NHS
East Kent
Hospitals University
NHS Foundation Trust

Integrated Performance Report

July 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.

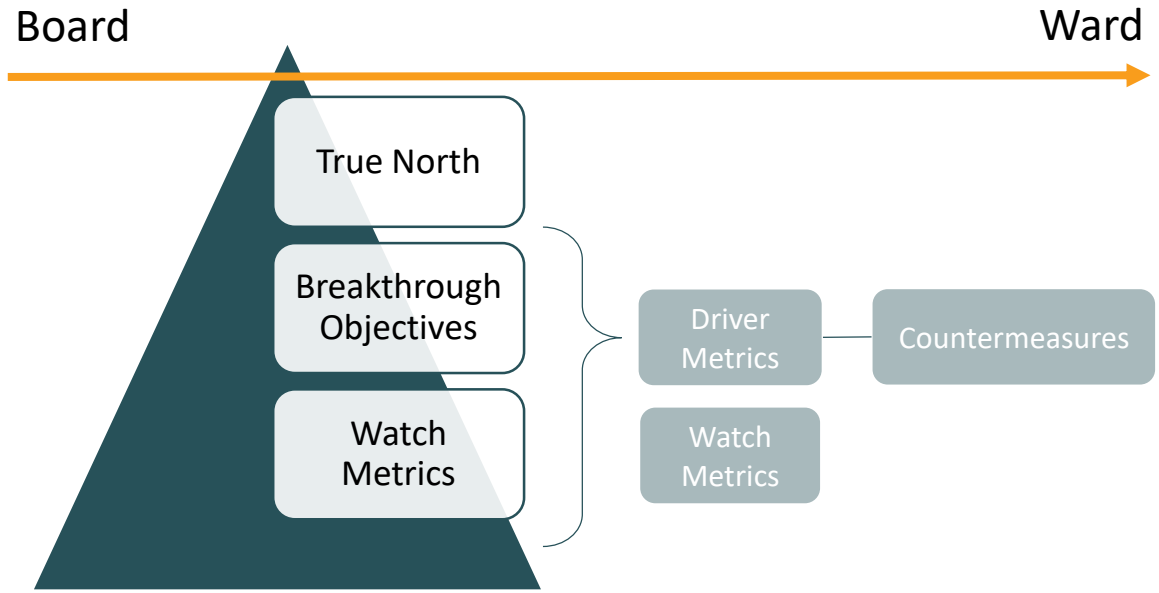
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
97.4	98.9	99.8	98.1	93.2	90.4	89.0	86.3				

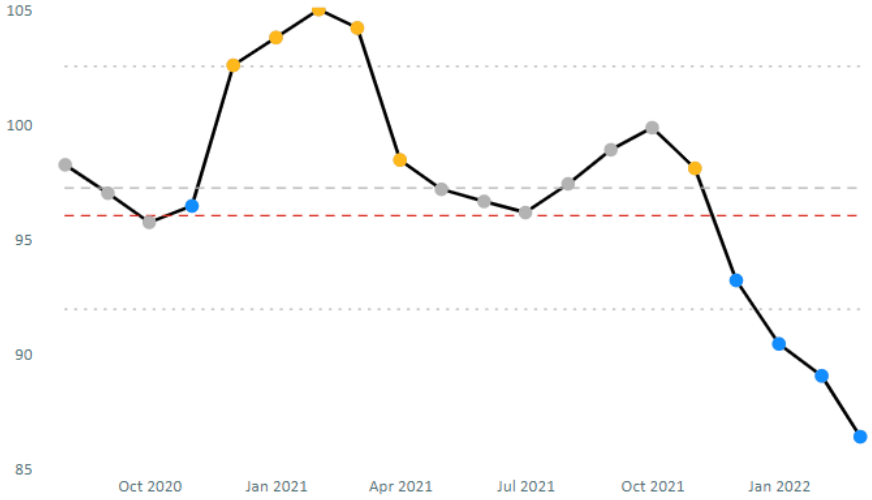
Variation indicates inconsistently passing and falling short of the target

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 and unchanged from last IPR.

The April 2022 data is not yet available as the Telstra Health platform does not receive M1 data but start the new year with M2 data. We anticipate receiving data to the end of May for next month providing there are no delays from NHSD.

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
- 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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
22	21	43	15	30	28	31	29	21	18	25	40

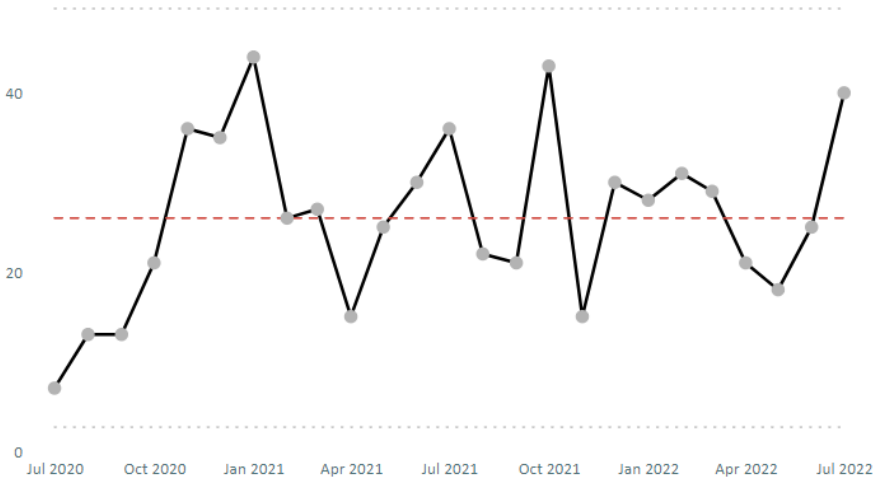
Variation indicates inconsistently passing and falling short of the target

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 40 incidents in July, which is above threshold and above June. The highest contributor to harm was falls with 10 harm incidents, an increase on previous months. The second highest contributor with 7 incidents is operation/procedures. For the last 4 months care/treatment and delay/failure have been the highest contributors. The third highest contributor in July is obstetric complications.

Intervention and Planned Impact

Safe staffing is a major factor contributing to patient harm, we are seeing a direct correlation between low staffing levels and harm and this was exacerbated in July. Our full capacity policy was initiated and we remained in OPEL 4 escalation for extended periods. Length of stay in our EDs increased and we reported significant 12 hour trolley breaches. More escalation areas were in use than previously utilised due to a significant high number of patients being cared for in corridors and other non-clinical areas. There was also an increase in C-19 related staff sickness so our demand for temporary staff increased, however 38% of our nursing (qualified and unqualified) shifts remained unfilled at the QEQM and 30% unfilled at the WHH. The inability to provide enhanced support and care to our patients was a contributory factor in all of the 10 harm incidents resulting in a fall. A deep dive identified that staffing levels resulted in delays and inconsistencies with risk assessments, inability to perform lying and standing blood pressure to determine postural drop and general visibility of patients. The speciality nursing teams continue to have an increased presence in both ED's and escalation areas to support clinically and educationally. The teams are working closely with the therapy teams to increase viability and promote intentional rounding to ensure patients are hydrated and have their toileting needs met in a timely manner. Safe staffing escalation processes remain in place, audit being undertaken to provide assurance that safer staffing policy being followed, refresher training taking place mid August. The Medical Director and corporate governance team are supporting with reviewing the learning from operation/procedures as 3 of the 7 harm incidents have been reviewed at care group M&M meetings. Focused improvement work is taking place in Maternity with oversight through MNAG and Board.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where enhanced care is required and could be managed with co-horting patients and increasing visibility in the bays, by re introducing bedside documentation which was discouraged in the recent pandemic. Ward leaders, Matrons and Therapy teams are on the floor supporting ward teams, increasing oversight that risk assessment and falls reduction 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.	Apr-22	May-22	Jun-22	Jul-22
Harm Events	W4		IPC: CDiff Infections		6	9	10	13	13
	W4		VTE Assessment Compliance		95.0%	91.5%	92.3%	92.0%	91.3%
			IP Spells with 3+ Ward Moves		Sigma	525	547	538	497
	W4		Serious Incidents Breached		0	102	114	103	99

IPC: C diff Infections

At this stage the trust is off target to achieve the external trajectory. This appears to be a situation that is being reflected regionally and nationally. Data for Kent and Medway are given below (Table 1). The reason for this wider phenomenon is not yet clear, in EKHUFT we will be convening an 'Antimicrobial Stewardship Summit' to address one of the known main drivers of Cdiff incidence.

VTE Assessment Compliance

VTE compliance remains below threshold and is driven by underperformance across half of specialties, with the remainder compliant.. The dashboard has now been updated to give a more accurate picture which the Clinical Directors are using to target change. The importance of VTE risk assessment was highlighted at Clinical induction for new cohorts of junior medical staff provided training and awareness and this will be followed up. The metric has been added to Care Group Performance meetings and Clinical Directors are due to report on progress ar upcoming performance reviews.

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.

Regional IPC position: Cdiff

To support commentary above (right) the regional position in relation to C difficile infections is shown in the table below.

Target/Trust	Apr to Jun 22	Total	Threshold 22/23	% of Threshold to date
D&G	12	12	21	57%
EKHUFT	32	32	82	39%
MTW	20	20	62	32%
Medway	13	13	34	38%

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
64.1%	63.3%	61.4%	61.8%	61.3%	59.6%	59.6%	60.1%	60.1%	61.1%	59.2%	59.5%

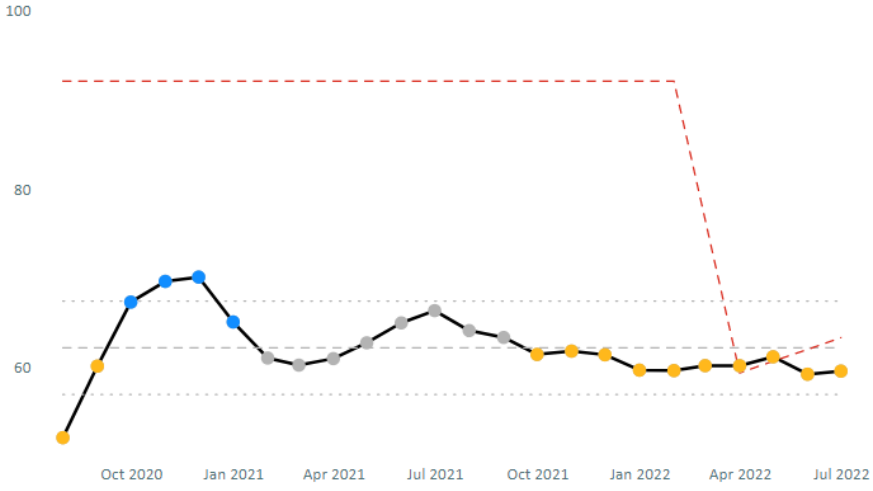
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

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 with complementary working groups now established for diagnostics, theatres and outpatients.
- Diagnostic improvement plan implemented which is yielding an improvement in key modalities (reducing backlog and improving DM01 performance).
- The Trust is organising a 'Super Surge Validation' which will focus on validation of the non-admitted pathway of patients waiting over 78 weeks.
- A focussed work stream of dating the Trust's longest waiting patients has resulted in the number of admitted patients dated over 78 week growing whilst the volume of patients awaiting treatment over 78 weeks is reducing.
- 104 weeks eliminated except where patients chose to wait or driven by a COVID delay. As at the start of August we have 13 patients over 104 weeks, plus a further 3 who will be over 104 weeks at treatment
- 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. A new theatre schedule commences early September aligning theatre capacity with the elective business planning.
- Year end activity forecast is under plan. Focused elective recovery plans in progress for Orthopaedics, Surgery, Urology, ENT, Ophthalmology and Cardiology – spanning non-admitted, diagnostic and admitted pathway – to bolster activity to address the deficit against plan.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
51	48	39	38	52	54	60	39	36	32	30	34

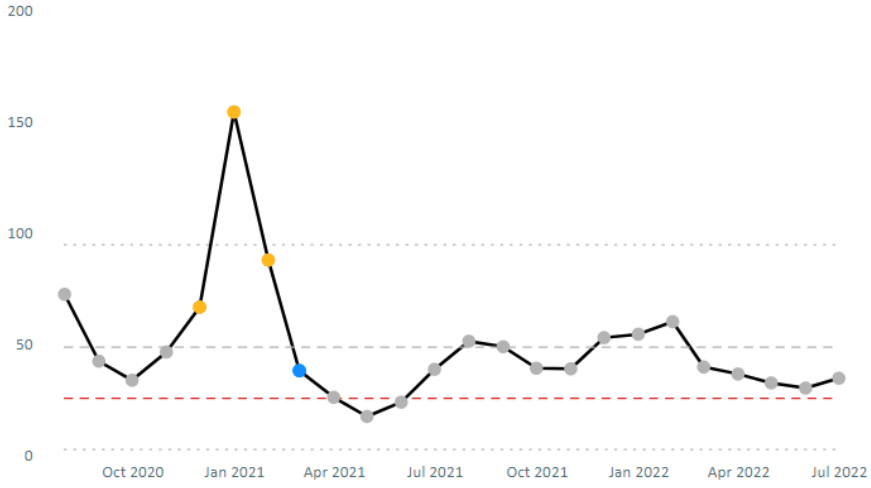
Variation indicates inconsistently passing and falling short of the target

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 34 sessions a week which has seen a marginal increase follow three consecutive months of improvement. Cancellations on day also increased in July from 147 in June to 164. Demand in month for emergency care put pressure on all aspects of the elective care pathway in July.

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. The current cases per session is at 2.3.
To facilitate this there are a number of measures that have been implemented, with further action required:

- We are optimising scheduling opportunities with the booking teams. This includes awareness of individual targets and discrepancies between planned and actual utilisation; July booking performance at 87.5%, with actual theatre occupancy at 78.5%.
- The 2022/23 elective activity plan is being translated into weekly sessions required, and has been used in the develop of the revised theatres timetable due to go live on 5th September. As such, theatre time will be proportionate to the activity required by each speciality.
- The theatre staffing business case will be finalised in September, recruitment at risk is underway.
- 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.
- A 'Super September' is being planned for the Elective Orthopaedic with High Volume, Low Complexity lists being planned for Hips and Shoulder aligning to GIRFT theatre session principles and maximising the number of patients treated per theatre session.
- For August there is a focussed piece of work across the Elective Orthopaedic Centre working with the teams to support increased utilisation and booking to mitigate against the impact of annual leave and on day cancellations

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
6.7%	6.0%	8.5%	9.8%	9.6%	9.5%	9.2%	10.5%	10.4%	8.7%	9.5%	11.2%

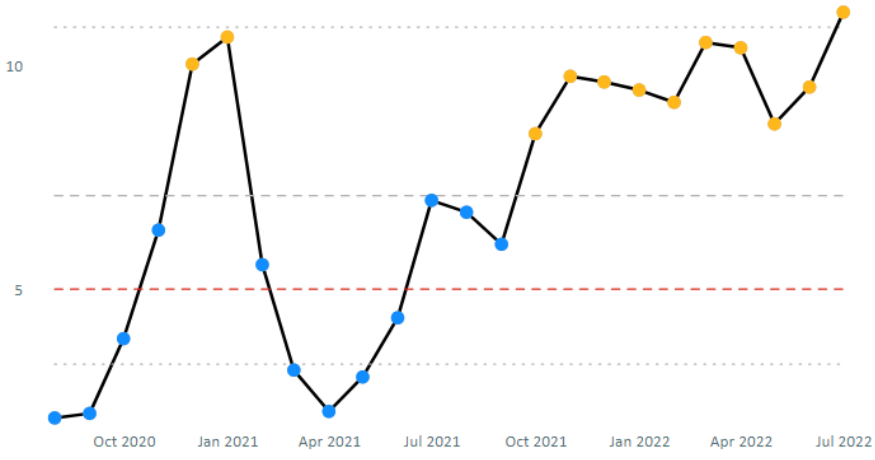
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group Astronomical Point

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.

July saw an increase to 11.2% 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. In July the Trust recorded the highest number of patients who remained in our care but no longer required an acute bed. With an increasing number of 'stranded' patients, it is greater challenge to find the appropriate bed for newly admitted patients result in an increased stay within our Emergency Department.

Intervention and Planned Impact

- The Trust continues to focus on maximising the utilisation of Same Day Emergency Care (SDEC) pathways ensuring patients that do no need to be admitted can access the specialist care they required on the day they attend the hospital. SDEC attendances increase from June to July.
- 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.
- Simple discharges for patients on Pathway 0 should not exceed beyond midday.

Risks/Mitigations.

- The number of super-stranded patients (those in our care for 21+ days) in July 2021 was 107 in June 2022 the number has increased to 221 in June and increased further to 247 in July. There is a direct correlation and impact between the number of super-stranded patients and ED performance for 12hr trolley waits metrics and flow.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
1,752	1,804	2,003	2,288	2,017	2,144	1,940	2,302	1,945	2,076	1,972	2,032

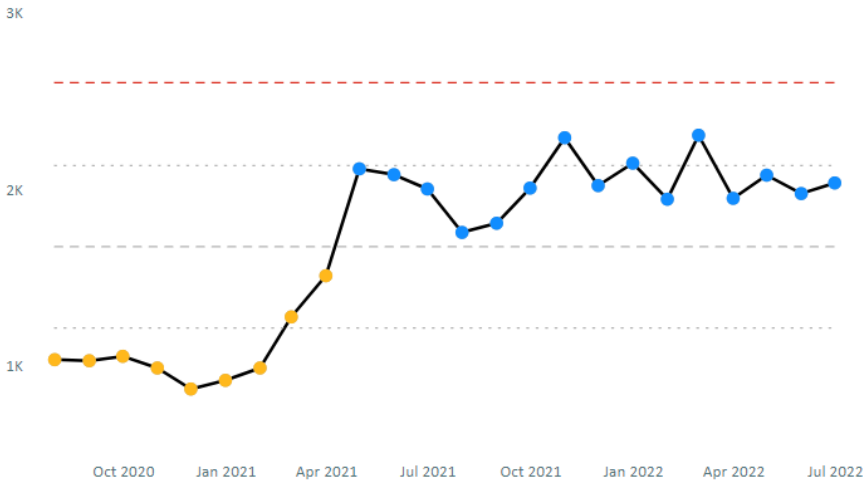
F — Variation indicates consistently falling short of the target

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 unit and Surgical Emergency admission. Both the Gynaecology assessment units (GAU) Children's assessment units have seen a decrease in July

Intervention and Planned Impact

- Following on from last months engagement piece in medical SDEC we have decided to hold Emergency village 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.
- The numbers of patients streamed to SDEC services is positive, clinical and operational colleagues will now work on reducing the time spent in ED prior to transfer.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
80.7%	78.8%	79.3%	84.3%	78.0%	75.6%	71.0%	74.5%	66.1%	61.7%	73.2%	76.1%

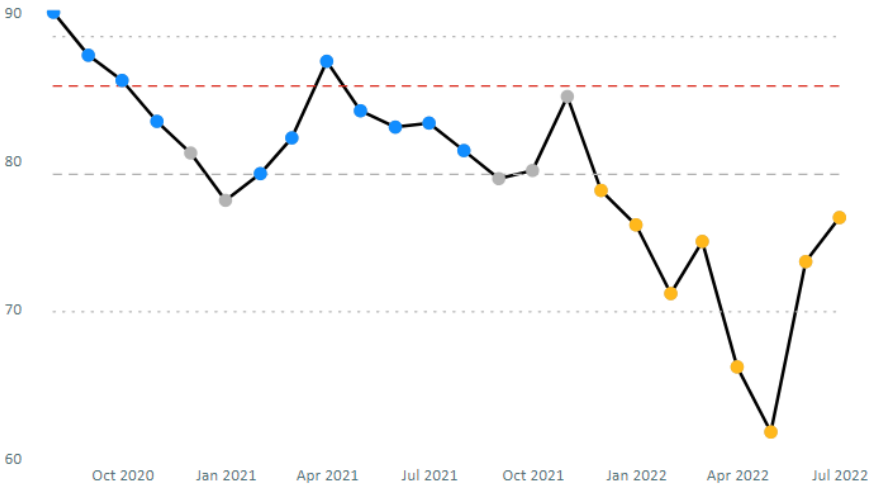
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

Performance has improved for two consecutive months 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.

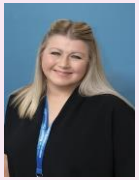
Intervention and Planned Impact

- 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.
- Improved patient communication:
- Shared learning across tumour groups for support with 28 days and implementation of template letters to update patients where a cancer has been excluded, aiming for timely patient communication and improving compliance.
- Engagement with care groups regarding backlog of 28 day letters for patients – Urology and Gastro making significant inroads in to the backlog.
- Further development of 2ww information of trust page to support patients and their relatives on suspected cancer pathway, to include useful numbers to aid communication and support
- Exploring options to provide walk in / drop in session for patients requiring urgent cancer pathway blood tests prior to recommended investigations. Cancer and CSS care group working in partnership to develop this potential service.

Risks/Mitigations

- Radiology reporting delays have increased. MDM radiology cover consistency continues to be a risk for August and September.
- Urology surgical capacity – securing mutual aid has not been possible and teams are booking patients but significant delays remain.
- The volume of patients on the PTL who will need to access lower GI pathways and diagnostics is high.

Our patients



Sarah Shingler

Patient Experience: Inpatient Survey

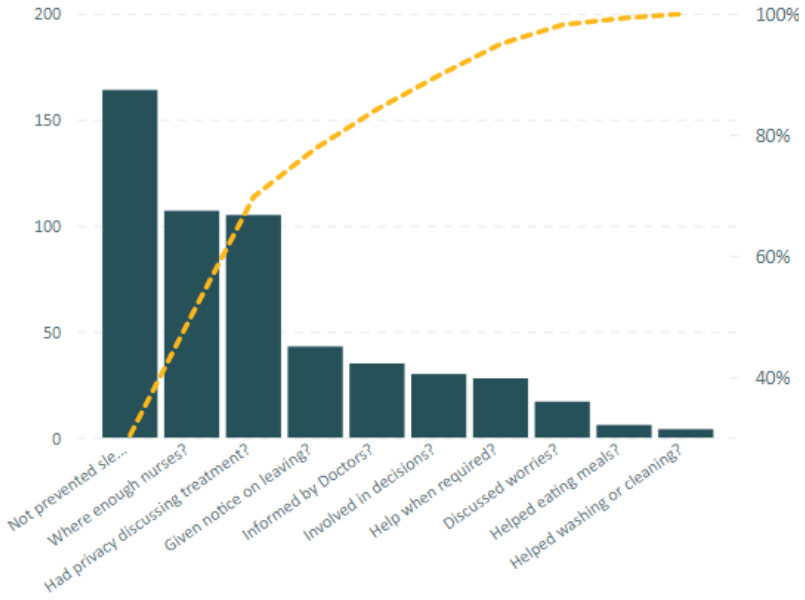
The National In Patient Survey published in October 21 (surveyed patients discharged in November 2020), completed responses for the trust were received from 515 patients (1250 invited) with a response rate of 43%. The survey consists of 45 questions and the trust scored below the national trust average on all questions, and in 23 out of the 45 responses the trust scored in the bottom five trusts in the region, and in the bottom five Nationally.

The Trust has chosen ten questions from the National In-Patient survey, and our average for our focused 10 questions is 7.13 compared to 7.65 as a national average.

41 adult in-patient wards will complete 50 surveys per month (2,050) using the tendable app using the 10 questions.

Our ambition is to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023.

Question # stratified by Question - Jul 22



Stratified By	Num	Den	Value	Thresh.	Pareto Value	Pareto
Not prevented sleeping by noise?	362	526	6.9	7.7	164	30.4%
Where enough nurses?	446	553	8.1	7.7	107	50.3%
Had privacy discussing treatment?	424	529	8.0	7.7	105	69.8%
Given notice on leaving?	283	326	8.7	7.7	43	77.7%
Informed by Doctors?	510	545	9.4	7.7	35	84.2%
Involved in decisions?	479	509	9.4	7.7	30	89.8%
Help when required?	516	544	9.5	7.7	28	95.0%
Discussed worries?	506	523	9.7	7.7	17	98.1%
Helped eating meals?	278	284	9.8	7.7	6	99.3%
Helped washing or cleaning?	403	407	9.9	7.7	4	100.0%

What the chart tells us

There were 562 Inpatient Experience surveys completed in July via Tendable (30 wards completed). The positive responses to 9 of the 10 questions asked were above target threshold of 7.7, with the exception of 31% of patients reporting that they had difficulty sleeping at night due to noise from other patients. For this specific question, the 'No' response is a positive, therefore the 69% (6.9) score is reflecting those patients that had a positive experience.

Intervention and Planned Impact

CNMO has set trajectory over the next 3 months for all wards to be completing 50 surveys per month to achieve the 2050 surveys per month: August: 750, September 1200, October 2050. HONs and DONs will be held to account at the Nursing, Midwifery & AHP board on a monthly basis by the CNMO to ensure that responsibility is taken for supporting the wards to complete their surveys and develop action plans to address poor responses. The data is also presented and reviewed at the monthly Fundamentals of Care Committee, measures are being explored to counteract the noise disturbances at night with the frontline teams. The guidelines for ward night duty are in the process of being reviewed, this will provide support to our newly qualified nurses and IENs.

The Head of Patient Voice and Involvement commenced in post on 15 August and will work closely with the Associate Director of Nursing for Quality and FOC. A key role of the patient volunteers and champions will be to support the wards in the completion of the surveys and also support in the development of the action plans.

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.	Apr-22	May-22	Jun-22	Jul-22
Cancer 62d			Cancer 2ww Performance		93.0%	95.1%	97.3%	97.0%	95.0%
	W4		Cancer 28d Performance		75.0%	62.9%	66.5%	66.0%	66.5%
	W4		Radiology Diags vs Plan		Traj.	16.0K	18.0K	17.5K	17.6K
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	682	642	527	480
	W4		DM01 Compliance		75.0%	64.4%	67.6%	69.6%	70.1%
	W4		RTT OP Booking Breaches		14,000	21.8K	22.8K	24.1K	24.3K
ED Compliance	W4		ED Compliance		90.0%	69.8%	69.4%	69.4%	68.1%
	W4		Clinician First Seen within 1h		50.0%	42.4%	39.2%	41.7%	42.9%
	W4		A&E Atts vs Plan		Traj.	22.4K	24.8K	23.9K	23.9K
	W4		Unplanned Re-attendance ED		10.0%	14.5%	13.7%	14.6%	14.7%
	W4		Super Stranded >21D		107	211	221	221	247
	W4		Discharges by Midday		15.0%	13.6%	13.6%	14.3%	13.9%
	W4		NEL Admissions vs Plan		Traj.	7,391	7,789	7,402	7,146

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 June as this is the latest national data available

Target/Trust	EKHUFT	MTW	Medway	Dartford
A&E 4 Hour	68.1%	84.0%	67.7%	73.5%
Cancer 62d	*73.2%	*85.3%	*84.7%	*62.3%
DM01	70.1%	94.9%	68.5%	88.7%
RTT 18w	59.5%	70.4%	61.7%	66.9%

RTT 18 Weeks

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 have recommenced discussions on the Strategic Initiative for outpatients with our System Partners to review long term patterns of referral and health need and health inequalities.

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 underway to improve the position.

ED Compliance

In July 2022 the 4h performance was 68.1%, with the number of 'super stranded' patients with a length of stay >21d at 247. In comparison in July 21, 4h performance was 73.8% with the number of patients with a length of stay >21d at 107.

Unplanned reattendance

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.

7% are patients returning for dressing changes and pain control which can and should be completed in primary or community care.

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 the 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 remains fairly static despite growth in other pathways. 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.	Apr-22	May-22	Jun-22	Jul-22
FFT	W4		FFT Maternity Response Rate		18.0%	13.5%	14.9%	14.7%	13.7%
	W4		Complaint Response		90.0%	7.1%	7.3%	0.0%	9.2%
	W4		Duty of Candour - Verbal		100.0%	41.7%	63.6%	60.9%	40.6%
	W4		Duty of Candour - Written 15wd		100.0%	48.4%	50.0%	54.5%	43.8%

Complaint Response

A validation of the fields for complaints reporting and recording has occurred, and the data is robust. Care groups have been focusing on addressing the backlog of complaints which has resulted in new breaches occurring. The backlog will be resolved by end of August 2022, and with the rollout of the new complaints process now complete, it is expected that the threshold will be reached from September. The Trust has recruited additional resources to assist complaints responses over the next 3 months.

Duty of Candour

There have been issues with the definition of data and validation of data entries, which has now been rectified. Datix remains the only source for recording Duty of Candour (DoC) compliance for reporting. Increased awareness of requirements for DoC has commenced, and this should result in increased numbers. The main reason for non-compliance is failure to record on Datix and failure to meet the 15 working day window for written responses. A recruitment process is underway to provide support for ensuring correspondence is sent to patients and families.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
6.28	6.28	6.41	6.41	6.41	6.35	6.35	6.35	6.26	6.26	6.26	6.33

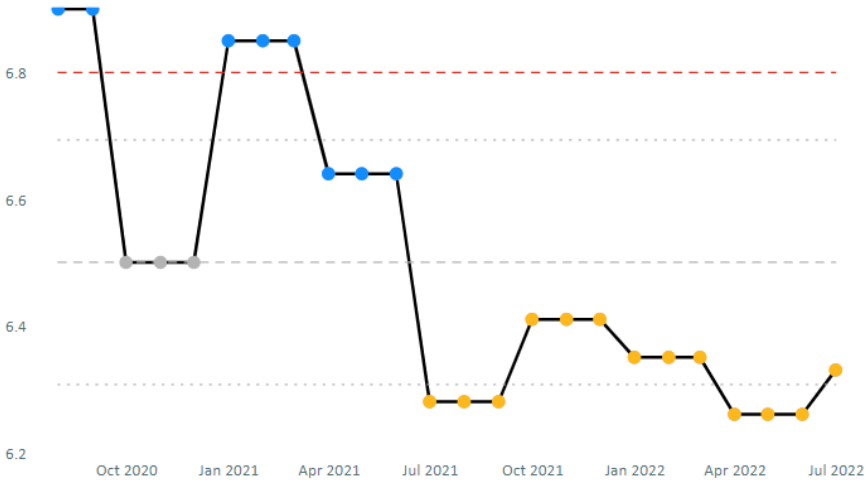
F — Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The data from the latest National Quarterly Pulse Survey which took place throughout July shows a 7-point improvement in Staff Engagement (from 6.26 to 6.33). The survey demonstrates improvements in 7 of the 9 questions relating to engagement. The 15-point improvement in involvement in particular is quite pronounced. The 2 questions which deteriorated were advocacy-related; regarding care being our top priority (down 1.5%) and recommending as a place for treatment (down 0.6%).

Interventions and Planned Impact

Each Care Group has socialised their NSS & NQPS results (from Q1). Discussions around this data and information has enabled greater understanding of challenges and areas of good practice. These have been captured through action plans which are reported to PCC. Crucially, the NQPS gives the first insight into these action plans beginning to demonstrate an impact as their focus has been on involvement – the area we have seen the most pronounced improvements quarter on quarter.

These actions will continue and will evolve according to the latest NQPS results from Q2. Plans are also underway for the National Staff Survey which will launch in September. This acts as the primary barometer of staff engagement and a Comm's plan is being finalised to encourage a majority response rate which gives an accurate picture of the staff experience.

Work is taking place to visualise the staff engagement data, which we now have at a more granular level in an SPC-style dashboard. There is also analysis taking place of staff engagement by We Care wave which will be reported to Board in October.

Risks/Mitigations

Nationally, levels of staff engagement are deteriorating and have been for the last 9 months. This is largely due to reductions in staff involvement and advocacy.

The True North for Staff Engagement is supported by a BTO for staff involvement, and it is positive to see that East Kent is defying this trend against staff involvement.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
6.10	6.10	6.35	6.35	6.35	6.20	6.20	6.20	6.13	6.13	6.13	6.28

F

Variation indicates consistently falling short of the target

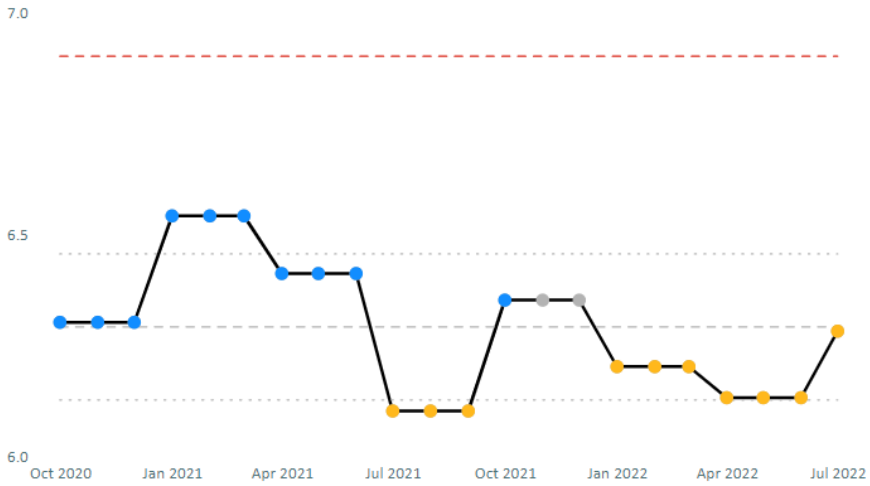
L

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

Flag Description

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

XMR Run Chart



What the chart tells us

The National Quarterly Pulse Survey in July demonstrated a 15-point improvement in Staff Involvement, from 6.13 to 6.28. The most pronounced improvements in engagement overall were seen in involvement, with each of the three related questions improving significantly as follows:

- Opportunities to show initiative frequently in my role ↑1.7% to **62.2%** (from 60.5%)
- Able to make suggestions to improve the work of my team/dept ↑2.2% to **64.4%** (from 62.2%)
- Able to make improvements happen in my area of work ↑4.1% to **51.4%** (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.	Apr-22	May-22	Jun-22	Jul-22
Staff Engagement	W4		Appraisals Compliance		80.0%	77.4%	72.3%	66.4%	67.4%
			Staff Turnover Rate		11.5%	10.8%	10.9%	10.8%	10.8%
	W4		Vacancy Rate		10.0%	13.3%	12.6%	12.4%	12.7%
			Staff Turnover: HCA		13.5%	13.1%	13.2%	13.7%	14.4%
			Premature Turnover Rate		25.0%	22.9%	23.6%	23.9%	23.1%
	W4		Medical Job Planning Rate		90.0%	35.8%	37.1%	40.5%	32.9%

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 is 80%, and the current in month compliance is **67.4%**. This is an increase on the previous month, although will need monitoring as many appraisals become due during the Autumn. A particular focus will be on ensuring that Admin & Clerical appraisals have been completed. 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

The calculation for Staff Turnover has been adapted, following consultation across the region, to ensure East Kent are measuring in a comparable manner to its counterparts. In order to measure true voluntary turnover, it was agreed to remove retirement and redundancy and focus on areas we can materially affect. The result is a reduction in turnover rate by ~2%, although it should be made very clear this is not related to an improvement. To enable greater transparency and to allow interrogation of the data, this change has been backdated.

Total turnover, when measured as a rolling 12-month average, now stands at **10.76%.** In-month it stands at 10.69%. The trend over the last 5 months has been an improving one but this is an uptick (from 9.55%) due to slightly elevated Nurse and HCA turnover.

Vacancy Rate

The overall vacancy rate has increased from 12.4% to 12.7% in July, reversing the downward trend over the previous 3 months. This is due to our budgeted establishment growing by 106wte over the previous month but actual staff in post growing by the lower figure of 67wte, thus increasing the number of wte vacancies. Nursing vacancies have reduced slightly to 19.7% reflecting the steady progress of the safer staffing recruitment pipeline.

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 for breakeven which improves from the figures quoted last month because of £6m additional inflation funding and £16m non-recurrent ICS funding.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
0.042	0.021	-1.494	-0.996	-0.941	-0.090	1.307	0.076	-3.700	-6.624	-6.604	-7.795

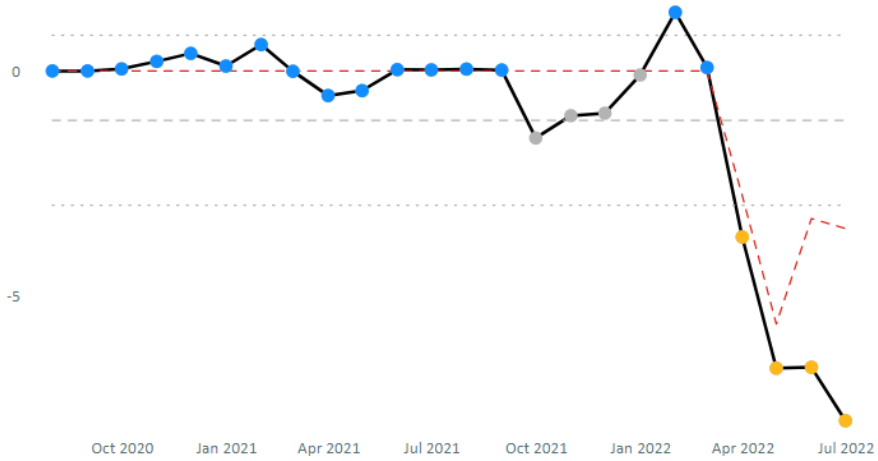
Variation indicates consistently passing the target

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 July which is a £7.8m deficit against a plan of £3.5m deficit. The key drivers behind the shortfall year to date are; £1.4m CIP behind plan, £0.5m Covid-19 overspend and the remainder driven by 60 escalation beds opened across the Trust. The figures exclude our shortfall on ERF activity currently £3.5m.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
7,351	7,092	6,783	7,255	6,441	7,168	7,403	9,148	7,890	7,497	8,894	8,702

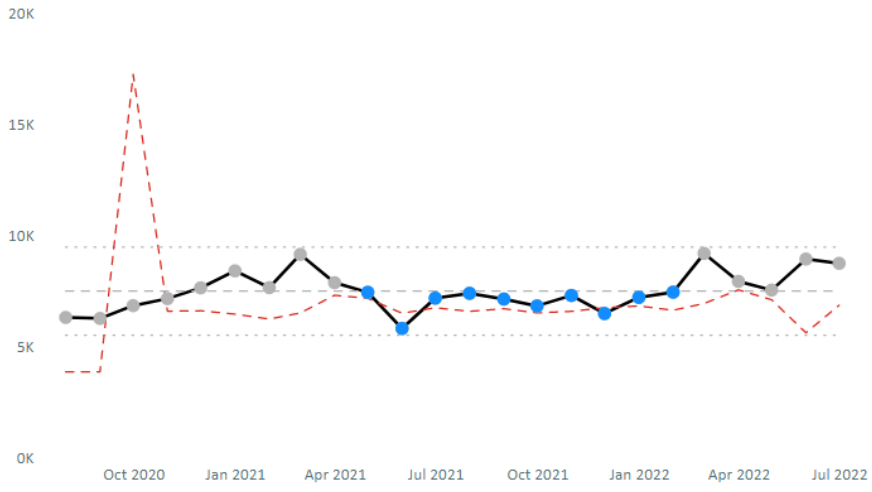
Variation indicates inconsistently passing and falling short of the target

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 July 2022 premium pay spend has decreased by £0.19m.

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 remainder of spend is caused by sickness and operational demand. The former should reduce but work is required to control and reduce the latter.
- 60 escalation beds opened increasing need for temporary staff

Our sustainability

Liz Shutler

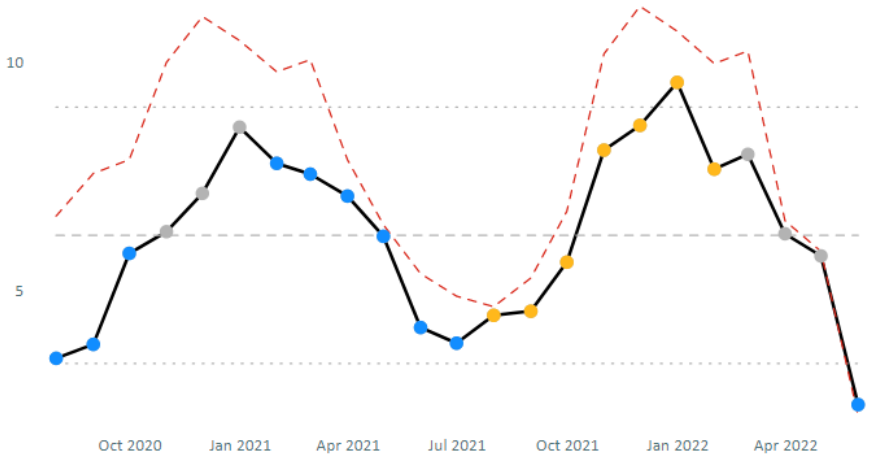
Carbon Footprint (CO2e)

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
4.44	4.53	5.61	8.06	8.60	9.55	7.65	7.97	6.23	5.74	2.49	

F	L	Flag Description
Variation indicates consistently falling short of the target	Special cause of improving nature or lower pressure due to lower values	Astronomical Point

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.
However, the position is reporting above the monthly trajectory of 2.24 at 2.49 kgC02e per m2 but is below the same period last year (reporting at 4.18). This is the first time the metric has reported above trajectory in 2022. The annual 10% reduction is a fixed value and the reduction is phased across the year and is based on seasonal phasing and on historic assumptions. While this allows greater tolerance in the winter months, it also increases the potential for missing the trajectory in month, because seasonal predictions can be difficult. We are, however, currently reporting that we will be within the annual 10% reduction for the end of the year.

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.

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.	Apr-22	May-22	Jun-22	Jul-22
Financial Position	W4		Total Pay		0.0%	-2.4%	-2.3%	-3.1%	-3.6%
	W4		Efficiencies YTD Variance (£M)		0.0	-0.5	-1.0	-1.0	-1.4
	W4		Efficiencies Green Schemes		90.0%	6.9%	13.2%	22.8%	32.8%
	W4		I&E Monthly Variance Trust (£)		0	-929.6K	-212.7K	-2.5M	-315.6K
	W4		I&E YTD Variance (£)		0	-929.6K	-1.1M	-3.7M	-4.0M

Total Pay

This metric is mainly driven by an excepted reduction in premium pay not being achieved. Premium pay reductions are still a focus of care groups as a break through or driver metric.

Efficiencies YTD Variance/ Efficiencies Green Schemes

The Trust has been slower than expected in developing its CIP programme due to operational pressures in Q4 of 21/22. The total CIP plan for the year is £30m for which £26m is identified. The executive team are monitoring progress through PRMs and CEMG. In addition the CFO is meeting with care groups on a fortnightly basis. The CFO has commissioned the FID to review all schemes and ensure turn green as soon as possible or identify replacements.

I&E Monthly Variance Trust/ I&E YTD Variance

The YTD position is driven by a £1.4m shortfall on CIP, £0.5m overspend on Covid and the remainder relating to 60 additional escalation beds across the Trust. The key actions are to give greater focus to the premium pay breakthrough objective and to bridge the CIP gap.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
299.6	303.0	299.5	332.0	346.2	314.3	320.4	336.2	351.1	352.9	354.9	402.6

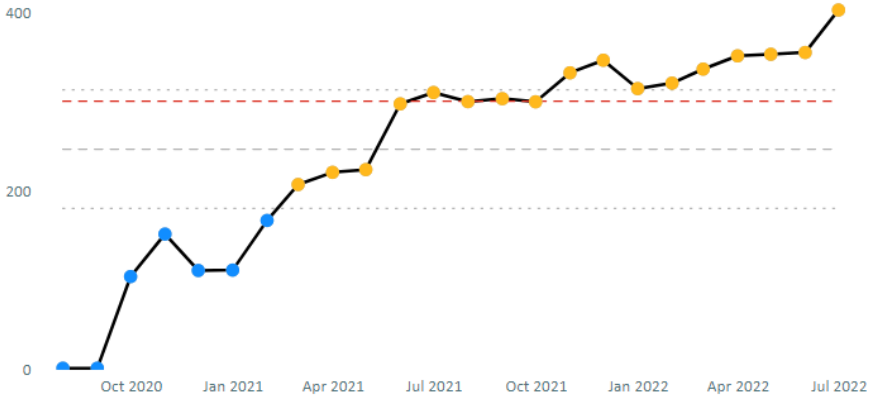
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

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. 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 and to the Kent and Medway Oversight Meeting. 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. The success of these board rounds is reflected in the Trust actively reducing the number of PW0 patients in July, whilst PW1, 2 and 3 continued to increase.
- 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.
- We need to start a piece of work to review the therapy prescription for inpatients and the interface with community therapy services.

Risks/Mitigations

- 25% of the Trust bed base is occupied by patients who no longer need our care. >60% of patients admitted via ED have a total time in ED of over 12 hours. The % of no longer fit to reside patients occupying the trust bed base is directly affecting our ability to admit patients on a timely way.

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.

Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
176	161	208	303	198	116	91	246	129	162	430	80

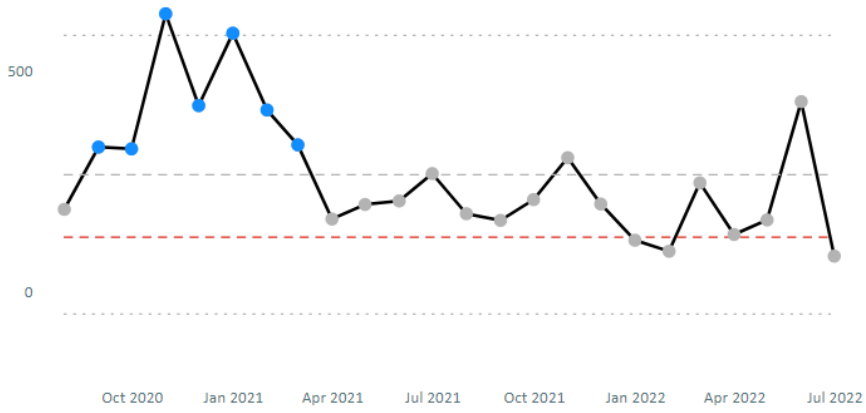
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

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 July position of 80 participants is below the threshold of 123 (negative). This is partly as a result of the large scale "opt out" maternity study finishing recruitment, as well as a high level of staff annual leave and sickness. The August position is also expected to be below the threshold.

Despite the low July position, the Year to Date position March –July of 801 is above the YTD trajectory of 492.

Intervention and Planned Impact

- The Clinical Trials Unit at QEQM opened in June and studies are now running through the CTU. Studies will be commencing shortly in the bedded area, with surgical, anaesthetics and radiology studies in the pipeline.
- 20 additional studies are already in the set-up phase or are due to start set-up imminently.
- 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

NHS
East Kent Hospitals University
NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Apr-22	May-22	Jun-22	Jul-22
Harm Events	W		Falls		Sigma	156	171	134	143
	W		IPC: EColi Infections		10	12	10	5	9
	W		IPC: Klebsiella Infections		6	0	5	3	8
	W		IPC: Pseudomonas Infections		3	1	2	2	1
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	203	225	243	227
	W		Medication Errors; Severity C+		1	0	1	1	2
	W		Nutrition Incidents		Sigma	51	61	73	47
	W		Pressure Ulcers: Cat 2		Sigma	22	32	27	40
	W		Pressure Ulcers: Cat 3 & 4		Sigma	1	1	1	2
	W		Pressure Ulcers: DTI		Sigma	6	8	3	8
	W		Pressure Ulcers: Unstageable		Sigma	12	6	1	8
	W		IPC: Audits Composite		85.0%	85.6%	86.2%	85.3%	86.5%
	W		Safeguarding Incidents		Sigma	15	19	14	19
	W		Clinical Incidents		Sigma	1,821	2,178	2,194	2,218
	W		Serious Incidents		Sigma	14	19	17	26
	W		Never Events		0	1	0	2	0
	W		Maternity Serious Incidents		2	4	2	5	6
Mortality	W		Extended Perinatal Mortality		6.32	4.94	4.30	4.41	4.10

True North Domain	BR	Flag	KPI	SPC	Thres.	Apr-22	May-22	Jun-22	Jul-22
Staff Engagement	W		Sickness		5.0%	6.0%	4.7%	5.2%	
	W		Statutory Training		91.0%	91.3%	92.8%	92.4%	91.9%
	W		Safeguarding Children Training		90.0%	92.1%	91.5%	90.0%	89.5%
	W		Safeguarding Adults Training		90.0%	91.4%	90.8%	90.3%	89.0%
	W		Staff Turnover: Nursing		10.0%	9.4%	9.5%	9.4%	9.4%
Financial Position	W		Non Pay		0.0%	2.8%	2.6%	1.0%	1.8%
	W		Efficiencies FOT Variance (£M)		0.0	0.0	0.0	-4.7	-2.3
	W		I&E FOT Variance (£)		0	0	0	0	0

True North Domain	BR	Flag	KPI	SPC	Thres.	Apr-22	May-22	Jun-22	Jul-22
Cancer 62d	W		Cancer 31d Performance		96.0%	98.3%	98.5%	98.7%	98.6%
	W		Endoscopy vs Plan		Traj.	1,204	1,559	1,348	1,394
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,361	1,469	1,681	1,661
	W		RTT 52w Breaches		Traj.	3,426	3,560	3,605	3,419
	W		OPA vs Plan		Traj.	66.4K	78.9K	73.4K	67.7K
	W		Elective Admissions vs Plan		Traj.	8,048	9,319	8,591	8,332
ED Compliance	W		Pathway 0 Patients >7 Days		Sigma	132	142	158	139
	W		NEL Readmissions		15.0%	11.0%	10.3%	10.3%	9.8%
	W		Stroke Ward within 4 Hours		50.0%	53.3%	56.0%	46.8%	54.7%
FFT	W		FFT IP Response Rate		15.0%	18.9%	19.8%	16.7%	19.2%
	W		FFT DC Response Rate		27.0%	30.8%	30.3%	28.1%	30.3%
	W		FFT ED Response Rate		12.0%	15.8%	15.2%	12.7%	14.4%
	W		FFT OP Response Rate		17.0%	20.4%	19.8%	18.8%	20.0%
	W		Complaints Number		Sigma	52	65	69	85
	W		Mixed Sex Breaches		Sigma	39	54	37	69
	W		Duty of Candour - Findings		100.0%	20.0%	12.5%	100%	20.0%

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	Date to be confirmed	• ESR/e-job plan reconciliation completed (report to be shared with medical workforce deployment group) • Care groups with greatest difference in e-job plan compared with ESR contacted to review job plans • Draft employee-based awards policy written (which incentivises compliance with job planning obligations) • Job planning data added to the Trust score cards	• Standardisation of medical change forms and governance process • Attending the NHSEI Levels of attainment conference • Job planning to be included for the next cohort of Kent Clinician Development Programme • Next round of job planning workshops to be constructed based on previous workshop feedback • Care groups to provide job planning compliance trajectory at the Medical workforce deployment group
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	• Meeting pending with SRO and Leads to review the future direction 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	• Recruitment process for Clinical Guidelines Manager continues • Meetings with Care group Clinical Directors continue	• Clinical Guidance Manager starts in post 22nd August • The Clinical Guidelines Policy is undergoing further revision before being presented at CEMG in August • Confirmation of meetings with Women's Health, paediatrics and three site medical directors when they are in post
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 due to changes in leadership

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
Fractured Neck of Femur	TBC	To agree, develop and implement a Trust wide Fractured Neck of Femur pathway that will address and improve the eight Key Performance Indicators on the National Hip Fracture database	TBC	• Improved the access to power tools at QE • Resolved access to the Image intensifier at WHH • Appointed a Hip fracture practitioner at QE • Met with Patient Safety Officer regarding the challenges of mobilising patients at the weekend • Confirmed clinical lead at QE	• Meet with lead of therapies to improve mobilisation at weekends • Meet with Head of Nursing to improve patients being admitted to correct ward • Confirm clinical lead at WHH
Maternity Ultrasound Booking	TBC	Provide a booking service for Ultrasonography that is linked to the patients pathway Improve the link between appointments team and clinicians Ensure PACs connects to the maternity systems Develop a robust workforce with clear roles and responsibilities to ensure a sustainable service Ensure capacity is available to meet the demand of the service	TBC	• Daily frontline discussions to review emerging issues and agree priorities for the day. • Monthly Operational meetings in place to identify any issues and working as a multidisciplinary team to resolve them • Review Booking processes and identify opportunities to improve efficiency	• Maternity & Radiology to continue to work collaboratively to improve Booking processes. • Identify opportunities to minimise lost or cancelled slots. • Agree next steps and actions

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.