NHS
East Kent
Hospitals University
NHS Foundation Trust

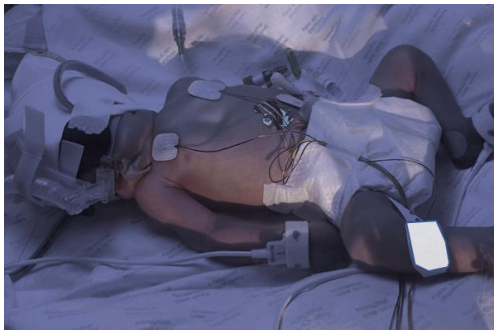
Integrated Performance Report

June 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.

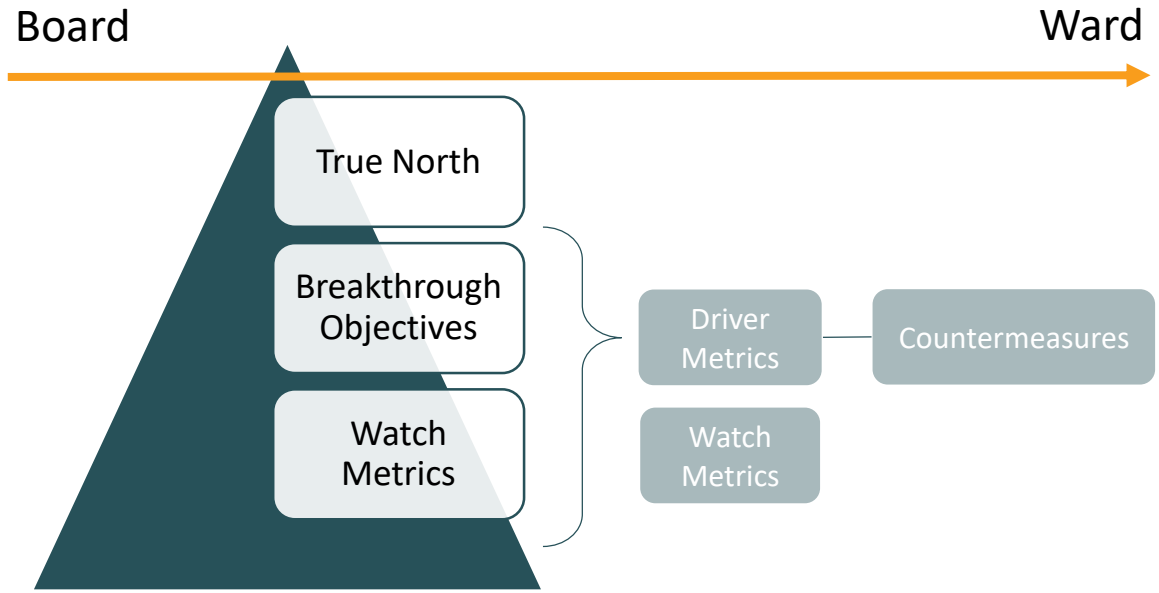
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
96.8	97.7	98.8	99.8	97.7	92.6	89.5	88.0	86.3			

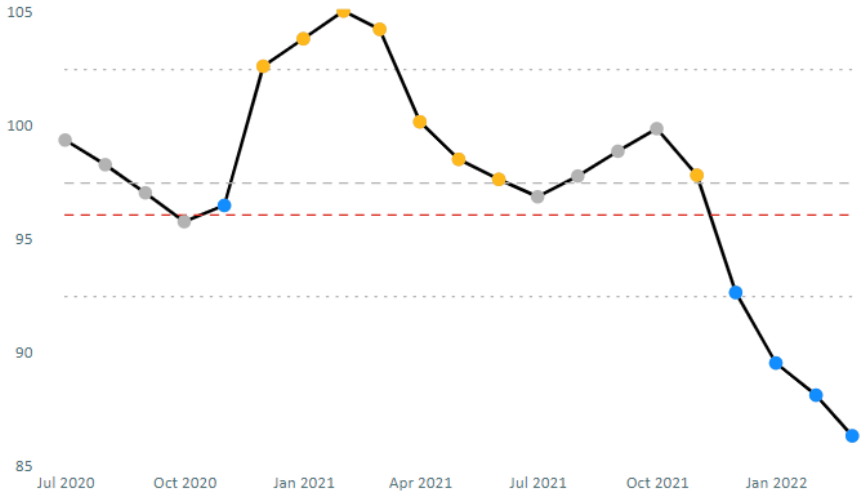
Variation indicates inconsistently passing and falling short of the target

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 its 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 March 2022 which is the last data release.

Nationally for all acute (non-specialist providers) we are 16th 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.. 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 (76.8) to March 2022) but there are still key indicators within the National Hip Fracture database that merit further improvement or need to demonstrate improvements are sustained 5/8 KPIs are now above the national average at WHH and 2/8 at QEQM. Further work is underway to understand the drivers of difference.

- 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 with the national baseline not stabilised.

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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
36	22	22	43	15	32	30	31	30	28	26	35

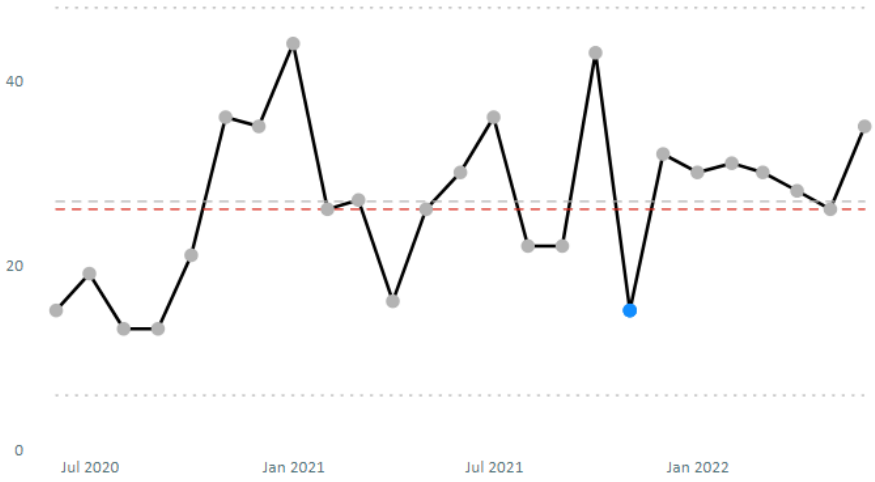
Variation indicates inconsistently passing and falling short of the target

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 35 incidents with a severity score of moderate and above in June which is above the 22/23 threshold. 5 incidents relate to women's health 'obstetric complication' with 4 incidents of women's health 'unexpected problem' also being reported, this increase in maternity incidents has impacted on June performance. Care/treatment was the single highest contributor with 8 incidents. For the last 3 months care/treatment and delay/failure have been the highest contributors.

Intervention and Planned Impact

Failure to act upon requested diagnostics or to initiate treatment has been recognised as a cause of moderate and above harm incidents. This is being addressed via the serious incident panel, learning from deaths and structured judgement review process. Clinicians have also been invited to attend the weekly driver meetings.

Focused improvement work is taking place in Maternity with oversight through MNAG and Board.

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. There were no moderate or above harm incidents related to pressure ulcers or nutrition for the second consecutive month and work is ongoing to ensure this position is sustained. Total falls reduced to 131 in June from 175 in May with only 1 severe harm recorded, there was a targeted approach throughout June with the speciality teams, therapy teams and senior nursing staff to focus on the areas where we saw an increase in low/no harm falls.

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 are 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.	Mar-22	Apr-22	May-22	Jun-22
Harm Events	W4		VTE Assessment Compliance		95.0%	92.6%	91.5%	92.3%	92.0%
	W4		Serious Incidents Breached		0	88	102	114	103
			Never Events		0	1	1	0	2

VTE Assessment Compliance

VTE compliance remains below threshold and is driven by underperformance across half of specialties, with the remainder compliant. Improvement plans are in place and monitored through patient safety committee. The dashboard has now been updated to give a more accurate picture which the Clinical Directors are using to target change.

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. There has been consistent work to complete investigations, however breaches remain. GSM remains the biggest contributor (33) although an improvement on last month, and UEC is consistent with 26 breaching. Women's health shows 24 breaching, which is significantly impacted by the absences/vacancies within the governance team.

Never Events

There were 2 Never Events declared in June 2022. One met the criteria for wrong site as a strip of skin was removed from the lateral aspect of a wound rather than the medial aspect, and one was due to a swab being left internally following an obstetric procedure. Immediate risk mitigation showed no LocSSIP in place which is now being addressed.

Our patients

Our patients

Rebecca Carlton

Trust Access Standards: 18wk Referral to Treatment

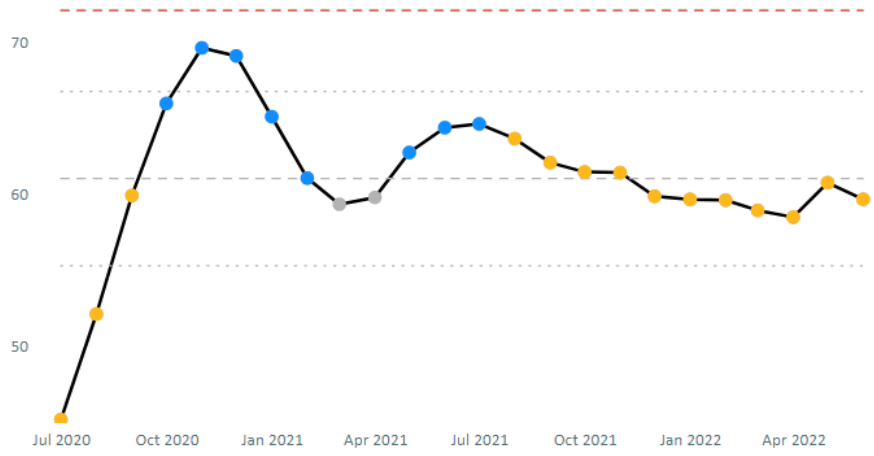
The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

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.

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

F	L	Flag Description
Variation indicates consistently falling short of the target	Special cause of concerning nature or higher pressure due to lower values	Below Mean Run Group

XMR Run Chart



What the chart tells us

Non-Admitted waiting lists have grown significantly over the last two years which is contributing to the reduced compliance in this metric. The initial phase of elective recovery in spring/summer 2021 saw an improvement in our performance, however we have not been able to recover the performance following the impact of waves two and three. Over the last 6 months performance has remained static however our long waiting patients have continued to reduce.

Intervention and Planned Impact

- Exception assurance reporting and enhanced monitoring has commenced from July via the Elective Delivery Group chaired by the COO.
- Analysis of non-admitted pathway underway to ensure recovery actions are aligned to reducing waiting times for patients, ensuring our plans reduce the elongated waits and where necessary revise recovery plans to prevent further deterioration within the recovery trajectories.
- Diagnostic improvement plan implemented which is yielding an improvement in key modalities (reducing backlog and improving DM01 performance).
- Focused elective recovery plans to be developed in Orthopaedics, Surgery, Urology, ENT, Ophthalmology and Cardiology – spanning non-admitted, diagnostic and admitted pathway.
- Theatre utilisation improved in May to 80% and has been maintained in June with focus on achieving 85%. Targeted work commences with specialties to increase the volume of cases per session aligned to activity plans.
- Two reported breaches against the 104wk trajectory excluding patients choosing to wait longer for surgery/impact of covid. Re focus 104wk oversight to 78wk recovery by March 2023
- Developing reporting process to record and track compliance against our harm review process.

Risks/Mitigations

- Finance and coding review commenced to ensure recorded activity is aligned to our Elective Service Recovery Fund (ERF) contribution.
- Theatre estate and vulnerability, planned works due to complete by 16th August.
- National supply issues with ENT equipment impacting ability to increase cases per session for longest waiting patients.

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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
38	51	48	39	38	52	54	60	39	36	32	30

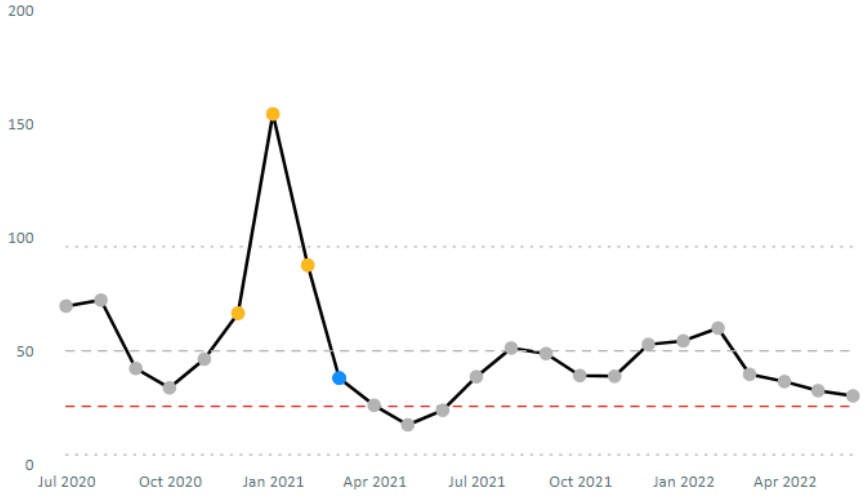
Variation indicates inconsistently passing and falling short of the target

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 30 sessions a week which is an improving position. Pareto analysis of the June data shows; 13 cancelled sessions, 6 sessions related to early finishes, 5 sessions related to turnaround times, 5 due to late starts and 1 due to cancellations on the day.
The top three contributing specialities are Ophthalmology, General Surgery and Orthopaedics.
Cancelled sessions remain the main contributor to this indicator of which staff availability is the greatest reason.

Intervention and Planned Impact

Utilising all of our available theatre sessions and returning to pre-covid cases per session (2.8) will enable us to treat more patients and reduce waiting times for patients waiting for surgical treatment. It will also enable the delivery of the elective activity plan set for 2022/23.
To facilitate this there are a number of measures that have been implemented, with further action required:

- Work is on-going with the booking teams to optimise scheduling opportunities. This includes awareness of individual targets and discrepancies between planned and actual utilisation; June performance 89%.
- On time starts remain static at 53.8%, work is starting with the hospital directors to develop a process that will reduce the on-time start delays as a result of bed capacity, including ITU.
- The 2022/23 elective activity plan is being translated into weekly sessions required, and will be factored into the revised theatre schedule. As such, theatre time will be proportionate to the activity required by each speciality.
- Staffing remains challenging, work is underway to finalise the theatre staffing business case.
- Implementation of 6:4:2 will be a priority for the revised theatre optimisation group that is starting in August, led by the Surgery & Anaesthetic Leadership team.

Risks/Mitigations

- Breakdown / Replacement of essential theatre estates and equipment will reduce available capacity - where planned we are reallocating sessions where possible.
- Staffing/ recruitment – theatre staffing business case in draft

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.

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

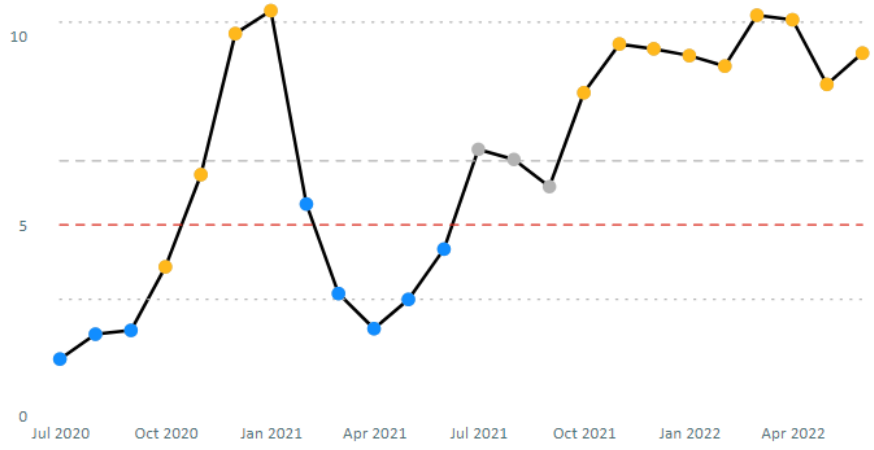
Variation indicates inconsistently passing and falling short of the target

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 12hrs in the emergency department, from arrival to admission, transfer or discharge. ED attendances have remained static and covid presentations and admissions have increased.

June saw an increase to 9.8% of patients spending more than 12 hours in ED. This is driven by our admitted pathway following an increase in patients who need to stay in a hospital bed for their treatment.

For patients who need to see a specialist for emergency care but who may not need a full inpatient admission the mean time is 3.6 hours. This pathway is known as Same Day Emergency Care (SDEC) and means that patients see a specialist for their presenting complaint and start treatment, it is often possible for these patients to conclude their treatment at home (see 22/23 break through objective).

Intervention and Planned Impact

- A weekly in depth review patients with no complex discharge needs has started led by the Medical Director and Head of Therapy at William Harvey, for any patients with a length of stay over 7 days. This is raising the profile of simple discharges and increased clinical engagement at ward level.
- Frailty Assessment Units (FAU) have seen an increase in activity resulting in reduced time in ED for our patients. WHH has successfully relocated the FAU to the emergency floor which has seen a direct correlation to an increase in activity. QEQMH are planning to transfer their FAU to the emergency floor to replicate the model and shared learning from WHH.
- make in Ambulatory Care and this month a focussed review of QEQM will support actions to improve NHSEI improvement support has been contributing to our understanding of the improvement actions

Risks/Mitigations.

- The number of super-stranded patients in July 2021 was 107 in June 2022 the number has increased to 221. The local health economy agreed trajectory is 133 for June. There is a direct correlation and impact between the number of super-stranded patients and ED performance for 12hr trolley waits metrics and flow.
- The increase in Covid presentation increased the IPC requirements which does slow transfers as extra care is taken in infection prevention.

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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
1,998	1,752	1,804	2,003	2,288	2,017	2,144	1,940	2,302	1,945	2,076	1,972

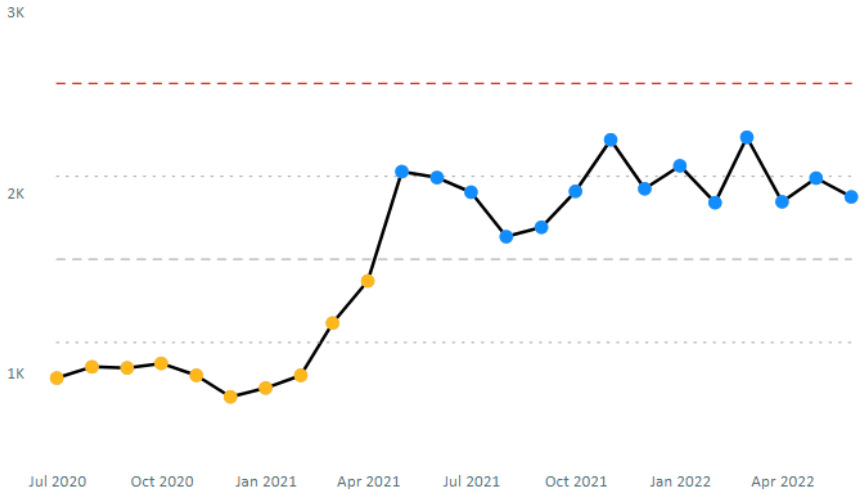
F — Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The number of patients being seen in total for our SDEC pathways has stabilised at approximately 2,000 patients a month, compared to ~1,000 at the beginning of the period. When looking into the specialist pathways data underneath this we can see an upward trajectory and have seen an increase in activity through the Frailty Assessment units, Surgical Emergency admission, The WHH Medical SDEC. and the Children's assessment units activity. Both the Gynaecology assessment units (GAU) and the QEQM Medical assessment units have seen a decrease in activity due to staffing challenges this month.

Intervention and Planned Impact

- Following on from last months engagement piece in medical SDEC we have decided to hold Emergency village speed dating planning events for both sites - first with internal stakeholders and then with external stakeholders - The planned impact is to increase awareness of pathways available and to link services in with stakeholders they may require to support growth of their units.

- Medical SDEC at the WHH are launching a pilot with NHS 111 on the 2nd August to accept direct bookings. This pilot will be a great opportunity to increase direct access to SDEC but also to support teaching and learning for any patients that are better suited to other pathways. If the pilot is successful we will be looking to roll this out to other SDEC services. This will directly impact on patients not having to attend ED but going straight to SDEC on arrival.

- FAU continues to see more patients at the WHH now that it is relocated as part of the emergency village. In June they went from an average of 80 patients a month to 107. QEQM are working on a similar estates change to support this model. The benefits of these specialist areas include an assessment mindset and culture, a real approach to home first.

Risks/Mitigations

- Workforce challenges for both QEQM medical SDEC and GAU are being worked through with clinicians and colleagues in HR to look at a different models of care and building a resilient workforce. There is also a review underway of where these services are located to see if we can locate with other services with similar workforce requirements to provide a more efficient and effective workforce model.

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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
82.5%	80.7%	78.8%	79.3%	84.3%	78.0%	75.6%	71.0%	74.5%	66.1%	63.2%	71.9%

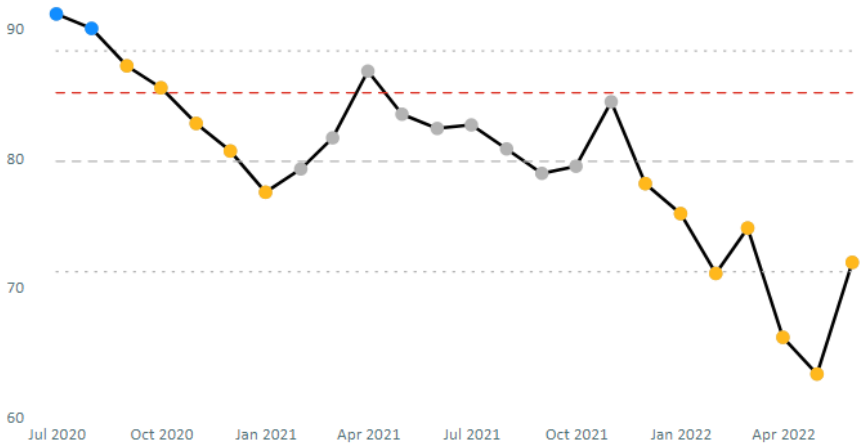
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Performance has improved in June despite the continuing huge volume of demand following public health campaigns and post pandemic surge. Teams are working hard to prioritise patients and deal with competing demand. K&M Cancer Alliance continued to record the lowest back log of all Alliances, East Kent Hospitals is the largest contributor to this.

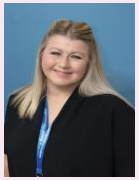
Intervention and Planned Impact

- 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. Contacts with patients are being monitored via the cancer reporting system, with actions including arranging transport to enable patients to access timely diagnostics across sites.
- A new three weekly update is provided from the compliance team to ensure all teams are aware of their successes and continued challenges
- New escalation process agreed with tertiary centres, demand and capacity work underway.
- Endoscopy continue to receive daily escalation of individual patients to be booked. This ensures cancer patients are prioritised to be booked within 14 days. A daily huddle is in place to review the cancer waiting list to ensure that all available capacity is utilised.
- Histology 10 Day: Performance improved in month 68% (+6%) against 90% standard. Non-cancer pathway biopsy and histology cases >45 days have also improved. Performance for main tumour site biopsy maintained at >80% cases reported within 10 days over the last 3 weeks of June. The overall backlog has also improved in month, now 276 cases (target <500) which is an improved position since last month of 386 cases. Biopsy backlog 52 cases and routine histology 224.

Risks/Mitigations

- The national shortage of chemotherapy products has been escalated through the cancer network and Kent and Medway system. Trusts are working together to provide mutual aid or advice where they are able to enable patients to start their treatment.
- There is increased demand for the aseptic service for chemotherapy treatment. Extended working hours and weekend working have been offered to mitigate the risk.

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.

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

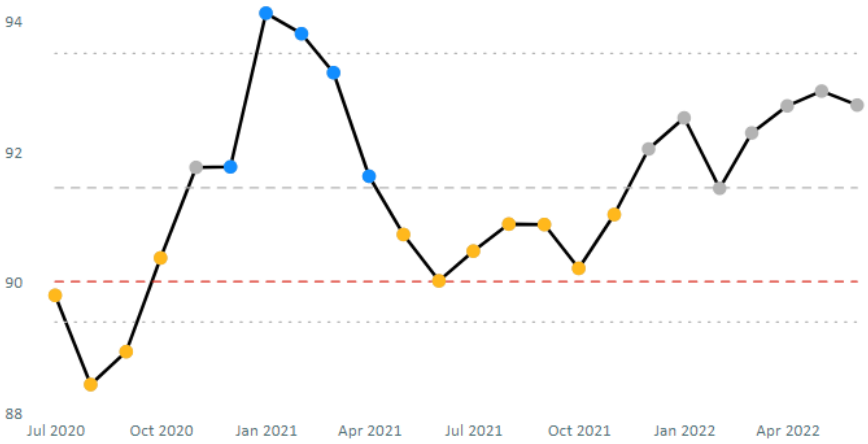
Variation indicates inconsistently passing and falling short of the target

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 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 and this went live on the 20th June. Alongside this the ward accreditation project is commencing, due to recruitment challenges this has been delayed until August/September. All in-patient adult wards now 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 reporting of this data from the Tendable audit will feature within the IPR in August 22. This data will also be presented and reviewed at the monthly FoC Committee. Initial feedback from patients has indicated that more than half of those surveyed are suffering disturbances at night so soft closing bins and ear plugs are being explored by the ward managers.

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.	Mar-22	Apr-22	May-22	Jun-22
Cancer 62d	W4		Cancer 28d Performance		75.0%	68.2%	62.0%	66.6%	66.1%
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	716	734	661	573
	W4		RTT 52w Breaches		0	3,755	3,674	3,566	3,663
	W4		DM01 Compliance		75.0%	67.2%	64.4%	67.6%	69.6%
	W4		RTT OP Booking Breaches		14,000	20.2K	21.8K	22.8K	24.1K
ED Compliance	W4		ED Compliance		90.0%	67.6%	69.8%	69.4%	69.4%
	W4		Clinician First Seen within 1h		50.0%	28.6%	42.4%	39.2%	42.5%
	W4		Unplanned Re-attendance ED		10.0%	12.7%	14.5%	13.7%	14.6%
	W4		Super Stranded >21D		107	195	211	221	221
	W4		Discharges by Midday		15.0%	13.1%	13.7%	13.6%	14.3%
			Pathway 0 Patients >7 Days		Sigma	124	132	142	158

Regional access position

The regional position has been included below to give context on the relative performance of EK within the System.

*Cancer figures shown are for May as this is the latest national data available

Target/Trust	EKHUFT	MTW	Medway	Dartford
A&E 4 Hour	69.4%	87.30%	68.6%	73.8%
Cancer 62d	*63.2%	*85.3%	*86.5%	*58.8%
DM01	69.6%	95.30%	71.6%	87.6%
RTT 18w	59.6%	70.90%	62.6%	66.9%

RTT 18 Weeks

We continue to focus on our very long waiting patients. 104ww has now reduced to one patients and we refocus on 78ww milestone.

Increased referrals are impacting on the RTT booking breaches for outpatients with waits for first outpatient appointment increasing. There is an urgency in developing PIFU pathways and working with our primary care colleagues on advice and guidance.

We need to further reduce the amount of lost or under utilised theatres session. The current BO is close to delivery. Following this we have identified outpatients booking as the next breakthrough objective for the RTT True North.

DM01 performance shows an improving position following an action plan shared with and supported by the national and regional teams. High risk remains CT Cardiac and there is a specific piece of work starting this week to improve the position.

ED Compliance

In June 2021 the 4h performance was 77%, during this time 'stranded' patients with a length of stay >21d were 99. In June 22, this number has more than doubled to 221.

Unplanned reattendance rate has increase in June 14.3%; 7% are patients returning for dressing changes and pain control which can and should be completed in primary or community care. We are discussing with colleagues in primary and community services to ensure the service model best fits patient need. Addressing these issues would bring the Trust back in line with national average.

Super stranded over 21 days

80% of these patients require additional services or have some degree of complexity that requires support from the community, residential or local authority care provision. We work with partners on a daily basis to ensure our patients access the services they need from other providers in a timely way.

Discharges by midday

This metric continues to be focus for the General Specialist Medicine Care Group. Discharge support has been increased at KCH, notably the site with the lowest performance. A clinical flow manager is also in place at the QE. The teams are identifying and auditing key delay points for those patients that do not go by midday; primarily being driven by late Electronic Discharge and patient suitability for using the discharge lounge.

Pathway 0

These are patients who have no complex needs or additional services that are required on discharge. The number of pathway 0 patients has increased along with the occupancy of the hospital which is now at xxx [LP]. Each hospital has now commenced medical, therapy and nursing lead 'Pathway 0' board rounds to help progress and understand the patient pathway and any discharge delays for this group of patients.

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.	Mar-22	Apr-22	May-22	Jun-22
FFT			FFT ED Response Rate		12.0%	14.6%	15.8%	15.2%	12.7%
	W4		FFT Maternity Response Rate		18.0%	10.1%	13.5%	14.9%	14.7%
	W4		Complaint Response		90.0%	12.0%	7.1%	7.3%	0.0%
	W4		Duty of Candour - Verbal		100.0%	47.1%	51.9%	35.7%	28.6%
	W4		Duty of Candour - Written 10wd		100.0%	23.5%	14.8%	21.4%	22.2%
	W4		Duty of Candour - Findings		100.0%	37.5%	33.3%	0.0%	33.3%

Duty of Candour

Compliance in Duty of Candour remains low due to both an ongoing issue with data validation, and as education of the requirements is cascaded to staff. There is an inconsistency in the reporting from Datix that has resulted in abnormally low rates this month, and this is being reviewed. A communications plan and education package is due to commence rollout in July, and an additional resource to review the backlog is also due to commence July. This should result in an overall improvement to the rating, and a better understanding of the trajectory for full compliance.

Our people


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

Our people

Andrea Ashman

Staff Engagement (score)

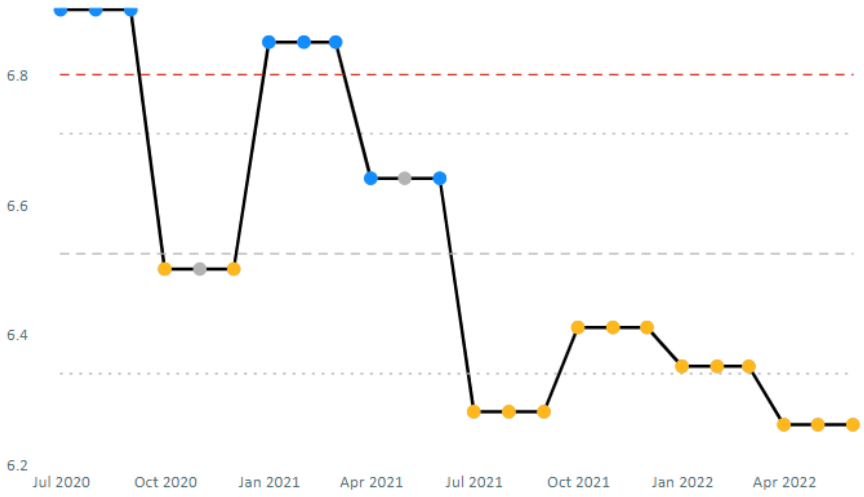
Staff Engagement levels have remained below the national average throughout the last five years. The Staff Engagement Index itself has been on a downward trend for three years and, as an organisation, we are one of the most challenged in the country, sitting in the bottom 20% nationally. Given the negative 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.

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

F	L	Flag Description
Variation indicates consistently falling short of the target	Special cause of concerning nature or higher pressure due to lower values	Below Mean Run Group Astronomical Point Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

The latest 'live' data coming from the current (July) National Quarterly Pulse Survey shows an improvement in Staff Engagement (to 6.33). In fact, the data demonstrates improvements in all six questions relating to both motivation and involvement, with both significantly improved against Q1. Advocacy scores are unchanged which is preventing larger scale improvements to the overall SE score. This is largely due to a fall in staff feeling care is the organisations top priority.

Interventions and Planned Impact

Each Care Group has now socialised their NSS results, taking the data and information from the newly developed dashboard and translating it to intelligence. This has led to further investigation (route cause analysis) and the implementation of actions (PDSA cycles). Care Groups have identified the key actions they are working on and are providing updates to PCC through an agreed reporting structure.

This allows the NSS to act as a barometer that drives year-round action. Much of this work has also taken place at Site or Specialty level owing to some considerable differences across Care Groups. The NQPS is providing a more regular update against engagement, wellbeing and positive culture. Areas can now access the data 'live' each quarter to see real-time improvements/ changes and the survey structure has been rebuilt in such a way we can identify more granular hotspots.

The NSS dashboard the Trust pioneered has been commended by NHSEI and, following presentation at a national People and Culture Conference on 14/07, East Kent have been asked to lead work sharing this best-practice with others nationally.

Risks/Mitigations

The True North for Staff Engagement is supported by a BTO for staff involvement. The NQPS is currently taking place and ensures up-to-date picture on staff engagement. The July NQPS has been updated to allow insights at sub-specialty, ward/ department, role and length of service level. A national toolkit has also been shared with Care Groups to support rollout of their action plans and an involvement toolkit is being developed to support tangible 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.

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

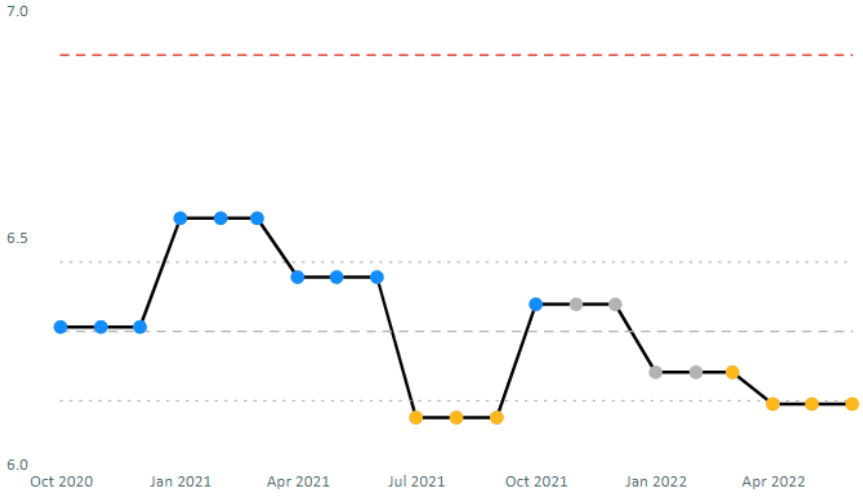
F — Variation indicates consistently falling short of the target

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 (not yet published opposite) shows that East Kent Hospitals' involvement score has begun to improve (from 6.13 to 6.28). As of 18/07 the 'live' data from the July NQPS shows that all three aspects of involvement are improving:

- Opportunities to show initiative frequently in my role ↑2.4% to **62.9%** (from 60.5%)
- Able to make suggestions to improve the work of my team/dept ↑2.3% to **64.5%** (from 62.2%)
- Able to make improvements happen in my area of work ↑4.5% to **51.8%** (from 47.3%)

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
- A delay in the implementation of the new intranet may hinder the progress of the staff suggestions mechanism

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.	Mar-22	Apr-22	May-22	Jun-22
Staff Engagement	W4		Appraisals Compliance		80.0%	77.9%	77.4%	72.3%	66.4%
	W4		Staff Turnover Rate		11.5%	12.9%	12.9%	12.9%	12.8%
	W4		Vacancy Rate		10.0%	12.7%	13.3%	12.6%	12.4%
	W4		Staff Turnover: HCA		13.5%	14.2%	14.5%	14.2%	14.7%
	W4		Staff Turnover: Nursing		10.0%	11.8%	11.2%	11.2%	10.9%

Appraisal

Appraisal compliance is an area of concern as it is a good indicator of staff engagement and personal development planning

Overall appraisal compliance has been on an upward trend during 2021 and 2022.The threshold was previously set at 77% but was revised upwards last month. Care Groups are identifying line managers who have not uploaded appraisals, or have not accessed ESR Self Service to ensure that true appraisal compliance is recorded following changes to administrative processes. Whereas previously, Appraisal Compliance was a driver for many Care Groups, this will now be supported through the Trust objective of Staff Involvement and tested at performance meetings.

Staff Turnover

Total turnover, when measured as a rolling 12-month average, is beginning to reduce and stands at **12.76%**. Whilst the 12-month average remains above the True North target (11.5%), in-month turnover has **reduced back to 11.32%.**

The in-month improvements are now beginning to create a positive downward trend.

Healthcare Assistant turnover **(14.7%)**, when measured as a 12-month rolling average is above the desired threshold (13.5%) and has been for the last six months. The in-month turnover position, was reflecting an improving picture, reducing month on month from November to May. However, when measured in June HCA turnover has risen to **14.90%.** This is the highest it has been since January. Internal career progression (17%) and work life balance have been contributory factors

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 for over a year at 8.03% and consistently below the threshold for 6 of the last 9 months.

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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
0.024	0.042	0.021	-1.494	-0.996	-0.941	-0.090	1.307	0.076	-3.700	-6.624	-6.604

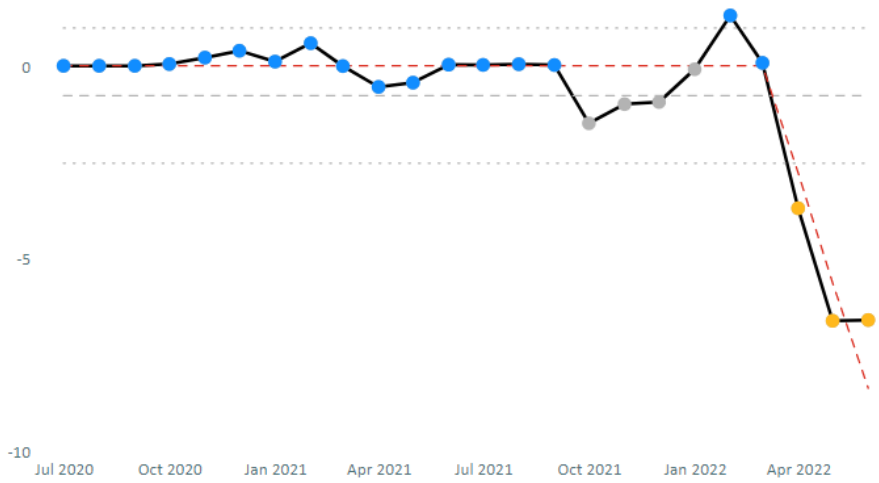
P — Variation indicates consistently passing the target

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 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 position in June which is a £6.6m deficit against a plan of £3.3m deficit. The key drivers behind the shortfall year to date are; £1m CIP behind plan, £0.9m of premium pay pressures, £0.7m overspend on Covid-19 related costs, £0.3m short on non-healthcare income (parking, catering etc, £0.2m short on private patient work, £0.2m short for recharges to other NHS providers. The figures exclude our shortfall on ERF activity currently £3.7m.

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. 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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
7,134	7,351	7,092	6,783	7,255	6,441	7,168	7,403	9,148	7,890	7,497	8,894

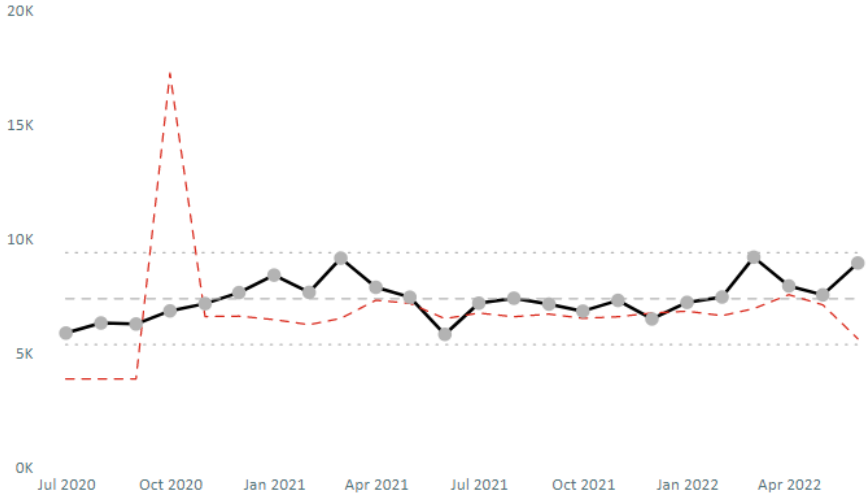
Variation indicates inconsistently passing and falling short of the target

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 June 2022 premium pay spend has increased by £1.4m.

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.
- Detailed focus by care groups on drivers of premium pay.
- 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 has formed but is in its infancy,
- 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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
3.83	4.44	4.53	5.61	8.06	8.60	9.55	7.65	7.97	6.29	5.80	

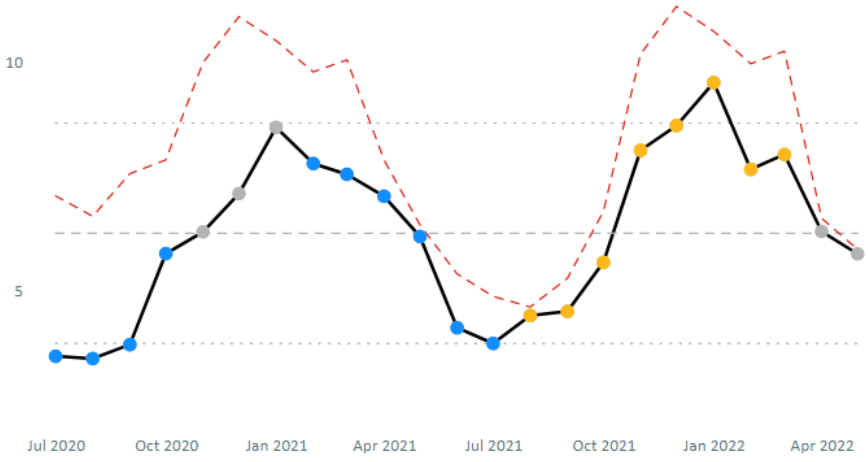
Variation indicates inconsistently passing and falling short of the target

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 May net position is below the monthly trajectory of 5.90 at 5.80 kgC02e per m2 and is slightly below the same period last year (reporting at 6.17). 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 finalised and a business case will be taken forward through internal governance in August / September. Schemes will focus on carbon reduction, rather than financial savings, although financial reductions will be part of the programme of work. The business Case should be ready for review in August. 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.	Mar-22	Apr-22	May-22	Jun-22
Financial Position	W4		Total Pay		0.0%	-2.0%	-2.4%	-2.3%	-3.1%

Total Pay

This metric is driven by premium pay usage which has increased in month. The care groups are reviewing all of the key drivers to the usage of premium pay.

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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
309.9	299.6	303.0	299.5	332.0	346.2	314.3	320.4	336.2	351.1	352.9	354.9

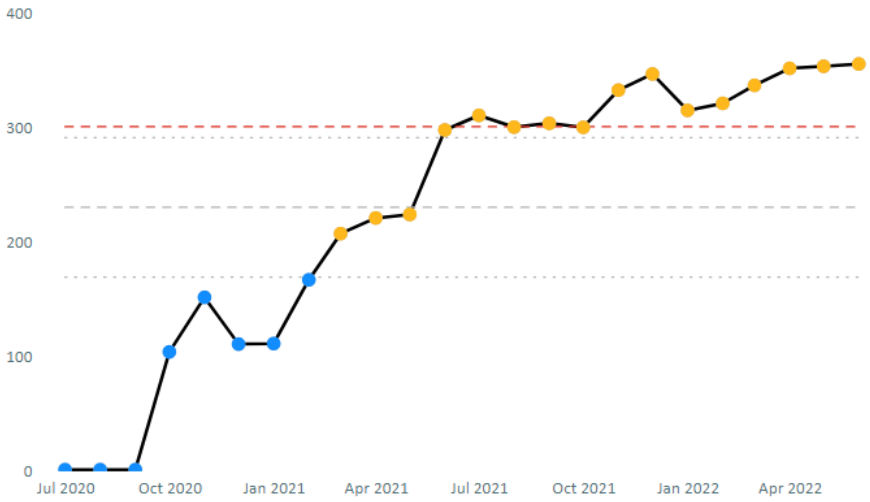
P — Variation indicates consistently passing the target

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 continued to increase over the past year with 221 patients being delays in June 2022. 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

- A review of the demand for PW1, PW2 and PW3 benchmarked against September 2021 has been presented to the Urgent Care Delivery Board which is a local health economy group. This information is being used to inform the capacity required under each Pathway to enable timely discharge from both the Acute and Community Hospitals.
- Weekly PW0 ward rounds are becoming established to ensure that there are no delays in our internal pathways.
- Matrons are leading on improving the understanding and recording of the C2R status.
- Hospital leadership teams at QEQM and WHH will focus on supporting ward teams to move discharges before midday from 14.5% to 33%, this has been static for the last three weeks and reflects the increase in super stranded patients >21 day LOS.
- Local nursing homes engagement meetings have been held to develop good communication and trust.
- Key stakeholders from the Local Health Economy are engaged in developing a Transfer of Care Hub which will simplify the referral process.
- The Transfer of Care Hub will prioritise discharges from the front door which will support early discharge and prevent unnecessary admission due to lack of external capacity.

Risks/Mitigations

- Insufficient external capacity to meet patients needs resulting in patients being delay or deteriorating to require a higher level of support upon discharge due to extended length of stay. Mitigation is to work through the LHE and regional meetings to escalate both individual and system capacity issues.

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.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
267	176	161	208	303	198	116	91	246	129	162	430

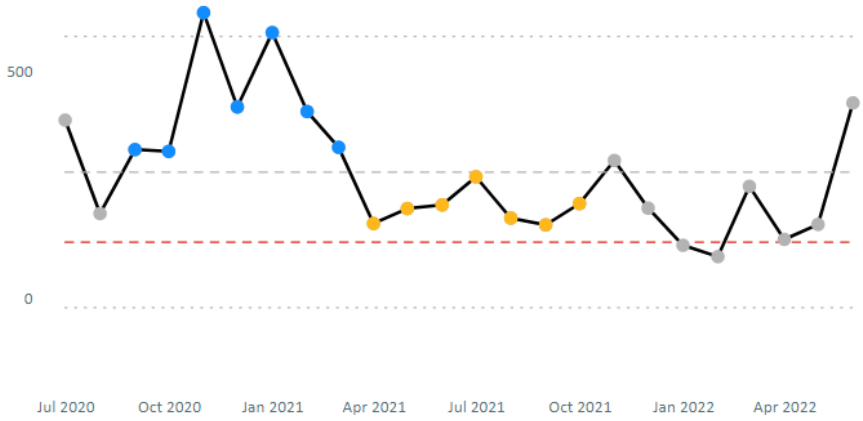
Variation indicates inconsistently passing and falling short of the target

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 June position of 430 participants is above the threshold of 123 (positive). The increase relates to 264 patients recruited to a Trauma and Emergency Care Trial. Even without this trial, the position was still above the agreed annual threshold, with 166 participants in the other specialties.

Intervention and Planned Impact

- The Clinical Trials Unit at QEQM opened in June and 13 studies are currently running or are in development through the CTU. Studies will be commencing shortly in the bedded area, with surgical, anaesthetics and radiology studies in the pipeline.
- Following identification of the four key growth areas, 3 additional surgical studies have been set up and recruitment is due to start following Sponsor sign off. Set up of anaesthetics and stroke studies are also complete.
- An Trauma and Emergency study detailed above, was run jointly with SECAmb and relates to older adults with a traumatic brain injury.
- DOLPHIN, our first multi-site study (3 sites across the UK), is ready to open in September.
- Funding of additional Clinical Fellow posts continues to be discussed with Anaesthetics, Surgery, Cardiology, Haematology and Vascular.
- 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 later in 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.	Mar-22	Apr-22	May-22	Jun-22
Harm Events	W		Falls		Sigma	146	156	171	133
	W		IPC: CDiff Infections		6	5	9	10	13
	W		IPC: EColi Infections		10	6	12	10	5
	W		IPC: Klebsiella Infections		6	4	0	5	3
	W		IPC: Pseudomonas Infections		3	0	1	2	2
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	211	203	225	237
	W		Medication Errors; Severity C+		1	0	0	2	4
	W		Nutrition Incidents		Sigma	67	51	61	72
	W		Pressure Ulcers: Cat 2		Sigma	33	22	33	27
	W		Pressure Ulcers: Cat 3 & 4		Sigma	2	1	1	1
	W		Pressure Ulcers: DTI		Sigma	5	6	8	3
	W		Pressure Ulcers: Unstageable		Sigma	17	12	6	0
	W		IPC: Audits Composite		85.0%	88.3%	85.6%	86.2%	83.3%
	W		Safeguarding Incidents		Sigma	9	15	19	14
	W		IP Spells with 3+ Ward Moves		Sigma	571	525	547	537
	W		Clinical Incidents		Sigma	2,294	1,822	2,181	2,194
	W		Serious Incidents		Sigma	23	14	20	18
	W		Maternity Serious Incidents		2	7	4	2	5
Mortality	W		Extended Perinatal Mortality		6.32	4.92	4.94	4.30	4.41

True North Domain	BR	Flag	KPI	SPC	Thres.	Mar-22	Apr-22	May-22	Jun-22
Staff Engagement	W		Sickness		5.0%	6.7%	6.0%	4.7%	
	W		Statutory Training		91.0%	91.3%	91.3%	92.8%	92.4%
	W		Safeguarding Children Training		90.0%	92.3%	92.1%	91.5%	90.0%
	W		Safeguarding Adults Training		90.0%	91.8%	91.4%	90.8%	90.3%
	W		Premature Turnover Rate		25.0%	19.2%	19.5%	20.3%	20.5%
Financial Position	W		Non Pay		0.0%	-6.0%	2.8%	2.6%	1.0%
	W		Efficiencies YTD Variance (£M)		0.0		-0.6	-1.0	-1.0
	W		Efficiencies FOT Variance (£M)		0.0		0.0	0.0	-4.7
	W		Efficiencies Green Schemes		90.0%		5.9%	13.2%	22.8%
	W		I&E Monthly Variance Trust (£)		0		-929.6K	-212.7K	-2.5M
	W		I&E YTD Variance (£)		0		-929.6K	-1.1M	-3.7M
	W		I&E FOT Variance (£)		0		0	0	0

True North Domain	BR	Flag	KPI	SPC	Thres.	Mar-22	Apr-22	May-22	Jun-22
Cancer 62d	W		Cancer 2ww Performance		93.0%	97.4%	95.1%	97.2%	96.9%
	W		Cancer 31d Performance		96.0%	98.8%	98.3%	98.6%	98.9%
	W		Radiology Diags vs Plan		Traj.		16,009	17,971	17,457
	W		Endoscopy vs Plan		Traj.		1,204	1,556	1,323
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,556	1,361	1,469	1,681
	W		OPA vs Plan		Traj.		66,420	78,791	71,872
	W		Elective Admissions vs Plan		Traj.		8,048	9,321	8,332
ED Compliance	W		A&E Atts vs Plan		Traj.		22,354	24,563	23,756
	W		NEL Admissions vs Plan		Traj.		7,391	7,790	7,363
	W		NEL Readmissions		15.0%	11.0%	11.0%	10.3%	10.2%
	W		Stroke Ward within 4 Hours		50.0%	66.7%	53.3%	57.7%	52.3%
FFT	W		FFT IP Response Rate		15.0%	18.4%	18.9%	19.8%	16.7%
	W		FFT DC Response Rate		27.0%	30.2%	30.8%	30.3%	28.1%
	W		FFT OP Response Rate		17.0%	19.7%	20.4%	19.8%	18.8%
	W		Complaints Number		Sigma	94	53	65	69
	W		Complaints Number (Sigma)		Sigma	94	53	65	69
	W		Complaints Number (UEC Sigma)		Sigma	2	1	1	1
	W		Mixed Sex Breaches		Sigma	48	39	54	37

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.	Meeting is pending to review the A3 and dates	• Further review of residential modelling to understand demand. • SOC for residential accommodation to be reviewed by executive team. • Review of training room booking process continues. • Project lead to link in with key stakeholders to improve space utilisation. • Development of Accommodation Management Policy	• Finalisation of Accommodation Management Policy • Feedback compiled by project lead on agile working with key stakeholders • Completion of residential modelling work.
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	Dates will be reviewed once VP is back	• Monthly online job planning workshop are in place • Online job planning workshop for Clinical Leads and General Managers • Job planning discussions taken place at the Kent Clinicians • Audit taken place to ensure full optimisation of licences being used • Some face to face team/specialty job planning training sessions have taken place. • Continue to report monthly to the Medical Workforce Deployment Group. • Development Programme for new consultants • Job planning metrics have been added to watch metrics	• CMO intranet pages to be updated • New project manager will report infographics to Clinical leads and Care groups every month and will monitor the questions being asked • Continue to utilise learning and feedback from workshop sessions • Working with Finance to optimise budget
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Dates will be reviewed at next A3 meeting	• Focus on examining Clinician engagement and ownership to determine where progress and improvement will best supported	• Review the aim of the project and update the A3

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	• Interviews organised for next week for Clinical Guidelines Manager • The Clinical guidelines Policy is to be presented at CEMG in August • Meetings with clinical care group directors continue • The uploading of clinical guidelines has started.
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 at next meeting	• Mapping of stakeholders towards specific workstreams is complete • Establishment of workstream action plans ongoing • Develop a training program to increase staffs knowledge and skills in EoLC – complete	• Mandatory training video is in production.
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)	TBC	• Project currently on pause	• Project is currently on pause

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	Complete
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Aug 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

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.