East Kent Hospitals University NHS Foundation Trust

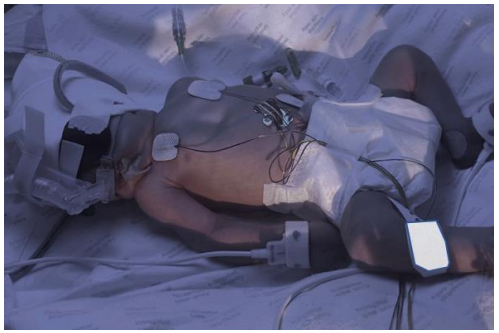
Integrated Performance Report

September 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.

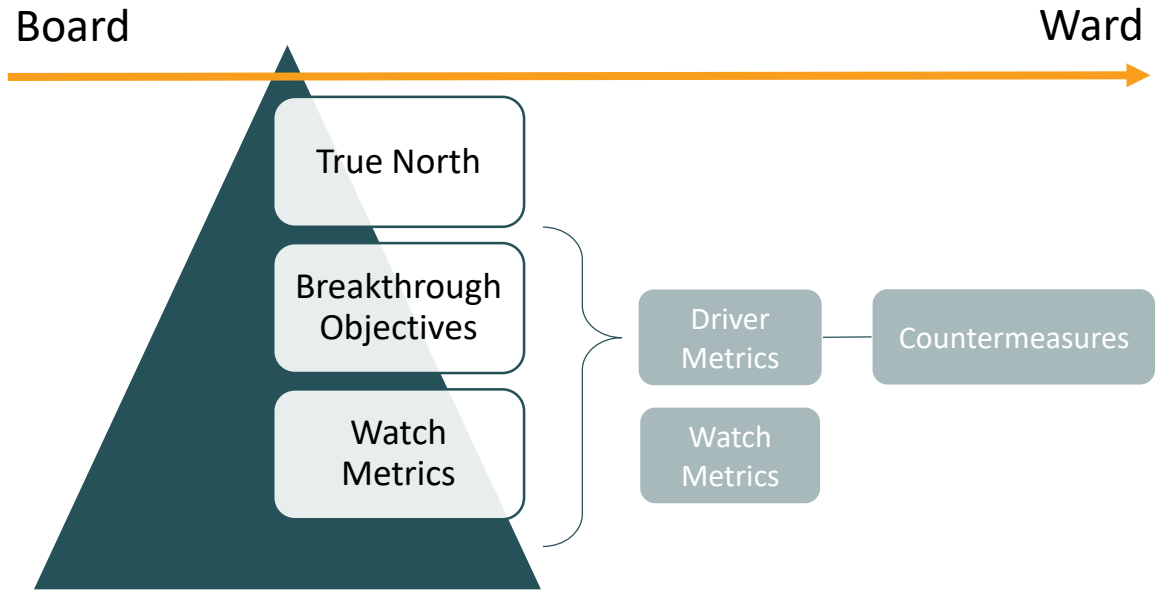
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
99.1	97.4	92.6	89.9	89.0	88.0	89.2	90.1	90.9			

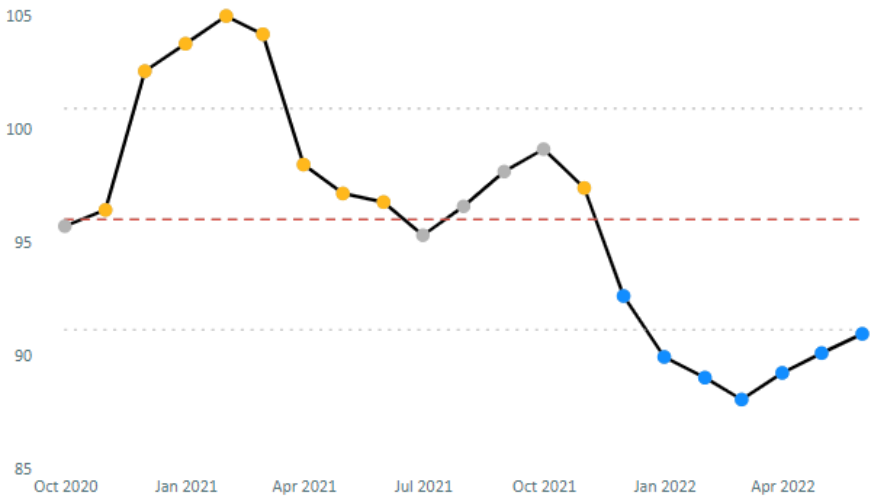
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The Trust HSMR remains below the lower control limit showing 'special cause variation of improving nature'. The metric demonstrates a 12 month rolling position to June 2022 which is the last data release. At time of reporting this remains 'lower then expected.'

From last month the Trust has maintained its position now lying 17th out of the 121 acute non-specialist Trusts on the Telstra Health platform.

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 90.6 (to June 2022) and is now 'as expected'.
- Mortality metrics continue to be reported and discussed at monthly Mortality Surveillance Group and intelligence used to drive deep dives into pathways where indicated.
- There were new alerts for residual codes (symptoms and signs) and biliary tract disease that are subject to further investigation.

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
43	15	29	26	29	25	21	13	23	32	25	33

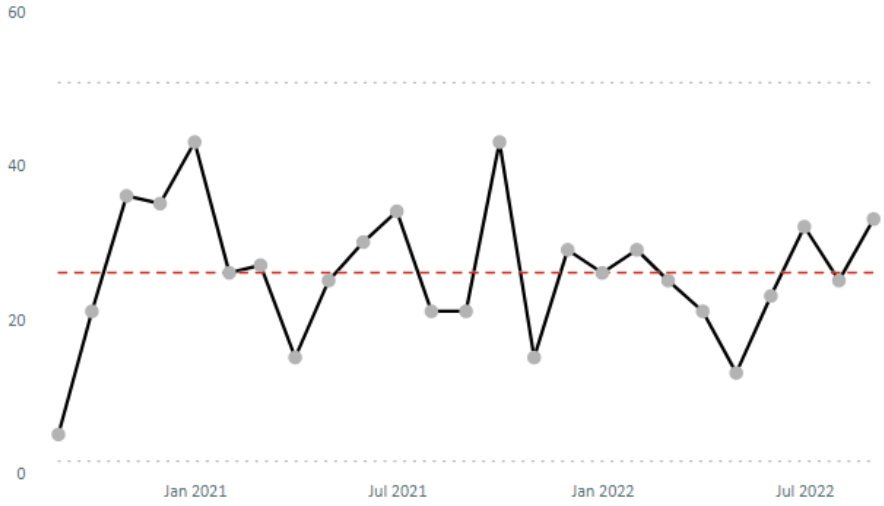
Variation indicates inconsistently passing and falling short of the target

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 33 incidents in September, which is above threshold. The highest contributors to harm were care/treatment with 9 harm incidents, which is an increase from the previous month, delay/failure was the second highest with 7 incidents. The third highest contributor was falls with 5 harm incidents but is a reduction on the past two months when falls was our highest contributor of harm. For the last 6 months care/treatment and delay/failure have both featured in the top three the highest contributors.

Intervention and Planned Impact

The Deputy CMO and corporate governance team are supporting with reviewing care/treatment and delay/failure incidents. Similar themes continue with delayed diagnosis for patients on the cancer pathway and delays in initiating the correct urgent referral and treatment pathway in ophthalmology patients. Focused improvement work is taking place in Maternity with oversight through MNAG.

Safe staffing continues to be a factor contributing to patient harm, we are seeing a direct correlation between low staffing levels and harm and this continued throughout September. Our full capacity policy has continued to be initiated and we remained in OPEL 3/4 escalation for extended periods. Length of stay in our EDs continued to increase and we reported significant 12 hour trolley breaches. Escalation areas continued to be utilised due to high numbers of patients being cared for in corridors and other non-clinical areas. A review at the falls steering group identified themes in the 5 harm incidents resulting in a fall. It was identified that reduced staffing levels resulted in delays and inconsistencies with risk assessments especially in relation to the use of bed rails, inability to perform lying and standing blood pressure and general visibility of patients which resulted in an increase in unwitnessed falls. The amount of repeat fallers increased in September to 13 from 6 in August but still remains lower than the monthly average. It was also identified that there were themes with the inappropriate use of sedatives in the elderly and this has resulted in reviews with pharmacy, clinicians and safeguarding. The speciality falls team continue to have an increased presence in both EDs, escalation areas and high contributing wards to support clinically and educationally. It must be noted that falls have reduced at the QEQM where there is consistent presence from the acute falls team, but increased at the WHH and KCH sites where there is a reduced acute falls service. Safe staffing escalation processes remain in place, audits are being undertaken to provide assurance that safer staffing policy being followed, refresher training has been taking place in led by the Associate Director of Nursing for Workforce.

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. 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. .

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.	Jun-22	Jul-22	Aug-22	Sep-22
Harm Events	W4		IPC: CDiff Infections		6	13	13	9	10
	W4		VTE Assessment Compliance		95.0%	92.6%	92.3%	92.4%	94.0%
	W4		Serious Incidents Breached		0	103	99	52	21

Regional IPC position: Cdiff

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

Kent and Medway Integrated Care System

CDI -Monthly count per 100,000 occupied bed days of all Hospital onset cases by acute trust per month

Count per 100,000 bed days cases per acute trust per month	Trajectory	April 22	May 22	June 22	July 22	Total
Dartford & Gravesham NHS Trust	N/A	29.45	28.50	11.78	33.83	25.65
East Kent Hospitals University NHS Trust	N/A	8.59	16.63	25.78	29.24	19.51
Maidstone & Tunbridge Wells NHS Trust	N/A	22.12	17.13	26.55	35.22	24.88
Medway NHS Foundation Trust	N/A	24.86	24.06	24.86	22.37	24.11
Kent total	N/A	18.77	20.30	23.19	30.29	22.81
England total	N/A	19.31	16.23	18.40	23.84	19.24

IPC: C diff Infections

The Trust remains above trajectory to achieve the external threshold for 2022/23. This position continues to reflect a local, regional and national change that is, as yet, unexplained. Locally we are working with the ICB to investigate risk factors for 'community onset, healthcare associated (COHA) cases, as East Kent is above the national rate for these cases. Data from Kent and Medway for Q1 show EKHUFT as having the lowest rate of Cdiff, regionally and close to the England average (figure).

VTE Assessment Compliance

While VTE compliance remains below threshold and is driven by under performance across three out of the six Care groups impacting on this metric, the impact of recent improvement work can be seen. This continues to be monitored through performance meetings and the Care Groups have improvement plans in place that continue.

Serious Incidents Breached

Declared Serious Incidents (SIs) must be investigated and closed within 60 days, to ensure timely understanding of issues, address gaps and provide learning to avoid repeated incidents. The work to reduce the backlog continued throughout September with all care groups except Women's Health achieving submission of outstanding reports. The focus remains on addressing the remaining backlog, although this has been prolonged due to the complexity of the reports and reduced access to clinical specialists to support the writing. The Trust is also now preparing for the transition to the new incident management framework, Patient Safety Incident Response Framework (PSIRF).

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
61.4%	61.8%	61.3%	59.6%	59.6%	60.1%	60.1%	61.1%	59.2%	59.5%	58.8%	58.3%

Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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Two Out Of Three Beyond Tw...

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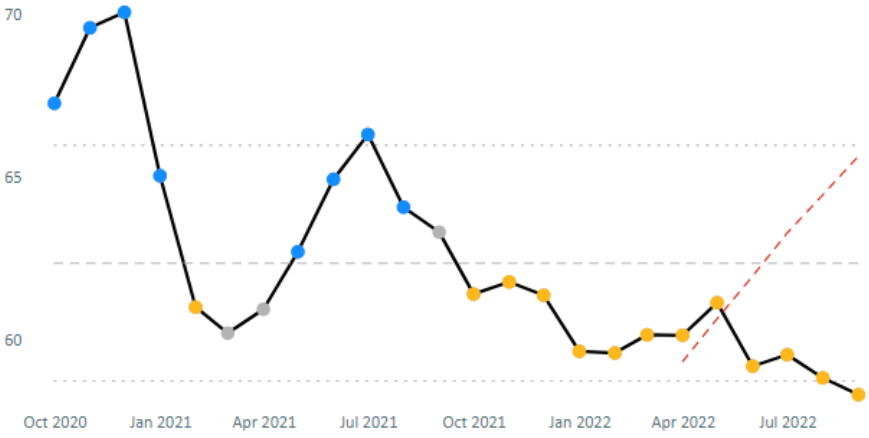

What the chart tells us

Over the last 6 months performance has remained static for the total waiting time however our long waiting patients have continued to reduce. In line with other Trusts in the region we have reduced our 104w waits almost entirely with exception for patients who have contracted covid or whom do not wish to proceed with surgery at the time. There has been good progress in addressing our 78w waits which as at the end of September were reduced to 396.

Intervention and Planned Impact

- Introduced enhanced 78 week recovery actions in Ophthalmology and Gynaecology to enable achievement of zero 78w waits by the end of March 2023.
- Revising validation process and considering how we can improve patient communication/engagement to reduce DNA rates and short notice patient cancellations. Our aim is to reduce DNA rates from an average of 9% to 7% in the first instance.
- Further improve utilisation of theatre capacity to achieve the target 85% following implementation of the revised theatre timetable.
- Enhance the recruitment and retention plan in the out patient service centre to improve the full booking process and maximise out patient capacity.
- Positive recruitment plan for two additional consultants in ENT reduce our waiting times for surgery.
- Secured out patient capacity across East and West Kent Independent Sector Hospital which will provide patients with greater choice when accessing secondary care services. GPs can also book directly into these services.

Risks/Mitigations

- We have invested 4.1M in theatre workforce as this remains the greatest risk to delivery of the activity and recovery plan. We continue to recruit additional staff and maximise productivity and efficiency of our theatre delivery.
- Ensuring that we continue a full elective programme during the expected challenge of winter and the potential rise of infection (Covid and Flu).

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
39	38	52	54	60	39	36	32	30	34	43	45

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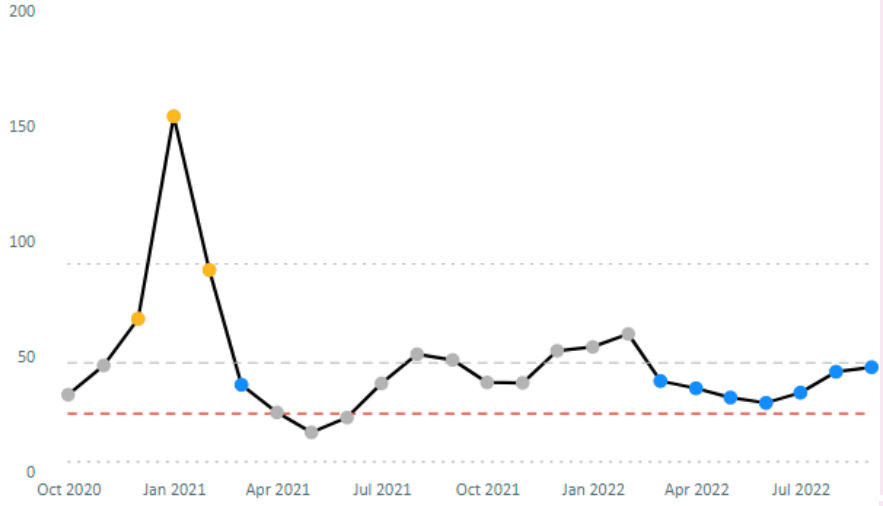


What the chart tells us

By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. The chart indicates that we saw a small deterioration in our performance. Since June this position has deteriorated with an increased opportunity not utilised of 45 sessions. Cancellations on day decreased from 167 in August to 157 in September.

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. which remains the same as August
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 September booking performance at 87.1% which was an increase of 1.2% on last month Actual theatre occupancy was 78.9%. Which was a slight decrease on August performance
The 2022/23 elective activity plan has been translated into weekly sessions required, and has been used in the development of the revised theatres timetable which commenced on 5th September.
Implementation of 6-4-2 booking commences from 3rd October which will focus specialities on booking ahead to maximise opportunity and improve patient experience
Late starts were a focus for General Surgery who have identified delays were due to waiting for confirmation of ITU beds resulting in booking a small case to be first on the list
Urology and General Surgery will focus in the next 2 months on creating standby patients to increase productivity
The theatre optimisation group meets fortnightly led by the Surgery & Anaesthetic leadership team This group is focusing on the development of SOPs regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance The site with greatest opportunity being K&C IN Orthopaedics/Urology & Ophthalmology
Orthopaedics have revised the timetables to align sub specialities to theatre sessions to improve the booking utilisation in Elective Orthopaedic Centre The booked occupancy improved to 85.2% but actual occupancy remained at 79% as a result of cancellations

Risks/Mitigations

- Theatre staff shortages in particular at WHH
- Funding provided already has enabled recruitment across sites and Anaesthetics
- Theatre Business case pending CEMG approval which would provide safe staffing levels across all sites & staff the current unfunded theatre sessions

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
8.5%	9.8%	9.6%	9.5%	9.2%	10.5%	10.4%	8.7%	9.5%	11.2%	12.1%	11.4%

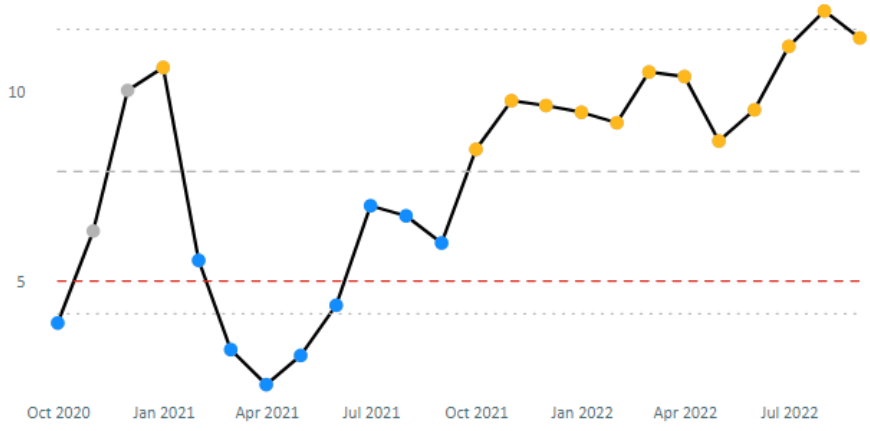
Variation indicates inconsistently passing and falling short of the target

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.

The number of patients reported as waiting more than 12 hours in the EDs saw a slight improvement in September (11.4% v 12.1% in August) with the number of reported 12 trolley waits (DTAS) showed an increase from 1026 in August to 1126 in September and remains an outlier nationally. This deterioration corresponds to the increase in the number of super stranded patients (>21 days) reported (283 v 271 in August) and is the highest number recorded in the last 12 months. The dwell time in ED against the 4 hour standard reports a mean time of 3.7 hours for non-admitted patients and 22.1 hours for admitted patients, both showing a deterioration from the previous month and the wait for admitted patients (mean time) is the highest reported in the last 12 months . Bed occupancy was 102% v 103% the previous month; over the last 3 months (July –September inclusive) reports the highest occupancy levels in the last 12 months of reporting.

Intervention and Planned Impact

The Emergency Care Delivery Board approved the planned approach to focus on the urgent and emergency pathways. This involves a hospital wide refresh of the existing improvement plan with newly established clinically led workstreams to deliver improvements, establish clinical pathways and services to ensure access to the 'right care first time' for patients. This plan aligns to the key national directives for urgent and emergency care and will include direct access pathways to reduce the need for patients to access the ED delivered through the refocused work. System partnership work on supporting the complex patients discharge pathway is in train to provide Virtual clinics, step-down community capacity and integrated SDEC. System partnership support is also being provided at the front door with support for Mental Health, triaging patients before they get to our ED. As part of the daily rhythm, the OCC (WHH) undertake a daily review with the ward teams on all pathway zero patients using a multi disciplinary approach to identify actions required to support timely discharge for patients. A process the team at QEQM are trialling.

Risks/Mitigations.

The phase 1 of the ED build at WHH was opened on the 26th September creating increased capacity in both the Rapid Assessment and Resuscitation units. The UEC have developed an internal escalation plan to support ambulance offload and ensure that patients are waiting safely for a bed through the utilisation of the SAL lounge as a designated area for these patients. The Site triumvirate have undertaken a review of all the patient areas across the EDs using the National Sit-rep guidance to safely manage patients in designated patient areas. This review and subsequent recommendations will be taken through the CEMG in October for approval.

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
2,003	2,288	2,017	2,144	1,940	2,302	1,945	2,076	1,972	2,032	1,793	2,007

F

Variation indicates consistently falling short of the target

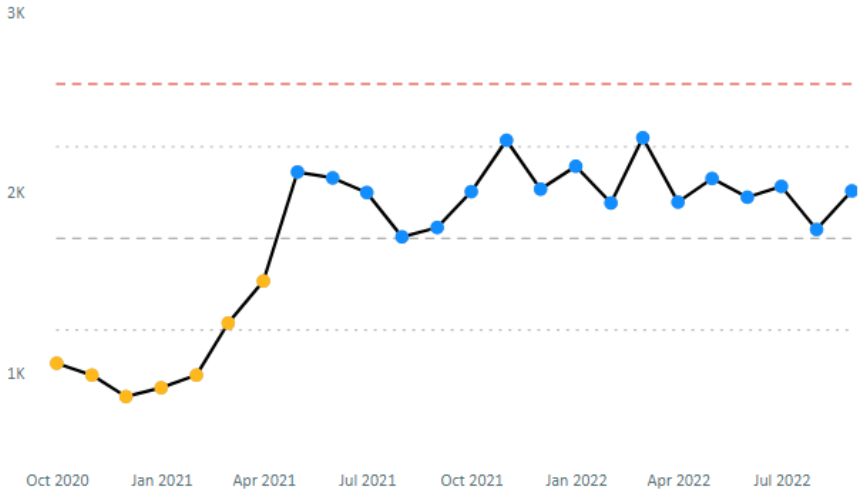
H

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

Flag Description

Above Mean Run Group

XMR Run Chart



What the chart tells us

The SDEC activity across all services saw an increase in attendances in September 2022 (2007 v 1793 in August), the increase can be attributed to the 'amber pick' pilot with Acute Physicians working closely with the ED to identify suitable patients to attend the SDEC service . The Emergency Care Delivery Group approved the newly established workstreams for emergency care in October 22 with a key focus on developing the SDEC and Direct Access models to optimise these pathways and establish a defined clinical model for the future.

Intervention and Planned Impact

A clinical forum supporting the delivery of SDEC was held in September 2022 with key outputs to focus on delivering optimal care through dedicated services including SDEC and assessment units to deliver a model that supported 'the right place first time' approach. Key messages and actions from the event included:

- A collaborative approach required to achieve the size of change along with pace to improve the emergency pathways ahead of winter.
- Consensus to reconsider existing pathways and processes to improve patient experience and align to national direction in establishing services for patients.
- Agree key principles in the future clinical models to ensure the services provide high quality care and outcomes for patients.
- Requires an organised approach, driven by senior clinicians with a governance structure to support.
- Establishing the times the service is open to reflect the demand in order to support the maximum of patients being able to access the services.
- Working with community partners to develop community SDEC with a pilot at Whitstable planned to go live in November.
- Access to appointment slots to SDEC and UTC for patients arriving OOH to reduce waits being established.

Risks/Mitigations

- Patients with long term conditions attending ED require the support of an integrated approach with community clinicians and acute hospital specialists. This work is being developed for winter as a partnership with KCHFT and will help patients to be maintained at the place they call home with appropriate medical support.
- ED Build loss of capacity. As part of the phasing building work the team have undertaken a review of the capacity and have instigated mitigations, using QIAs, utilising co-located areas to support the ED footprint during the phasing of 2/2a . The total loss of funded trolley capacity is 1 and the capacity lost for the designated escalation areas is 3 . However this review and approach has reduced the use of the corridors to address the patient safety/experience.

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
79.3%	84.3%	78.0%	75.6%	71.0%	74.5%	66.1%	61.7%	73.2%	77.2%	70.1%	65.1%

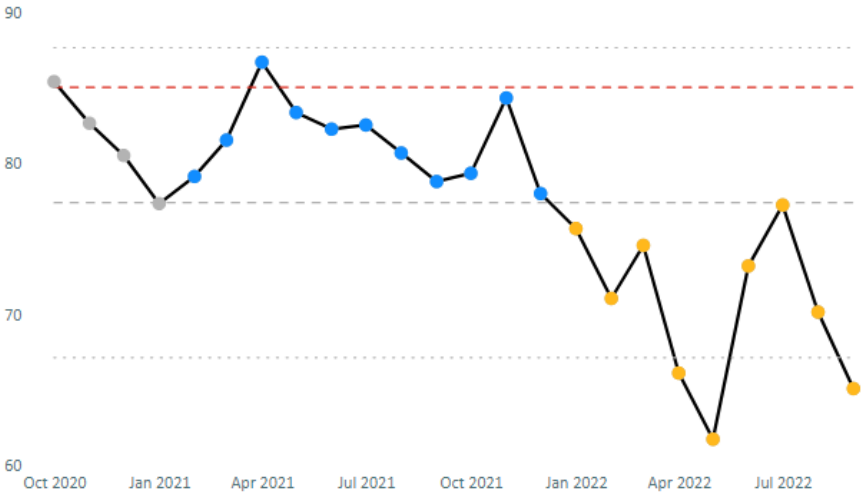
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

Performance has reduced in September with a lower number of overall treatments than the previous months and higher number of breaches treated in month. K&M Cancer Alliance continued to record the lowest back log of all Alliances, East Kent Hospitals is the largest contributor to this.

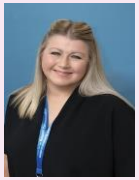
Intervention and Planned Impact

- Weekly updates for teams redesigned to give teams clearer oversight of where they are with performance.
- CSS service are currently piloting some walk in services at WHH, these will be reviewed and we will ask the Alliance to support further if successful. We are also working on the 28day patient information electronically for GPs and Acute organisation
- Consistent high levels of 2ww referrals. Patients are being supported with the development of 2ww information on the Trust web page to include information on suspected cancer pathway and useful contact numbers to aid communication and support.
- Proactive management of long waiting patients to understand how we can best manage these groups through to treatment. Patients above day 40 on the lower GI pathway have been contacted to ensure they are fully supported and are aware of next steps. A group has been set up with MTW colleagues to improve joint understanding of their pressures, benefit working relationships, reduce delays and improve patient experience
- Lower GI straight to test (STT) implementation continues with PGDs for bowel cleansing approved at the DTC meeting end of September. FDS manager has commenced escalation meetings 3 times weekly with the endoscopy booking team, along with clinical support from FDS clinical nursing lead and qFIT project facilitator to discuss complex patients and improve booking times. FDS manager has successfully appointed and trained lung navigator This has shown a real improvement with the 28 day pathway and reduced the backlog from an average of 70 patients to just 10.

Risks/Mitigations

- Delays to diagnostics booking remains a risk due to teams challenges and competing demands for resources
- Endoscopy booking delays persist but teams working together on sustainable solutions. New support call commenced with Endoscopy to provide additional clinical support
- Theatre capacity and skill set for Urology, Head & Neck and Lower
- For urological surgical capacity mutual aid has been explore but is not possible to secure, the teams are booking but significant delays remain

Our patients



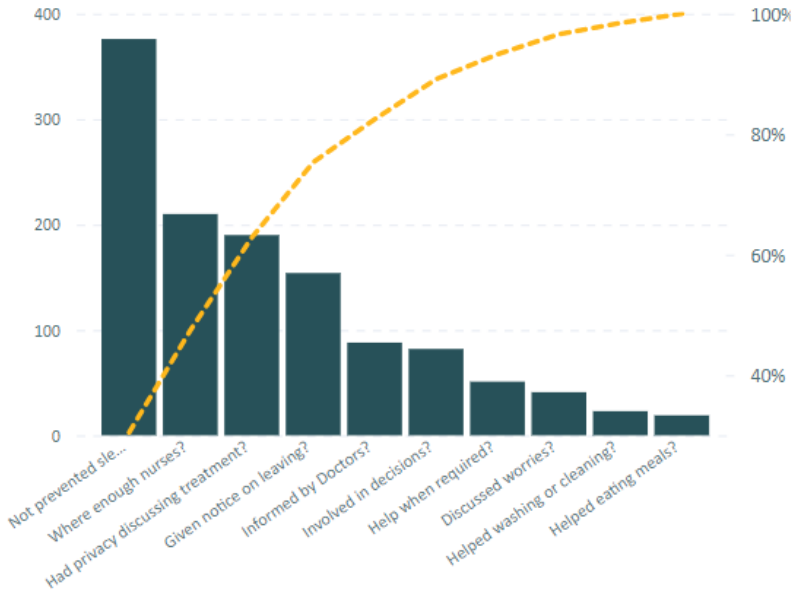
Sarah Shingler

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 (1,250 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 - Sep 22



Stratified By	Num	Den	Value	Thresh.	Pareto Value	Pareto
Not prevented sleeping by noise?	813	1,189	6.8	7.7	376	30.5%
Where enough nurses?	1,084	1,294	8.4	7.7	210	47.5%
Had privacy discussing treatment?	1,075	1,265	8.5	7.7	190	62.9%
Given notice on leaving?	656	810	8.1	7.7	154	75.4%
Informed by Doctors?	1,168	1,256	9.3	7.7	88	82.5%
Involved in decisions?	1,145	1,227	9.3	7.7	82	89.1%
Help when required?	1,223	1,274	9.6	7.7	51	93.3%
Discussed worries?	1,203	1,244	9.7	7.7	41	96.6%
Helped washing or cleaning?	947	970	9.8	7.7	23	98.5%
Helped eating meals?	766	785	9.8	7.7	19	100.0%

What the chart tells us

There were 1303 Inpatient Experience surveys completed in September via Tendable across 51 wards, this exceeded the target of 1200 set for September. The positive responses to 9 of the 10 questions asked were above target threshold of 7.7, with the exception 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 68% (6.8) score is reflecting those patients that had a positive experience.

Intervention and Planned Impact

CNMO has set trajectory for all wards to be completing 50 surveys per month to achieve the 2050 surveys per month: Octobers target is 2050. The accreditation team are supporting ward areas who are not currently reaching their target of 50 surveys per month and this is monitored daily

HONs and DONs are 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 actions to address poor responses. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FOC), measures are being explored to counteract the noise disturbances at night with the frontline teams. The guidelines for ward night duty are being developed, this will provide support to all our newly appointed staff. All areas are being encouraged to stock ear plugs and eye masks to offer patients at night with a focus on our escalation areas and corridors where disturbances at night are hard to avoid due to the nature of the current operational challenges. An in-patient information booklet has been developed to help meet expectations whilst in hospital and provide reassurance in the flow of a ward over a 24 hour period. The dementia working group are also contributing to this booklet to raise awareness of patients who are living with dementia, address perceptions and explain how we support these vulnerable patients as health care professionals, this is as a result of direct patient feedback. The booklet is currently being reviewed by senior nurses and will be ratified at the FoC Committee.

The Head of Patient Voice and Involvement is working 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. A priority is to identify a patient champion/member of the public to become an active member of the monthly FOC committee.

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.	Jun-22	Jul-22	Aug-22	Sep-22
Cancer 62d			Cancer 2ww Performance		93.0%	97.0%	95.4%	94.5%	95.4%
			Cancer 31d Performance		96.0%	98.7%	98.0%	98.7%	94.9%
	W4		Cancer 28d Performance		75.0%	66.0%	67.7%	68.3%	67.9%
	W4		Radiology Diags vs Plan		Traj.	17.5K	17.6K	17.7K	17.5K
	W4		Endoscopy vs Plan		Traj.	1,348	1,419	1,439	1,302
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	527	480	448	396
	W4		DM01 Compliance		75.0%	69.6%	70.1%	65.8%	64.0%
	W4		RTT OP Booking Breaches		14,000	24.1K	24.3K	26.6K	27.2K
	W4		OPA vs Plan		Traj.	73.8K	71.1K	71.6K	71.6K
	W4		Elective Admissions vs Plan		Traj.	8,637	8,502	9,182	8,718
ED Compliance	W4		ED Compliance		90.0%	69.4%	68.1%	65.0%	68.1%
	W4		Clinician First Seen within 1h		50.0%	41.7%	40.2%	42.0%	48.4%
	W4		A&E Atts vs Plan		Traj.	23.9K	23.9K	22.0K	22.2K
	W4		Unplanned Re-attendance ED		10.0%	14.6%	14.5%	14.1%	14.2%
	W4		Super Stranded >21D		107	221	247	271	283
	W4		NEL Admissions vs Plan		Traj.	7,400	7,184	7,098	6,690

Regional access position

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

*figures shown are one month in arrears as this is the latest national data available

Target/Trust	EKHUFT	MTW	Medway	Dartford
A&E 4 Hour	68.10%	84.70%	68.80%	75.80%
Cancer 62D	*70.10%	*86.10%	*83.80%	*61.20%
DM01	64.0%	90.00%	71.70%	82.80%
18w RTT	58.30%	68.30%	60.90%	69.39%

RTT 18 Weeks

The electronic referral system (ERS) is now live in Dermatology (adult and paediatric), Sleep Diagnostics and Breast surgery. A further 11 specialities are revising their Directory of Services (DOS) and outlining their Referral Assessment Service (RAS) where multiple pathway choices exist for patients (telephone, web, face to face).The advantage of implementing a directly bookable service is that it allows patient choice in booking an appointment time/location agreeable to them and therefore reduces the booking administration time. This also improves the DNA rate as the patient will have chosen their own appointment time.

ED Compliance

September 2022 reported a slight upward trajectory in the 4 hour performance 68.1% against 65% for August.

The number of patients admitted (NEL) for September decreased for the 3rd consecutive month (6,690 v 7098 in August). The number of patient over 21 days stays continues to increase with the highest number reported in September (283 September v 130 October 21) against the last 12 months.

Unplanned reattendance

September reported a slight deterioration against the August reported data with 14.2% of patients reattending v 14.1% in August. Focused work reviewing data will support conversations with our primary and community service partners 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. .

The introduction of Inter-professional standards will improve the timeliness of decision making at the start and conclusion of the patients attendance and inpatient stay. These standards have been endorsed by the Clinical Executive Management Group and will be an important part of how emergency care and treatment are delivered.

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.	Jun-22	Jul-22	Aug-22	Sep-22
FFT	W4		FFT Maternity Response Rate		18.0%	14.7%	13.8%	13.4%	7.7%
	W4		Complaint Response		90.0%	0.0%	10.4%	20.3%	44.6%
	W4		Duty of Candour - Verbal		100.0%	81.0%	61.3%	67.7%	69.6%
	W4		Duty of Candour - Written 15wd		100.0%	81.3%	66.7%	58.6%	45.5%

Complaint Response

The complaints response has remained below threshold. This has been impacted by a number of issues. The care groups continued to prioritise the backlog in order to address the longest waiting. Several teams have been managing absences, including significant vacancies in the corporate team. As a result, new complaints have not been addressed within the policy time period, although the length of breach has been much less than the previous backlog. Furthermore, the external support has reduced due to one staff member resigning at short notice, within weeks of commencing. A new recruitment campaign will commence, and intensive support to the corporate team and care groups is being arranged.

Duty of Candour

The Duty of Candour compliance has fallen due to failure to achieve the timelines required. Meetings have been set with the Care Groups to provide support and oversight to ensure a robust approach is in place. The trajectory for improvement remains, and can still be achieved as the number of incidents has not increased excessively. Trajectory for improvement sees >90% compliance by December 2022.

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.

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

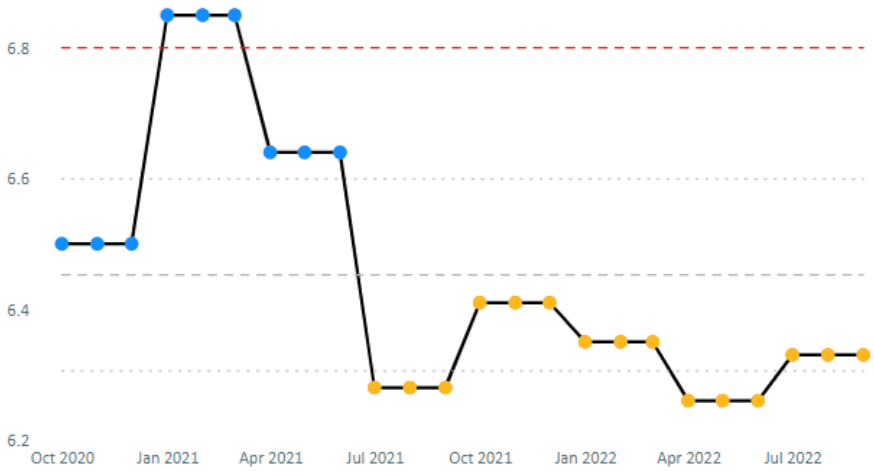
F — Variation indicates consistently falling short of the target

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

Fieldwork for the National Staff Survey (NSS) is currently underway, the results of which will provide a revised Staff Engagement position. It is important to note that, following conclusion of the NSS on 25th November, these results will not become available until January 2023.

There had been a subtle (7-point) improvement in Staff Engagement (from 6.26 to 6.33) in July, and this will need to continue consistently in order for the organisation to achieve the targets it has set.

Interventions and Planned Impact

The Trust was the first to launch the National Staff Survey this year and has a wide programme of activity taking place to ensure all staff have an opportunity to share their voice. At the time of writing, the response rate is **31%** (2,786 respondents) which is 15% ahead of the national average (16%).

The activity taking place includes; polling stations, a booster campaign, targeted visits, attendance at audit days, weekly webinars to myth-bust and encourage transparency, 'We Said We Did' weekly communications, the development of a Managers Toolkit, a weekly Care Group barometer to encourage healthy competition and a detailed tracker to view areas requiring the greatest input.

Response rates are currently lowest in ENT (11%), Trauma & Orthopaedics (18%), Acute Medicine Wards (18%) and Obstetrics & Gynaecology (19%). By contrast, response rates are highest in Rheumatology (81%) and Medical Physics (74%).

Risks/Mitigations

There is a risk that Dr Kirkup's Report has a significant and deleterious impact on the NSS, particularly due to the publication of the timing mid-survey. Whilst this could primarily impact overall advocacy (and therefore Staff Engagement), it has the potential to impact all scores. The organisation is being prepared to try and mitigate impact, and provided with wellbeing support to stabilise motivation. We Care and TED programmes are being extended to drive staff involvement in particular.

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.

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

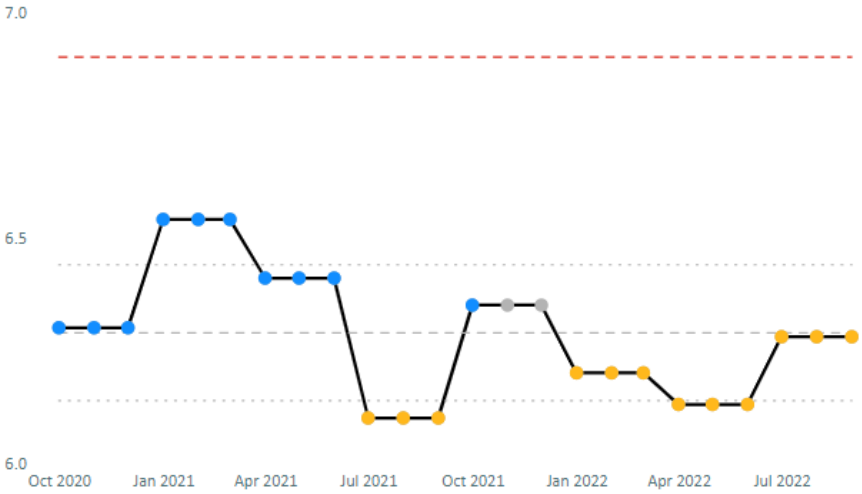
F — Variation indicates consistently falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

Model Health indicates that Staff Involvement is currently in the 2nd quartile, defined as the mid-low 25%. In July, there was a 15-point improvement in Staff Involvement, from 6.1 to 6.3. This means we are now <0.1 away from both the national average (6.4) and that of our peers (also 6.4).

The score is improving (by 2-4% in July), but needs to do so consistently over each of the next quarters in order to achieve the desired position. Whilst only a proxy of staff involvement, it is promising to see the NSS response rate at 31% - showing strong engagement with the organisation from colleagues.

Intervention and Planned Impact

- 20 areas have now been trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology, with a further 16 planned before the end of November
- The We Care rollout has been extended beyond the 20 'units' surveyed in July as part of the NQPS and will also include Urology and Cardiology
- Two of the priority areas identified as part of the National Staff Survey data review (those with the lowest scores for involvement) are completing KENT Fundamentals in September.
- The new staff intranet, Interact, has been reviewed and can provide; sentiment analysis, target pulse surveys and an online suggestion area, the effectiveness of which will be piloted
- An 'Involvement Toolkit' is being finalised to provided support at team leader, speciality and Care Group level throughout the NSS

Risks/Mitigations

- Nationally, levels of staff involvement in the NHS have been on a downward trend for the last 3-4 years and there has been a pronounced fall in recent quarters
- Dr Kirkup's Report could have a significant impact on overall staff morale and may affect the way colleagues respond to the National Staff Survey questions
- Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores

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.	Jun-22	Jul-22	Aug-22	Sep-22
Staff Engagement	W4		Appraisals Compliance		80.0%	66.4%	67.4%	69.4%	69.9%
			Safeguarding Children Training		90.0%	90.0%	89.5%	88.2%	87.0%
			Staff Turnover Rate		11.5%	10.8%	10.8%	10.8%	10.8%
			Safeguarding Adults Training		90.0%	90.3%	89.0%	87.9%	86.3%
	W4		Vacancy Rate		10.0%	12.4%	12.7%	13.6%	12.3%
	W4		Staff Turnover: HCA		13.5%	13.7%	14.4%	14.9%	14.3%
			Premature Turnover Rate		25.0%	23.9%	23.1%	22.9%	23.5%
	W4		Medical Job Planning Rate		90.0%	40.5%	32.9%	34.0%	31.5%

Appraisal

Overall appraisal compliance had been on an upward trend during 2021 and 2022. August and September saw an increase, with compliance at 70% in September. This is below the alerting threshold of 80%. The compliance by Care Group ranges from 89% for Surgery HNBD, to 59% for UEC. The Corporate areas are the lowest of the groups at 56%. Teams are working to book appraisals in during the next two months to improve compliance. Non-compliance is highest within the Nursing & Midwifery and A&C staff groups. Appraisal compliance is an area of concern as it is a good indicator of staff engagement and personal development planning. In addition, Health & Wellbeing conversations and updated Covid Risk Assessments form part of the appraisal process. Whereas previously, Appraisal Compliance was a driver for many Care Groups, this will now be supported through the Trust objective of Staff Involvement, which is also a Driver for some Care Groups.

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.

Staff Turnover

Staff Turnover currently stands at **10.84%.** This is below the desired threshold (11.5%) and has remained consistent for each of the last four months. When measured in-month, turnover has risen from 9.5% in June to 13.5% in September. This is largely due to a rise in HCSW turnover, but is also a phenomenon we tend to see each September. In September 2021 for example, turnover had also risen to 13.3%. This then reduced and stabilised for a period of 9 months. Actions to mitigate turnover concerns are underway, from joining the NHS England HCSW Direct Support Programme to tailored interventions in hotspot Specialty areas and monthly delivery of the Ready to Care Programme.

Vacancy Rate

The overall vacancy rate has improved, decreasing from 13.6% to 12.3% in September, largely due to an increase in nursing staff through the IEN recruitment plan. There is also a rolling programme of recruitment in place for HCSW posts plus a marketing campaign supported by the East Kent Healthcare Partnership. Vacancy rates for AHP/HSS/APS have also improved and career development pathways established, to mitigate risks.

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
-1.494	-0.996	-0.941	-0.090	1.307	0.076	-3.700	-6.624	-6.604	-7.795	-11.453	-13.015

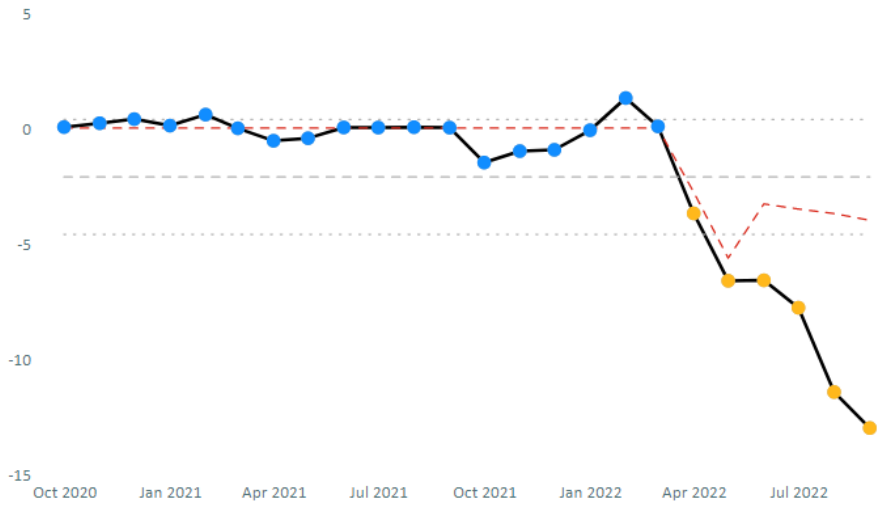
Variation indicates inconsistently passing and falling short of the target

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 September which is a £13m deficit against a plan of £4.0m deficit. The key drivers behind the deficit are: £0.6m behind plan on CIPs, £4.0m on escalation areas (additional 60 beds), £1.3m bank and reductions not seen, overspends on work permits £0.8m and Covid overspend £0.4m.

Interventions and Planned Impact

The 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. Fortnightly meetings being held with clinical and corporate areas, use of national benchmarking data, plus detailed budget reviews underway.
- Premium pay deep dives are being held with care groups to test plans and review further actions to be taken.
- Away day held in September which had a focus on efficiencies, the PMO are working through the outputs to identify key areas of development.

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
6,783	7,255	6,441	7,168	7,403	9,148	7,890	7,497	8,894	8,702	8,809	9,618

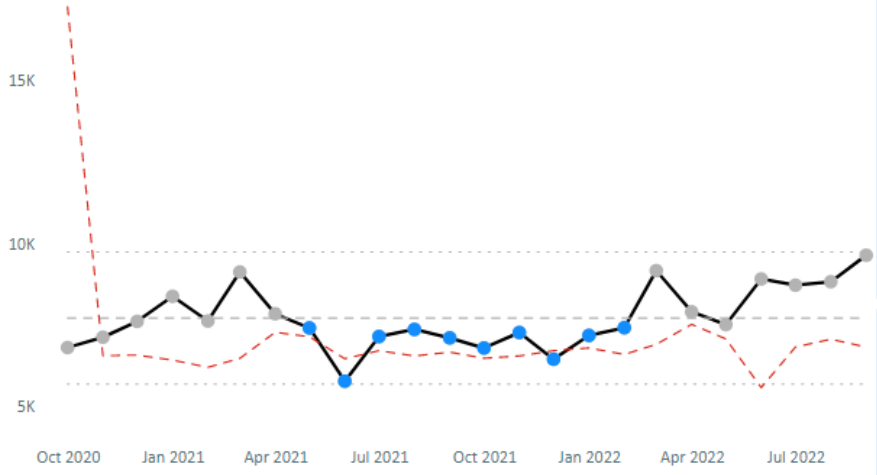
Variation indicates inconsistently passing and falling short of the target

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. This is caused by the Trust ensuring all costs in that financial year are captured and include unpaid claims due in year.

This information is the baseline for which we will measure improvement over 2022/23. In September 2022 premium pay spend has increased by £0.8m. £0.5m of the increase is due to the backdated pay award for bank staff

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:
- Detailed focus by care groups on drivers of premium pay. Premium pay deep dives occurring through November.
- 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.
- Ensuring exit plans in place for high cost medical agency locums

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.
- Escalation beds opened plus more specialing increases 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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
5.61	8.06	8.60	9.55	7.65	7.97	6.17	6.69	2.46	4.26	4.67	

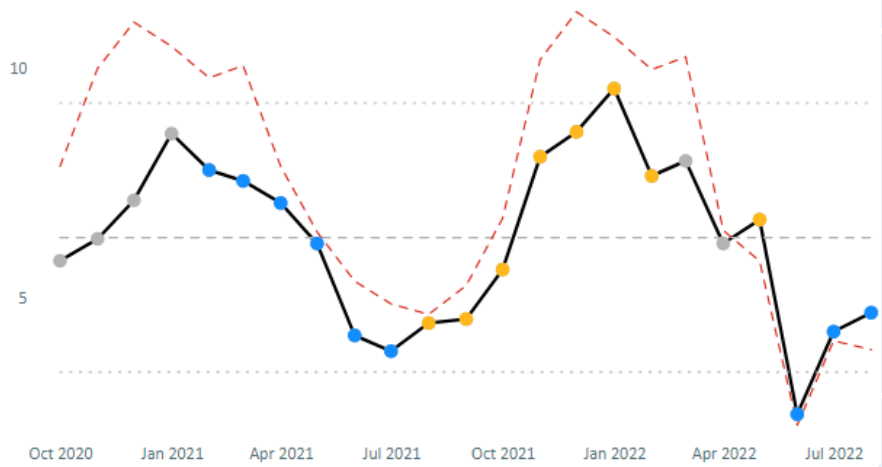
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's carbon footprint as demonstrated in the chart. However, the position is reporting above the monthly trajectory of 3.87 at 4.67 kgC02e per m2 and is slightly above the same period last year (reporting at 4.44). It should be noted that the increase in 2022 will be in some part due to the increase in m2 in 2022 (new ITU build at the William Harvey Hospital). In addition the installation of Combined Heating and Power (CHP) equipment has increased the amount of gas used this year. 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 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

Breathe Energy has been working with the Trust and 2gether to identify carbon reduction schemes that could be commissioned in the new financial year. The Trust, with 2gether, has produced a business case which identifies the installation of heat pumps on the three acute sites funded via the PSDS 4 Grant. The Trust submitted its bid on 15 October 2022. It is expected that the outcome of all submissions will be made public in December/January 2022/3. The Trust's bid for capital being £25.2m. The total annual carbon emissions saved by the use of heat pumps 3,370 tonnes per annum which constitutes a 22% contribution to the Trust's trajectory (80% reduction in Co2 by 2030). The scheme put forward focusses on carbon reduction, rather than financial savings, although financial reductions will be part of the programme of work.

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.	Jun-22	Jul-22	Aug-22	Sep-22
Financial Position	W4		Total Pay		0.0%	-3.1%	-3.6%	-4.0%	-6.6%
	W4		Efficiencies YTD Variance (£M)		0.0	-1.0	-1.4	-1.6	-0.6
	W4		Efficiencies FOT Variance (£M)		0.0	-4.7	-2.3	-3.1	-2.7
	W4		Efficiencies Green Schemes		90.0%	22.8%	32.8%	41.5%	53.6%
	W4		I&E Monthly Variance Trust (£)		0	-2.5M	-315.6K	-3.1M	-11.6K

Total Pay

This metric is mainly driven by the expected reduction in premium pay not being achieved. Premium pay reductions are still a focus of care groups as a break through or driver metric. Other key drivers are the opening of escalation beds and a shortfall in CIP.

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 key drivers behind the deficit are: £0.6m behind plan on CIPs, £4.0m on escalation areas, £1.3m bank and reductions not seen, overspends on work permits £0.8m. To mitigate the position the care groups and clinical areas have fortnightly meetings with the CFO and financial improvement director. In addition we are having premium pay deep dives for key areas.

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
299.5	332.0	346.2	314.3	320.4	336.2	351.1	352.9	354.9	402.6	385.9	358.3

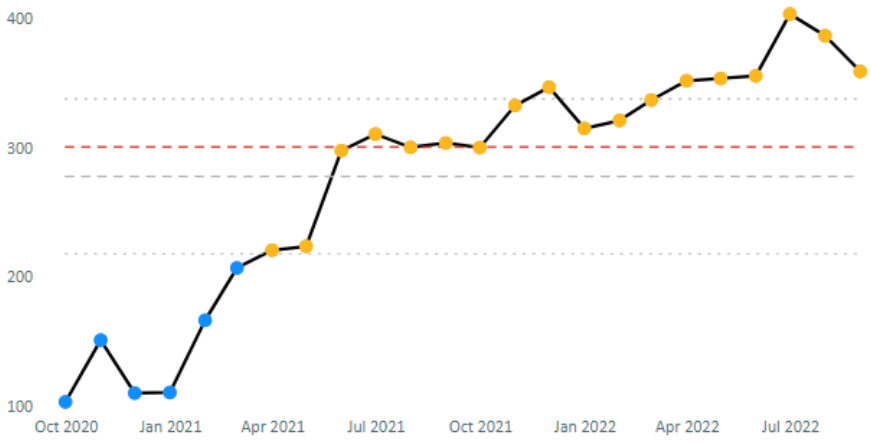
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

This chart should be seen in the context of the Total Time in Emergency Department True North and specifically the impact on the admitted pathway who are delayed in ED (12hr trolley waits). Patients who cannot leave hospital and are delayed will in turn reduce the available beds for emergency admissions from the Emergency Department. Nationally it has been recognised that systems across England are under severe operational pressures. The ability of any system to support people ready to leave hospital will be an area of renewed focus as we approach winter.

Intervention and Planned Impact

Recently EKHUFT, KCHFT and KCC have collaborated on a plan to improve patient flow for our collective residents. This involves proactive collaboration focussed on three priorities, SDEC, Virtual ward, Bridging. This work continues at pace with progress :

1. Identification of key pathways and areas where the community and specialist teams can link up
2. Virtual Ward
3. Bridging arrangements that help people leave an acute hospital bed prior to care at home or long term residential care being available

In support of the improvement work we have additional leadership and improvement input from a very experienced improvement lead in the field of system integration, frailty and improving discharge planning. This shared resource has met teams and is helping progress our thinking.

As part of this work we will be refocussing our efforts to ensure expectations for patient choice are set on admission and enhance early planning.

We are also aligning the work of the support provided to patients who need to access care outside of hospital in ED with the Rapid Transfer Teams that work closely with the ward teams for patients who have completed hospital care but continue to need support in their own home or in residential care on discharge.

Risks/Mitigations

- 30% 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.
- A higher than usual number of patients leave EKUHFT to residential care settings. The process for understanding choice and early decision making is part of our collaborative work with KCC and KCHFT

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.

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
208	303	198	116	91	246	129	162	430	82	161	190

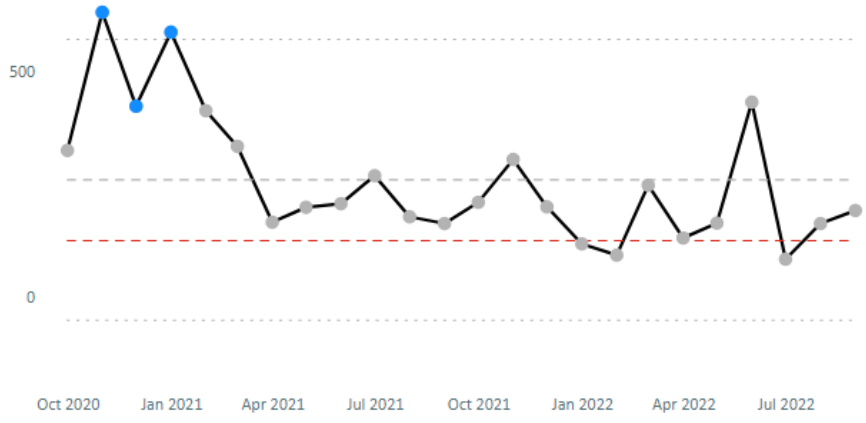
Variation indicates inconsistently passing and falling short of the target

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. The September position of 190 participants is above the threshold of 123 (positive) and an increase from last month. The April – September cumulative position is 1,154 patients recruited to trials, which is above the year to date trajectory of 738. Successes this month include the SQUEEZE anaesthetics study, which opened in August at WHH and in September at QEQM, with the QEQM successfully recruiting an additional 82 patients. The study is looking at the use of anaesthetics post operatively and the impact on blood pressure, with a view to improved outcomes and reduced reliance on HDU/ITU.

Intervention and Planned Impact

- The Clinical Trials Unit at QEQM opened in June and studies are now running through the Unit.
- The Harmonie trial commences in November. The study is looking at how strongly babies can be protected from serious illness due to RSV infection (respiratory syncytial virus) by giving them a single antibody dose.
- The DOLPHIN study, focusing on the use of technology and AI to support physiotherapy in children with Haemophilia, has opened. The Trust is the lead site and the other sites include GOS.
- The Anaesthetic Clinical Fellow post has now been appointed to, and funding of additional Clinical Fellow posts continues to be discussed with Surgery, Cardiology, Haematology and Vascular.
- Further studies in maternity are currently in the pipeline.
- Work continues to identify ways to capture staff numbers across all healthcare professionals. Whilst this is expected to be via the new research database being produced, the publication of this has been delayed and the expected date is currently unknown.

Risks/Mitigations

- Space at K&C has been identified as a constraint with the key risk being the impact on the Trust's ability to continue to provide a number of cancer trials. Space requirements are being reviewed urgently.
- Lack of recurrent funding to support the additional research fellow posts.
- Lack of outpatient space for follow-ups. As trials increase, this will become more challenging
- The delay in the new research database will delay the Trust's ability to identify accurately the number of staff involved in research and the current metric will need to continue.

Appendix 1
Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Harm Events	W		Falls		Sigma	134	148	143	154
	W		IPC: EColi Infections		10	5	9	8	9
	W		IPC: Klebsiella Infections		6	3	8	5	0
	W		IPC: Pseudomonas Infections		3	2	1	2	2
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	243	232	222	214
	W		Medication Errors; Severity C+		1	1	1	1	1
	W		Nutrition Incidents		Sigma	73	47	60	60
	W		Pressure Ulcers: Cat 2		Sigma	27	40	35	28
	W		Pressure Ulcers: Cat 3 & 4		Sigma	1	2	0	0
	W		Pressure Ulcers: DTI		Sigma	3	8	11	12
	W		Pressure Ulcers: Unstageable		Sigma	1	8	12	10
	W		IPC: Audits Composite		85.0%	85.3%	86.5%	85.7%	85.7%
	W		Safeguarding Incidents		Sigma	14	18	19	22
	W		IP Spells with 3+ Ward Moves		Sigma	538	496	507	459
	W		Clinical Incidents		Sigma	2,194	2,228	1,966	1,859
	W		Serious Incidents		Sigma	16	25	14	21
	W		Overdue Incidents		Sigma			6,698	6,531
	W		Never Events		0	2	0	1	1
	W		Maternity Serious Incidents		2	6	6	1	3

True North Domain	BR	Flag	KPI	SPC	Thres.	Jun-22	Jul-22	Aug-22	Sep-22
Mortality	W		Extended Perinatal Mortality		5.93	4.41	4.25	4.11	4.27
Staff Engagement	W		Sickness		5.0%	5.2%	6.0%	5.0%	
	W		Statutory Training		91.0%	92.4%	91.9%	91.7%	91.1%
	W		Staff Turnover: Nursing		10.0%	9.4%	9.4%	9.4%	9.5%
Financial Position	W		Non Pay		0.0%	1.0%	1.8%	0.7%	0.9%
	W		I&E YTD Variance (£)		0	-3.7M	-4.0M	-7.1M	707.2K
	W		I&E FOT Variance (£)		0	0	0	0	0

True North Domain	BR	Flag	KPI	SPC	Thres.	Jun-22	Jul-22	Aug-22	Sep-22
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,681	1,652	1,718	1,626
	W		RTT 52w Breaches		Traj.	3,605	3,419	3,453	3,386
ED Compliance	W		Discharges by Midday		15.0%	14.3%	13.9%	13.6%	15.1%
	W		Pathway 0 Patients >7 Days		Sigma	158	139	135	134
	W		NEL Readmissions		15.0%	10.4%	9.8%	9.6%	9.0%
	W		Stroke Ward within 4 Hours		50.0%	47.5%	55.7%	57.1%	59.6%
FFT	W		FFT IP Response Rate		15.0%	16.7%	19.2%	18.1%	20.9%
	W		FFT DC Response Rate		27.0%	28.1%	30.3%	30.5%	29.5%
	W		FFT ED Response Rate		12.0%	12.7%	14.5%	14.3%	15.1%
	W		FFT OP Response Rate		17.0%	18.8%	20.0%	20.2%	20.5%
	W		Complaints Number		Sigma	61	86	73	69
	W		Mixed Sex Breaches		Sigma	37	69	46	69
	W		Duty of Candour - Findings		100.0%	100%	75.0%	61.5%	55.6%

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	Meeting is pending to review the A3 and dates	• Residential modelling is completed and used to manage high demand, additional 24 temporary rooms created at WHH • Review of training room booking process continues. • Project lead continues to engage with care groups to identify office usage following new agile working policy	• Finalisation of Accommodation Management Policy • Feedback compiled by project lead on agile working with key stakeholders • Residential modelling forward view to be developed.
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	• Consistency and pre-sign off review process commenced to review/improve quality of job plans approved at 3rd sign-off and provide feedback to sign-off clinicians about common issues found at 3rd sign-off. • Next KCDP cohort launched with job planning included in agenda. • CEA draft policy taken to LNC for comments. • Medical workforce deployment group re-launched.	• Continue with PDSA cycles testing the new 3rd sign-off process • Review and edit the terms of reference of the MJPCC following lessons learned from the 3rd sign-off PDSA. • To standardise the medical change form and governance process (draft SOP/flowchart sent around for comments) • Confirm the construction and timeline for the next round of job planning workshops • To finalise process of reviewing appraisal and revalidation system to determine next steps for reviewing e-JobPlan system. • To finalise/approve draft policy/SOP for CEA and consultant recruitment
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	• Operational issues have delayed the meeting with SRO and Leads to review the future direction of the project and update the A3.	• Project paused • As part of the We Care improvement Journey a number of wards across the sites are looking at improving their discharge process.

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 was submitted to the Policy Authorisation Group (PAG) – for 19/10/2022 meeting. • Project has officially entered the Transition Phase (following set-up) and was presented to SLT on 05/10/22. • Preparation of MicroGuide for roll-out has progressed with planning of structure and content, plus alternative storage for documents that are not clinical guidelines.	• Further analysis of current MicroGuide Content and usage. • Highlighting of MicroGuide documents that require re-location to alternative storage (non-clinical guidelines). • Selection of initial specialty for full, supported implementation of MicroGuide.
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	• First event of NHSE/I EoLC collaborative – project 'EoLC hub / beds on Sandwich Bay'. • Establishing project group • Work with Judith Banks as ReSPECT lead to raise IT functionality issues with CCG and Trust IT around introduction of ReSPECT • Finalising script and filming locations for EoL film. • 1st pilot of an in house 'introduction to communication skills' course 14th October – well evaluated • Developing relationship with Patient Voice and Involvement Team to begin to scope EoLC involvement	• EoLC film filming scheduled 24-26th October • First meeting of NHS E/I project team at QEQM • EoLC story to board via patient voice and involvement team. • 2nd pilot of in house 'introduction 11th November to communication skills' course.
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	• Clinical Audit TPIP re-drafted and agreed at CAEC 27.9.22 • Clinical Audit Policy signed off at CAEC 27.9.22 • Workshop held and SOP/Guidance on clinical audit drafted • Clinical Audit Platforms reviewed and scored against suitability • Review of the Clinical Audit systems and processes carried out considering external expectations of reporting with additional Key Performance Indicators identified and agreed at CAEC in order to provide further assurance	• Continue to update A3 • Clinical Audit Policy to be presented at PAG • Clinical Audit SOP/Guidance to be agreed and finalised • Business case for Clinical Audit Platform to be completed • Revised KPIs to be reported

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	• Met with therapies to understand mobilisation issues. • Liaised with the trauma co-ordinators to ensure patients are ready for theatre and not listed on "theatreman" without being optimised • Liaised with the Hospital site teams regarding compliance for getting our patients to the right ward • QE meetings ongoing. The WHH meetings have been re-established	• The new Deputy Head of Nursing is in place and will be leading this project across both sites. • Handover of this project is this week • Plan is to initially meet with the trauma coordinators from both sites and organise a multidisciplinary work shop to discuss the Hip fracture patient pathway.
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 continue agree priorities for the day. • Monthly Operational meetings continue identifying any issues • Work shop was held, working group established and actions agreed	• Write a clinical priority list for maternity referrals to Sonography • Pilot agreed to look at DNA rates. • Review information and explanation documentation supporting Women's needs • Contact Information department for feasibility of auto notification once pregnancy details are added to referral PTL

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Safeguarding	Sarah Shingler	Timely assessment of patients with mental health &/or cognitive impairment risks, to determine the level of support required carried out for 100% of patients. Provision of individualised treatment plan to optimise support and care to maintain safety.	Mar 2022 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to: (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 3: Glossary of Terms

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 3: Glossary of Terms

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.