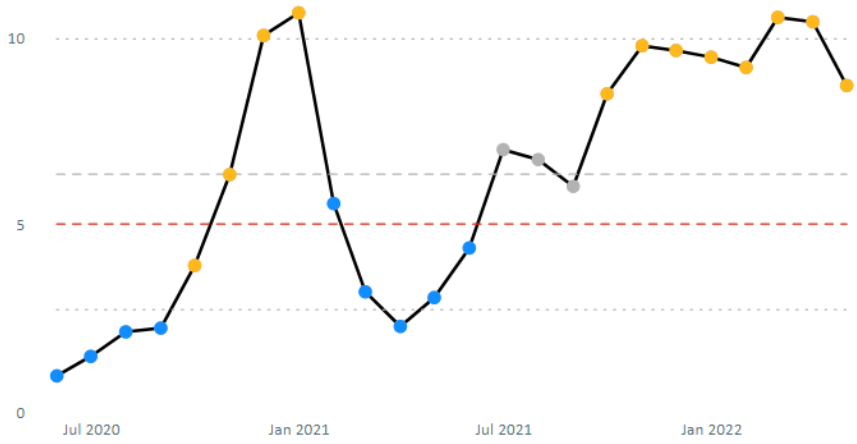
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group
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.

ED attendances have continued to increase, impacting on performance.

May performance is a further reduction to 8.7%. Our aim last month was to reduce this total time to 8% ambition with a trajectory to 5% by year end, we are making good progress towards this aim.

Intervention and Planned Impact

- A focus on discharges before midday has to date seen an improvement which is releasing early assessment space in admitting wards.
- There has been a focus on end of life patients and prioritising transport.
- We have increased the clinical site leaders working directly with the emergency department and the ward areas. These roles are focussed on right patient right bed and particularly total time in dept AMU length of stay and long length of stay patients. All areas are seeing improvements.
- A PDSA on the electronic handover process, handover of patients between ED and Ward, has been carried out. This has reduced time to transfer, improved documentation and improved communication of patient specific needs and reduced the number of calls between ED and wards.
- There has been a renewed focus on our simple patient pathway, the Medical Director will pilot a review of any patient without a complicated discharge pathway and a length of stay >7d to improve discharges.

Risks/Mitigations.

- In June 2021 the total time in department was 4.4%, during this time 'stranded' patients with a length of stay >21d were 99. In May 22 this number has more than doubled to 221.
- SDEC, patients who are seen and assessed outside of the Emergency Department by the specialty team has increased by 6%. Of these patients a high proportion are discharged from SDEC and do not receive onward admission to an inpatient ward.

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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
2,079	1,998	1,752	1,804	2,003	2,288	2,017	2,144	1,940	2,302	1,945	2,064

F

Variation indicates consistently falling short of the target

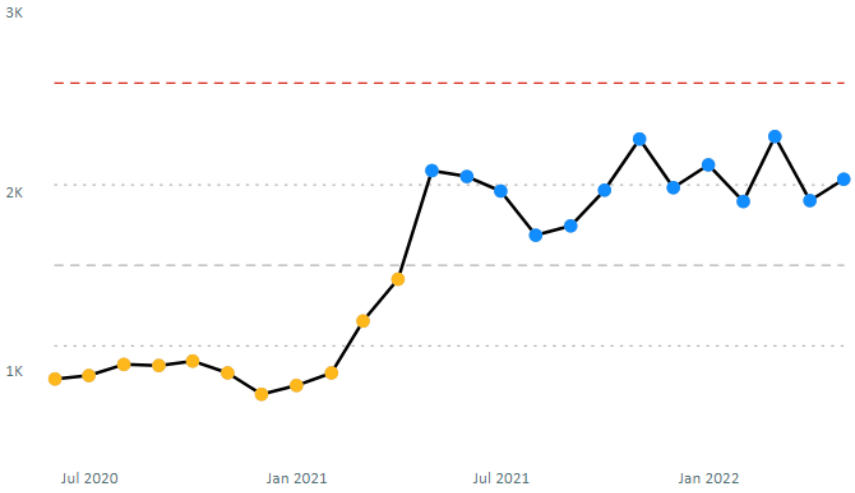
H

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 moving the True North closer to its target of 2,600 patients per month.

In May 2022, a total of 2,064 patients were treated via an SDEC pathway,

Intervention and Planned Impact

- Following the estates changes for Medical and Surgical SDEC we have seen an increase in throughput for these areas.
- Plans are being considered for a 24/7 SDEC to increase availability to all patients regardless of time of attendance to the emergency department.
- A proposal has been made for patients attending ED for cardiac intervention to access same day emergency care procedures this will also increase capacity for patients who require an inpatient cardiac stay.
- Way finding and menu of alternatives to admission. Video walk throughs are happening with Clinicians alongside weekly site updates to all staff on site raising awareness of all services
- Medical SDEC have done an engagement piece with all stakeholders to understand if there are any other conditions for patients that teams would be supportive of developing pathways for. They also have asked for feedback on the service to keep improving accessibility and referral processes
- Further development of virtual wards with our system partners will also allow patients to access clinical and specialist support in their own home.
- An additional medical registrar is now working with teams in the emergency department to identify and rapidly assess patients who can transfer to a same day emergency care pathway.

Risks/Mitigations

- Ensuring a consistent model of care at both acute sites. The SRO for the breakthrough objective is working with WHH and QEQM.

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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
82.2%	82.5%	80.7%	78.8%	79.3%	84.3%	78.0%	75.6%	71.0%	74.5%	66.1%	63.9%

Variation indicates inconsistently passing and falling short of the target

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

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Astronomical Point
Two Out Of Three Beyond Two Sigma Group

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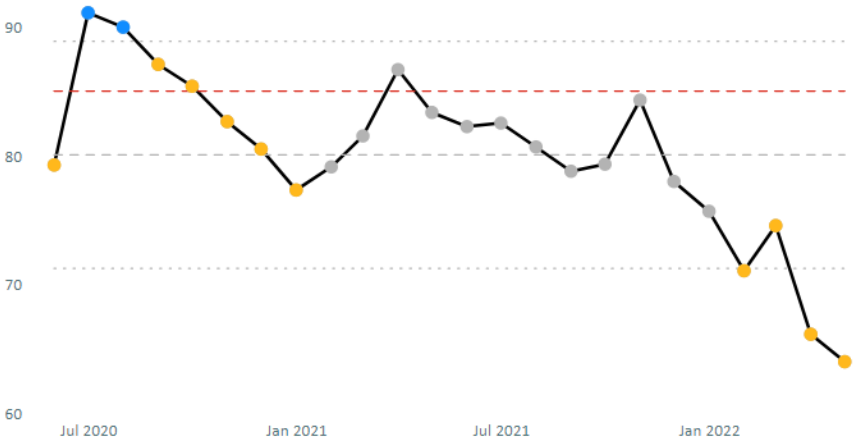


What the chart tells us

Performance has continued to deteriorate with the huge volume of demand following public health campaigns and post pandemic surge. The teams are working hard to prioritise patients and deal with competing demand. Although performance has deteriorated K&M Cancer Alliance continued to record the lowest back log of all Alliances, East Kent Hospitals is the largest contributor to this.

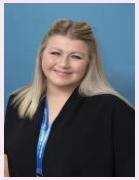
Intervention and Planned Impact

- The patients on the Cancer waiting list over 62d peaked at 248 and is now at 193 following 4 consecutive weeks of improvement. This is a significant indicator in the ability of the organisation to improve delivery of the 62d standard.
- Utilising slots at BHD Community Diagnostic Centre continues to drive improvement in the diagnostic pathway. The services are working at a patient level to ensure timely diagnostics.
- Lead Clinical Nurse Specialists are following up with patients who do not attend to support access and treatment.
- Process in place to highlight all breach dates to the relevant teams to ensure patients are booked within breach time.
- Weekly meetings established between Radiology and Cancer services to confirm demand and capacity required to achieve timely diagnostics. This continues to have a positive impact on utilisation of slots. Availability of ring-fenced capacity for MRI and CT scans has seen a reduction in waiting times from 27 to 7 days this has been sustained with a further ambition for 5 days or less.
- Where patients do not have a diagnosis of Cancer the Care Groups are working to ensure this information is available to patients promptly.

Risks/Mitigations

- Whilst the performance has reduced at Trust level, from a national perspective the backlog of patients waiting >62d in Kent & Medway is proportionally the smallest in the country with EKHUFT being the biggest contributor in K&M. The total PTL is now less than 4,000 which is further improvement on last month.
- The ability to schedule and complete biopsies in a timely way is being impacted on by Covid sickness in the Interventional Radiology workforce .

Our patients



Sarah Shingler

Patient Experience (FFT)

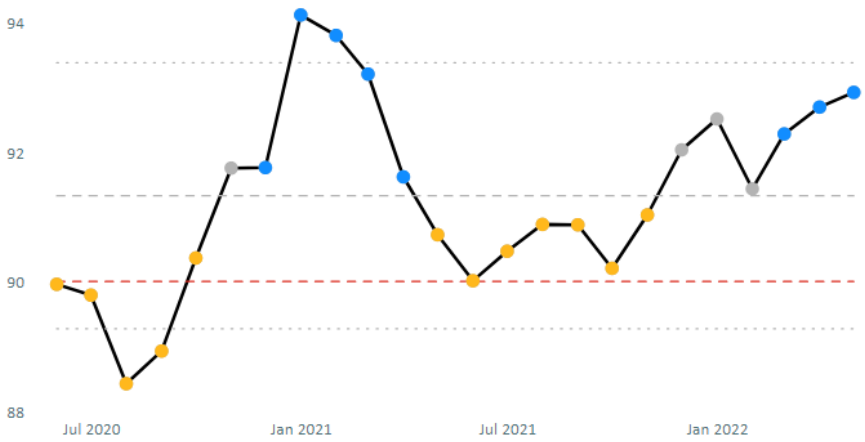
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
90.0%	90.5%	90.9%	90.9%	90.2%	91.0%	92.0%	92.5%	91.4%	92.3%	92.7%	92.9%

Variation indicates inconsistently passing and falling short of the target	Special cause of improving nature or lower pressure due to higher values	Flag Description
		Two Out Of Three Beyond Two Sigma Group

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 a month on month improvement from the February position, we have been consistently at 92% since March 22.

Intervention and Planned Impact

The True North for Our Patients has been 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. Throughout May staff have been trained how to use the Tendable app and the wards will commence their 50 in-patient surveys per month from 20th June when the Tendable app goes live at EKHUFT, the reporting of data within the IPR in July 22. This data will also be presented and reviewed at the monthly FoC Committee.

The Patient Voice and Involvement Team posts have all been successfully recruited to with all postholders due to be in post by August 22.

Maternity patient experience project 'Your Voice is Heard' commenced in April 22, our ambition is to capture feedback from every woman who gives birth in one of our units (6,000 births per year) 6 weeks post delivery. 1st round of communications took place in mid May with rich sources of information already captured.

Risks/Mitigations

If culture and behaviours do not change and the patients voice continues not to be heard, 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.	Feb-22	Mar-22	Apr-22	May-22
Cancer 62d	W4		Cancer 28d Performance		75.0%	71.3%	68.2%	62.0%	66.0%
RTT - 18 Weeks	W4		RTT 52w Breaches		0	3,891	3,755	3,674	3,566
	W4		DM01 Compliance		75.0%	68.0%	67.2%	64.4%	67.6%
	W4		RTT 35w Waiters (w/o TCIs)		8,500	9,514	9,571	9,651	9,637
	W4		RTT OP Booking Breaches		14,000	19,696	20,245	21,783	22,762
ED Compliance	W4		ED Compliance		90.0%	72.0%	67.6%	69.8%	69.4%
	W4		Clinician First Seen within 1h		50.0%	36.0%	28.6%	42.4%	39.7%
	W4		Unplanned Re-attendance ED		10.0%	11.4%	12.7%	14.5%	13.5%
	W4		Super Stranded >21D		107	175	195	211	221
	W4		Discharges by Midday		15.0%	14.9%	13.1%	13.7%	13.6%
FFT	W4		FFT Maternity Response Rate		18.0%	10.4%	10.1%	13.5%	14.9%
	W4		Complaint Response		90.0%	13.6%	12.0%	7.1%	7.5%
	W4		Duty of Candour - Verbal		100.0%	56.0%	39.4%	40.0%	21.7%
	W4		Duty of Candour - Findings		100.0%	25.0%	33.3%	33.3%	0.0%
	W4		Duty of Candour - Written 10wd		100.0%	20.0%	21.2%	16.0%	22.2%

Cancer

28 and 62 day performance has deteriorated in month due to delays in endoscopy booking, oncology, virtual colonoscopy and diagnostic biopsies. Although there has been an improvement in the waiting time for MRI and CT, the volumes of 2ww referrals continues to be a challenge with an increase in 1st appointments being booked closer to 14 days than 7 a significant issue. Follow up appointment capacity for most teams is also compromised and affecting delays. Combined delays contribute to a consistent PTL size of 4,300 patients, a figure that is causing increased difficulties.

RTT 18 Weeks

The number of patients waiting over 52 weeks continues to reduce as we treat long waiting patients. DM01 performance demonstrates an improving position. RTT 35w waiters. Increased referrals are impacting on the RTT booking breaches with waits for first outpatient appointment stretching.

ED Compliance

ED 4hr compliance is static despite growth in attendances. In June 2021 the 4h performance was 77%, during this time 'stranded' patients with a length of stay >21d were 99. In May 22 this number has more than doubled to 221.

Unplanned reattendance rate has reduced in May to 13.5%.

Duty of Candour

Duty of Candour (DoC) has regulated elements: 1- saying sorry (Duty of Candour – Verbal), 2- written apology and acknowledgment within 10 working days (Duty of Candour – Written 10wd), and 3 – written update of findings from an investigation and actions to avoid future events (Duty of Candour – Findings). The Trust must record completion of each element in Datix. Compliance across all care groups is low, and an education program is underway to increase understanding of DoC reporting. Duty of Candour related to Serious Incident declaration is 100%.

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 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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
6.64	6.28	6.28	6.28	6.41	6.41	6.41	6.35	6.35	6.35	6.26	6.26

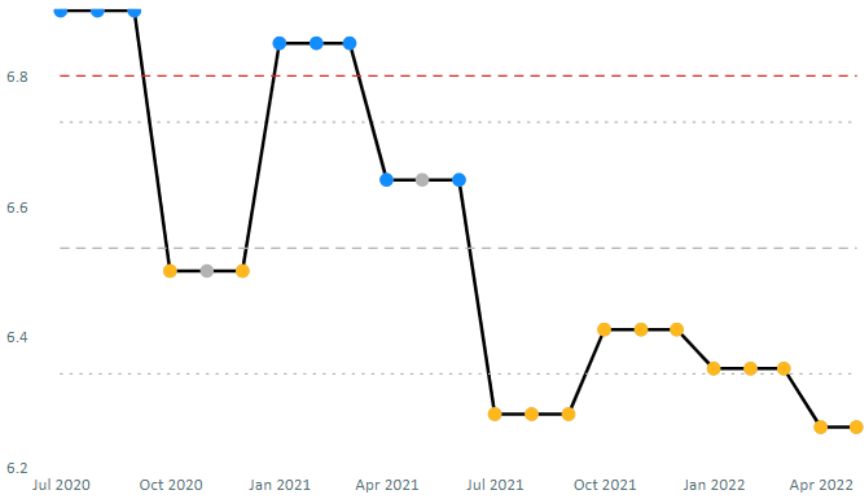
F — Variation indicates consistently falling short of the target

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

Staff Engagement levels (6.26) have fallen and now sit below the lower control limit of the SPC chart. The most recent data indicates a continuing decline in involvement and a pronounced reduction in advocacy – with all three aspects of engagement below 2021 NSS levels. Staff engagement remains well below mean performance, is consistently missing the desired threshold and the latest results put EKHUFT on par with the worst performing Trusts nationally.

Interventions and Planned Impact

NSS and NQPS results have now been socialised with all Care Groups and subsequent meetings have taken place with relevant stakeholders to develop targeted action plans. Work has taken place with each Care Group Triumvirate to enable them to identify where respective focus needs to be directed. Positive dialogue is taking place across many of these areas to determine the most appropriate interventions and this has been captured and socialised in an additional report to PCC.

Care Groups are now beginning to consider countermeasures. Throughout this process, it has become clear that engagement is enhanced and plans improved by focusing these at Site and/or Specialty level (as appropriate). HR & OD Business Partners have met to review best-practice, share challenges/ barriers and agree a consistent means of future reporting that is continuous throughout the year.

In addition, the NSS dashboard has been commended by NHSEI for its ability to support improved visualisation and dialogue around data and there are a number of Trusts across the country seeking to follow our practice.

Risks/Mitigations

The True North for staff engagement is supported by a BTO for staff involvement. The NQPS is taking place throughout July to ensure an accurate and up-to-date picture on staff engagement and has been updated to allow insights at sub-specialty, ward/ department, role and length of service level.. A national toolkit has been shared with CGs to support rollout of the action plans and an involvement toolkit is being developed to support Care Group level action.

22/23 breakthrough objective

Staff Involvement Score

EKHUFT's staff involvement score 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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
6.41	6.10	6.10	6.10	6.35	6.35	6.35	6.20	6.20	6.20	6.13	6.13

F

Variation indicates consistently falling short of the target

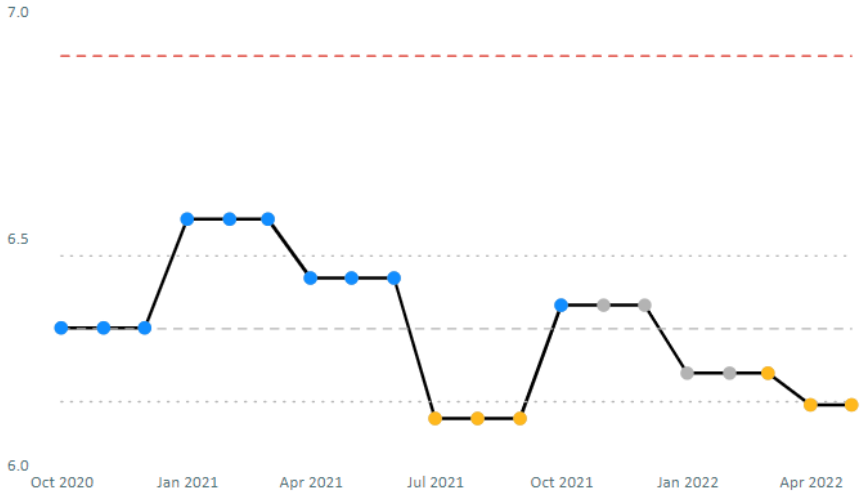
L

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The most recent data from the national quarterly pulse survey shows that EKHUFT's involvement score has once again declined (from 6.20 to 6.13) Staff involvement is 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
Less than half of respondents (47%) to the recent pulse check feel that they are able to make improvements in their area of work.

Intervention and Planned Impact

- Staff survey data has been reviewed and 10 priority areas have been identified (worst scores for involvement). Initially, four of these areas have been chosen and invited to attend KENT fundamentals to develop A3s and attend weekly driver meetings, with the aim of improving involvement within their areas
- Another of these areas will be included in the pilot of the team engagement and development (TED) programme roll-out
- The new staff intranet will provide a mechanism for staff to provide suggestions
- An 'Involvement Toolkit' is being developed to provided support at team leader, speciality and Care Group level

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

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.	Feb-22	Mar-22	Apr-22	May-22
Staff Engagement	W4		Sickness		5.0%	5.4%	6.7%	6.0%	
	W4		Appraisals Compliance		80.0%	77.8%	77.9%	77.4%	72.3%
	W4		Staff Turnover Rate		11.5%	12.6%	12.9%	12.9%	12.9%
	W4		Vacancy Rate		10.0%	12.7%	12.7%	13.3%	12.6%
	W4		Staff Turnover: HCA		13.5%	14.1%	14.2%	14.5%	14.2%
	W4		Staff Turnover: Nursing		10.0%	11.8%	11.8%	11.2%	11.2%

Sickness

Sickness absence remained above the alerting threshold of 5% for a fifth month albeit a decrease to 6.0%, lower than the 6.7% recorded in March 2022. The Trust investment into support for Health & Wellbeing, along with supporting early interventions through return to work interviews and occupational health referral have supported the reduction in the WTE time lost and the length of absence related to stress and anxiety. This has supported the reduction of long term sickness absence.

Appraisal

Overall appraisal compliance has been on an upward trend during 2021 and 2022. In common with previous years in May and June the appraisal rate fell back and dropped to 72% in May and the metric is below the reviewed alerting threshold of 80%. The threshold was set at 77% prior to this month when it was revised upwards. Whereas previously, Appraisal Compliance was a driver for many Care Groups, this will now be supported through the Trust objective of Staff Involvement, which is also a Driver for some Care Groups.

Staff Turnover

Total turnover, when measured as a rolling 12-month average, has **stabilised at 12.93%**. It remains above the True North target (11.5%).

Real-time turnover however has **reduced back to 11.59% -** around our desired threshold. Nurse turnover remains above the alerting threshold. However the 12-month rolling average has reduced significantly in recent months and it is currently the lowest it has been in over a year. HCA turnover is currently **12.13%.** This is below the desired threshold, **has reduced across each of the last six months**, and has improved by 10% since a peak in September 2021.

Vacancy Rate

The overall vacancy rate has improved with a decrease from 13.3% to 12.6% in May, reflecting the impact of increased recruitment activity and improvement in levels of retention. The vacancy rate in nursing as at March 22 is 20.10%, a slight improvement on the previous month. A plan to recruit 713 nurses is currently behind target but together with improved nurse retention is still anticipated to deliver planned numbers year end.

Our sustainability

Our sustainability

Phil Cave

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the years up to 2019/20, 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 (ERF) income of £18m. The current plan is a deficit of £22m however during June we have been notified of additional income of £22m which will be reflected in the plan from next month's reports.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
0.030	0.024	0.042	0.021	-1.494	-0.996	-0.941	-0.090	1.307	0.076	-3.700	-6.624

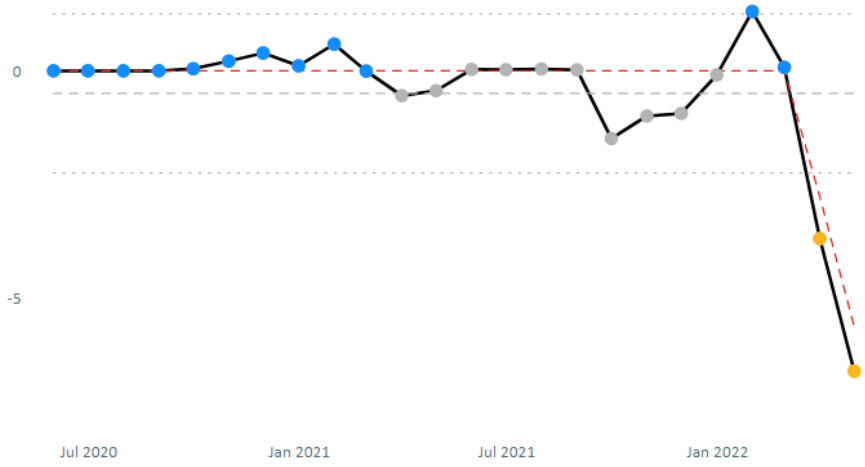
Variation indicates consistently passing the target

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

Flag Description

Outside Moving Range Limit
Astronomical Point
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

The first two years of the graph show the monthly financial performance of the organisation which has resulted in both years being breakeven. The final graph point shows the first month's financial performance in the total £22m deficit plan for 2022/23. The plan for 22/23 is a deficit of £8.4m in Q1, £6.6m in Q2, £4.5m in Q3 and £2.3m In Q4. The improvement in phasing over the year is due to the implementation of the savings plan. At the end of M2 the Trust had a deficit of £6.6m which is £1.0m worse than plan driven by a shortfall in savings.

Interventions and Planned Impact

The three largest interventions for the plan are:

- Delivery of the £30m CIP programme, the largest pillar of this is the reduction of premium pay which is a breakthrough objective.
- The reduction of covid-19 related spending which is being assisted by the Executive Director of Infection Prevention and Control (DIPC) to ensure reasonable costs are removed.
- The delivery of ERF funding which requires additional activity to be completed over the 2019/20 threshold. There are plans in place with each of the care groups to deliver the activity.

Risks/Mitigations

For 2022/23 the key risk and mitigations are:

- Efficiency target of £30m, PMO team working with care groups and executive 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 is working closely with NHS England 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 the most influenceable 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 may be refined once the full project plan is developed.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
5,768	7,134	7,351	7,092	6,783	7,255	6,441	7,168	7,403	9,148	7,890	7,497

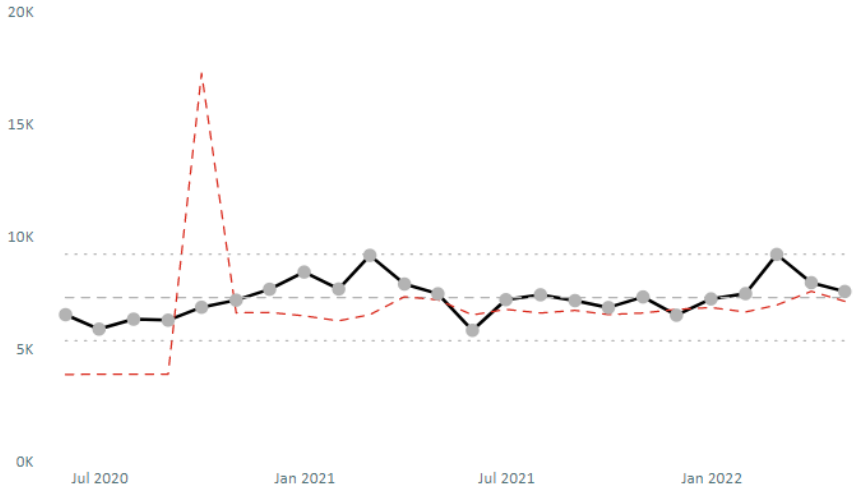
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart 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. In May 2022 premium pay spend has dropped by £0.4m it is still £1.0m over the 10% reduction required.

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 complete 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 yet fully established but will be in June.
- Most Care Groups have identified premium pay as a driver and will need support to align and focus on the biggest opportunities for reduction
- A significant proportion of premium pay is caused by vacancies and will need targeted recruitment support to fill
- 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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
4.18	3.83	4.44	4.53	5.61	8.06	8.60	9.55	7.65	7.97	6.64	

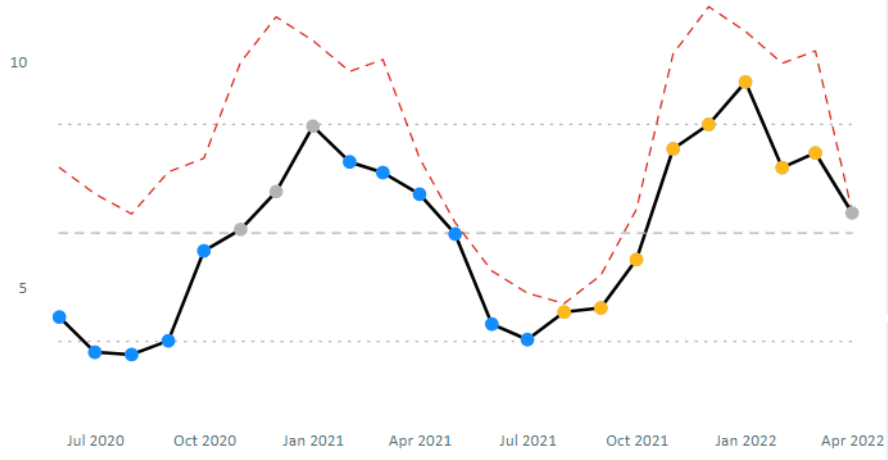
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

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 April net position is below the monthly trajectory of 6.67 at 6.64 kgC02e per m2 and is slightly below the same period last year (reporting at 7.06). The Trust adapted the currency of measurement from February 2022 from C02e tonnes per day to net kgC02e per m2. The trajectory now compares performance against historical data to a trajectory of systematic carbon reduction in line with NHSE/I's 'Delivering a Net Zero NHS'. This allows the measurement of carbon used to be proportionate to the size of the Trust's estate. An increase in our site footprint will, as a consequence, increase the use of carbon and 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 monies to enable long term carbon reduction as part of the Public Sector Decarbonisation Scheme. Schemes are currently being developed, focussing on carbon reduction, rather than financial savings, although financial reductions will be part of the programme of work. 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.	Feb-22	Mar-22	Apr-22	May-22
Financial Position	W4		Total Pay		0.0%	-1.3%	-2.0%	-2.4%	-2.3%

Total Pay

The pay position is adverse to plan due to higher than planned use of temporary staffing primarily to backfill staff who were either sick or isolating due to the Covid-19 Omicron variant. This metric will be supported by the driver metric of premium pay through the year with a greater focus on expensive agency or overtime and more focus on recruiting permanent staff.

Our future


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

Our future

Rebecca Carlton

Not fit to reside (patients/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. This allows us to easily identify the ongoing support and care patients need to leave hospital.

Patients are delayed in hospital awaiting a supported discharge which may be 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 in partnership with the 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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
297.1	309.9	299.6	303.0	299.5	332.0	346.2	314.3	320.4	336.2	351.1	352.9

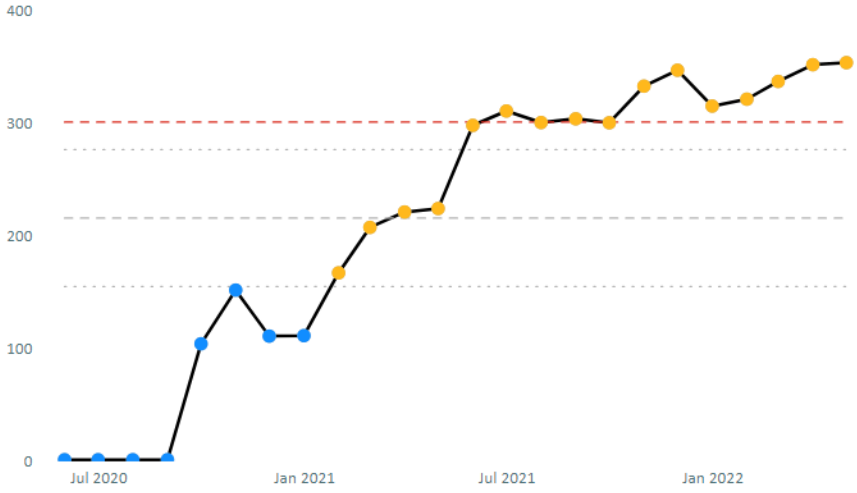
P — Variation indicates consistently passing the target

H — 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 but stabilised in May 22. This largely reflects the lack of external capacity to enable patients to be discharged on the correct pathway immediately they do not meet the Criteria to Reside. This chart should be seen in the context of the Total Time in Emergency Department True North. Patients who cannot leave hospital and are delayed will in turn reduce the available beds for emergency admissions from the Emergency Department.

Intervention and Planned Impact

- Agreed review of additional schemes to support increased capacity needed for East Kent to deliver the reduction in occupancy to 90%, current occupancy is XX.
- Weekly Multi Disciplinary ward round by hospital Medical Director and Nurse Director to review all patients with a length of stay >7d who do not have a complicated discharge pathway, these patients are referred to as being on pathway 0. These are patients who the hospital can help return to their home following treatment without needing other agency input.
- Daily board rounds include documentation of the C2R category, reported daily within Trust & LHE. Further work is required to ensure that the criteria to reside data is complete.
- Hospital leadership teams at QEQM and WHH will focus on supporting ward teams to move discharges before midday from 14% to 33%, this has improved in the last 4 weeks.
- Newly established monthly Site Integrated Discharge Meeting to bring together all the Pathways, understand cross agency challenges and joint working to improve pathways and links with care homes.
- Events on each site with local nursing homes to improve communication and help patients return to their nursing home in a timely way.
- This is an area which we will include in our health inequalities data review.

Risks/Mitigations

- Insufficient external capacity, particularly in pathways 1,2 & 3 to meet patients needs; Mitigation is to work through the LHE and regional meetings to highlight capacity to be commissioned.
- Risk of patients drifting into needing further care. Mitigation regular review meetings.

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.

Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
205	267	176	161	208	303	198	116	91	246	129	152

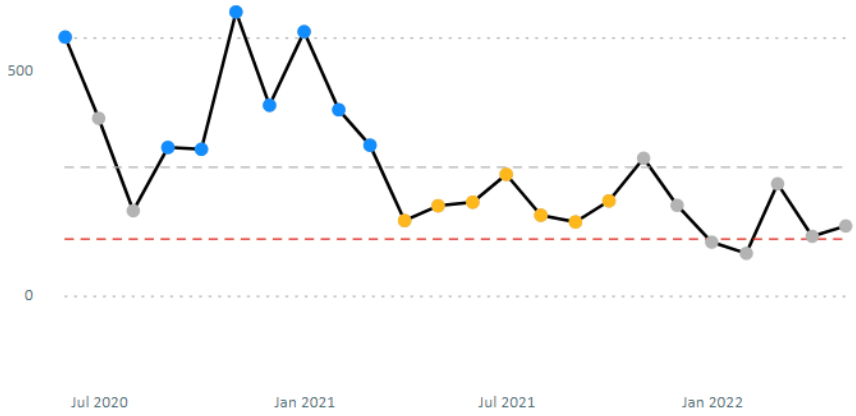
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

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 May position of 152 patients recruited to trials is above the threshold of 123 (positive) and a positive increase on the April position of 129.

Intervention and Planned Impact

- The Clinical Trials Unit at QEQM opens on 23rd June 2022, which will increase capacity and space for trials.
- Following identification of the four key growth areas, additional key studies are being set up in Cardiology (x1), Surgery (x3) and Haematology (x2).
- The Trust is among 200 Trusts that submit data nationally for interventional studies and achieved an improvement in Q4 of 2021/22, moving into League 2. The current position indicates that this improvement is continuing.
- Additional Clinical Fellow posts are continuing to be discussed with Anaesthetics, Surgery, Cardiology, Haematology and Vascular with some specialties. With R&D fully funding some of these posts and agreeing to a 50% contribution for others.
- A programme of modules to form part of a course that would lead to a post graduate qualification in research is being finalised with the University.
- Work continues to identify ways to capture staff numbers across all healthcare professionals. This is likely to be via the new research database that is expected to be available in Summer of 2022.

Risks/Mitigations

- Lack of recurrent funding to support the additional research fellow posts. Discussions are underway with the Care Groups. Funding into these posts will release savings/generate income. Delays in securing funding will limit the ability to progress with some trials.
- 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.
- Lack of outpatient space for follow-ups. As trials increase, this will become more challenging.

Appendix 1
Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-22	Mar-22	Apr-22	May-22
Harm Events	W		Falls		137	151	146	154	175
	W		IPC: Total Infections		18	22	18	25	34
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		110	213	211	190	191
	W		Medication Errors; Severity C+		1	3	0	0	2
	W		Pressure Ulcers: Cat 2		32	40	33	22	31
	W		Pressure Ulcers: Cat 3 & 4		3	3	2	1	1
	W		Pressure Ulcers: DTI		10	13	5	6	9
	W		Pressure Ulcers: Unstageable		10	10	17	13	5
	W		IPC: Audits Composite		80.0%	87.7%	88.3%	85.6%	86.2%
	W		VTE Assessment Compliance		90.0%	91.5%	92.1%	90.9%	91.8%
	W		Safeguarding Incidents		20	18	9	20	37
	W		Clinical Incidents		2,500	2,116	2,293	1,818	2,009
	W		Serious Incidents		18	13	23	14	20
	W		Never Events		0	0	1	1	0
	W		Maternity Serious Incidents		2	1	7	4	2
Mortality	W		Extended Perinatal Mortality		6.32	4.77	4.92	4.94	4.30

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-22	Mar-22	Apr-22	May-22
Cancer 62d	W		Cancer 2ww Performance		93.0%	96.6%	97.4%	95.1%	97.1%
	W		Cancer 31d Performance		96.0%	98.1%	98.8%	98.3%	98.2%
	W		Radiology Diags vs Plan		Traj.			16,010	17,970
	W		Endoscopy vs Plan		Traj.			1,205	1,539
RTT - 18 Weeks	W		OPA vs Plan		Traj.			65,803	75,340
	W		Elective Admissions vs Plan		Traj.			8,055	9,132
ED Compliance	W		A&E Atts vs Plan		Traj.			22,357	24,580
	W		NEL Admissions vs Plan		Traj.			7,393	7,781
	W		NEL Readmissions		15.0%	10.4%	11.0%	11.0%	10.2%
	W		Stroke Ward within 4 Hours		50.0%	60.8%	66.7%	54.7%	60.6%
FFT	W		FFT IP Response Rate		15.0%	18.1%	18.4%	18.9%	19.8%
	W		FFT DC Response Rate		27.0%	30.1%	30.2%	30.8%	30.3%
	W		FFT ED Response Rate		12.0%	14.8%	14.6%	15.8%	15.2%
	W		FFT OP Response Rate		17.0%	18.4%	19.7%	20.4%	19.8%
	W		Complaints in 3 Days		90.0%	100%	98.9%	100%	100%
	W		Mixed Sex Breaches		500	126	48	39	54

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-22	Mar-22	Apr-22	May-22
Staff Engagement	W		Statutory Training		91.0%	91.6%	91.3%	91.3%	92.8%
	W		Safeguarding Children Training		90.0%	91.3%	92.3%	92.1%	91.5%
	W		Premature Turnover Rate		25.0%	19.6%	19.2%	19.5%	20.3%
Financial Position	W		Non Pay		0.0%	-0.5%	-6.0%	2.8%	2.6%

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.	Mid-term goals by Dec 22 Long-term goals by Jun 23	• Further review of residential modelling to understand demand. • SOC for residential accommodation to be reviewed by executive team. • Review of training room booking process underway. • Project lead to link in with key stakeholders to improve space utilisation.	• Development of Accommodation Management Policy • Development of space utilisation comms plan • Training needs/space usage analysis to support a case for additional training venue
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	To get to >65% completed by Nov 22, then BAU	• Additional online job planning workshop for doctors took place then will take place monthly. • New online job planning workshop for Clinical Leads and General Managers • Developments towards optimisation of licences • Developments towards CMO webpages • Some face to face team/specialty job planning training sessions. • Continue to report monthly to the Medical Workforce Deployment Group.	• Additional Feedback workshops • Job planning discussions to take place at the Kent Clinicians Development Programme for new consultants • Continued development of CMO intranet pages • Utilise learning and feedback from workshop sessions to improvement communication plans and content, engagement towards the process and the quality of guidance available
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Dec 22	• Focus on examining Clinician engagement and ownership to determine where progress and improvement will best supported	• Review of progress to date with SRO to establish refined plan of support and decision of future direction of the TPIP • Align with GSM Care Group Driver relating to discharges before midday

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	• Clinical guidelines Policy for review by PSC/ CAEC • Recruitment process for Clinical Guidelines Manager	• Meetings with clinical care group directors • Upload of clinical guidance onto microguide • Recruitment process for Clinical Guidelines Manager
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	Dec 22 then transfer to BAU	• Continue to engage stakeholders and implement countermeasures as per A3	• Mapping of stakeholders towards specific workstreams • Establishment of workstream action plans
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)	Aug 22	• Project currently on pause	• Project is currently on pause • Consider transfer to BAU and Closure report

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

East Kent Hospitals University NHS Foundation Trust

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

NHS
East Kent
Hospitals University
NHS Foundation Trust

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.