NHS
East Kent Hospitals University
NHS Foundation Trust

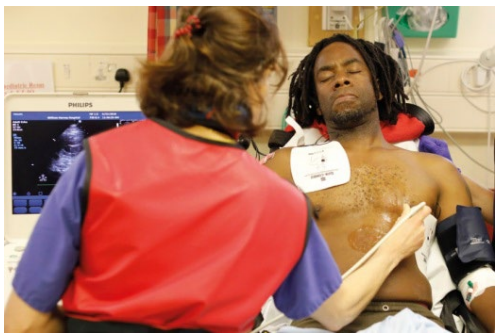
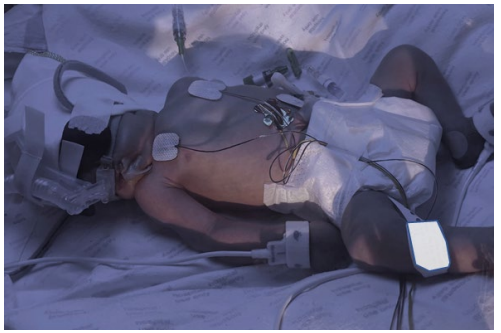
Integrated Performance Report

October 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)?

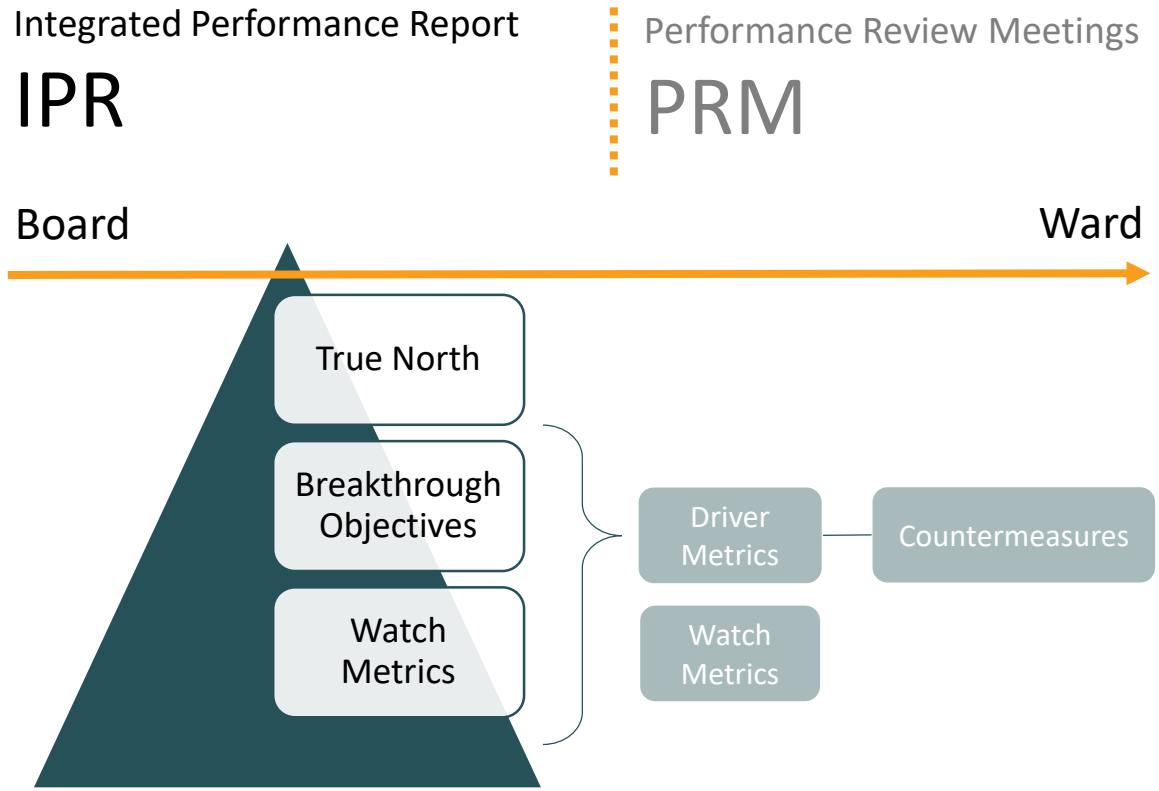
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- 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.



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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
97.4	92.3	89.3	88.1	86.9	88.2	89.1	90.4	90.8			

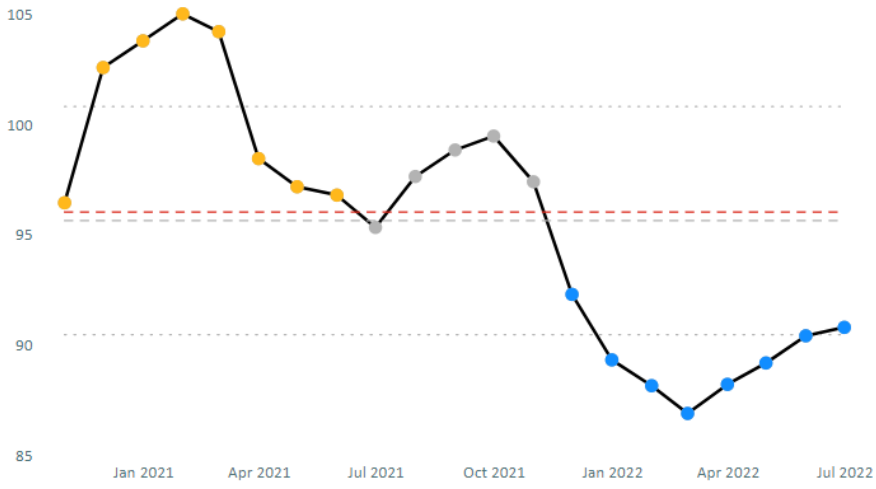
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

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 July 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 16th 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 93.7 (to July 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 no new alerts for this month
- Work continues to dive into the biliary tract disease alert reported last month

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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
14	28	26	29	25	21	13	21	31	22	32	40

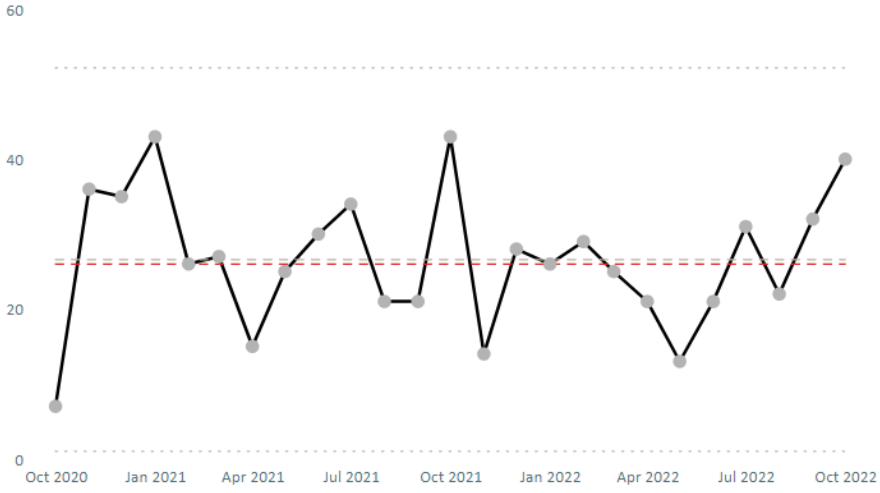
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 40 incidents in October, which continues to be above threshold. The highest contributors to harm for the second month were care/treatment with 12 harm incidents, which is an increase from the previous month, delay/failure was the second highest with 7 incidents and this is again an increase. The third highest contributor were pressure ulcers with 4 harm events but this is the first time in over 6 months that pressure related incidents have caused moderate harm to our patients, 2 of these incidents are directly linked to patients in ED with a length of stay over 24 hours. For the last 7 months care/treatment and delay/failure have both featured in the top three highest contributors. There have been no moderate harm or above incidents related to falls during October.

Intervention and Planned Impact

The Deputy CMO and corporate governance team are supporting with reviewing care/treatment and delay/failure categorisation of incidents and themes. These vary but are mostly delayed diagnosis for patients on the cancer pathway and delays in initiating the correct urgent referral and treatment pathway in ophthalmology patients. Recognition and escalation of the deteriorating patient and failure to implement Treatment Escalation Plans (TEP.) A decision was taken by the CMO in November to have an in depth review by the site triumvirates to determine the site based themes and these will be reported to the December Patient Safety Committee for action. A priority will be to review the deteriorating patient pathway and auditing sepsis screening compliance.

Safe staffing and our current capacity challenges continue to be a factor contributing to patient harm, we continue to see a direct correlation between low staffing levels and harm and this has continued throughout the previous months. Our full capacity policy has continued to be initiated and we have 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. Both ED's are reporting into the Fundamentals of Care (FOC) committee on their harm events and compliance with the corridor escalation SOP and their ability to deliver basic care to our patients. The speciality tissue viability team have an increased presence in both ED's and escalation areas to support clinically and educationally and ensure all patients have had a risk assessment and are placed on a pressure relieving device. The Trust has now purchased repose trolley mattress toppers and these are now in place in both departments. A revised and quicker risk assessment is being trialled in both ED's.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where high risk patients are cared for. Ward leaders, Matrons and Therapy teams are on the floor supporting ward teams, increasing oversight that risk assessments for pressure areas, falls and nutritional requirements are completed and reduction strategies are being used. The teams actively promoted the national "stop the pressure day" on the 17th November.

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.	Jul-22	Aug-22	Sep-22	Oct-22
Harm Events	W4		IPC: CDiff Infections		6	13	9	18	13
	W4		VTE Assessment Compliance		95.0%	92.4%	92.4%	94.0%	
	W4		Serious Incidents Breached		0	99	52	21	16

IPC: C diff Infections

The Trust remains above trajectory to achieve the external threshold for 2002/23. 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 currently and historically above the national rate for these cases. Each hospital onset case is investigated using a Root Cause Analysis to identify learning. No cases of transmission have been identified in the reporting year to date, nevertheless existing infection prevention measures are being reinforced.

VTE Assessment Compliance

While VTE compliance remains below threshold and is driven by underperformance 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. There is currently no data for October 22 due to an upgrade to the data collection system.

Serious Incidents Breached

Over the last four months there has been significant improvement in the number of breaches. There are currently 16 SIs that have breached, and they are all within Maternity Services. Of the sixteen cases there are two historical cases which have been reopened and which will be removed from this list as they are undergoing an adapted process. Two of the remaining fourteen cases breached in October 22 and there have been no further breaches since. It is the expectation within the Maternity Services that there will be no further breaches. For the remaining breaches all of these reports apart from two, have been completed and all of them are will either being signed off at the MDT meetings on either the 18th, 21st, 25th November 22, or with the Care Group for Action planning and local sign off.

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 population health work with the HCP early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
61.8%	61.3%	59.6%	59.6%	60.1%	60.1%	61.1%	59.2%	59.5%	58.8%	58.3%	56.4%

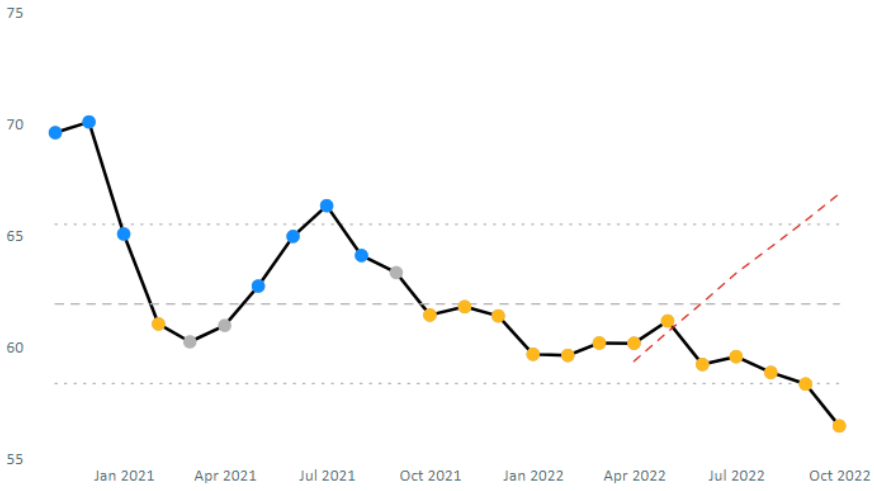
F — Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

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 EKHUFT have reduced 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 78w waits which, as at the end of October, were reduced to 380. The deterioration in performance in October for the 18w standard is due to the volume of patients in month waiting in excess of 18 weeks for a first out patient appointment.

Intervention and Planned Impact

- Outpatient waiting lists continue to grow – The Trust is targeting areas of transformation to improve this element of the service. The Trust is working with the Kent and Medway System Team to develop a new approach for managing referrals in 2023/24.
- 104 week breach position has reduced from 34 in April 2022 and is now 9 as of September 2022 (due to patient choice and Covid); this risk of 104w breach is reducing rapidly as EKHUFT are treating patients earlier in their pathway to minimise the risk of the 7 week delay should a patient test positive.
- 'Super weeks' have been scheduled for orthopaedic elective surgery with a planned extension to other specialities to support the 78 week recovery plan.
- DNA rate in outpatients has reduced from 11% to 7.8% and focussed work continues to increase the volume of patients fully booked to improve the DNA rate further.
- Increasing volume of patients are accepting transfer to alternate providers across East and West Kent for elective assessment and/or treatment.
- Recruitment of Theatre Operating Department Practitioners, Administration Booking Staff and Radiology Staff remains a key priority to enable the recover of our outpatient, diagnostic and elective services.
- Improving the efficiency and productivity metrics across all diagnostic and elective services continues to be key feature in our recovery journey.

Risks/Mitigations

- Winter planning initiatives to maintain elective and diagnostic are a key priority for the Trust.
- The Trust continues to reduce waits for admitted care.
- In order to mitigate the risk of an elongated outpatient pathway, there is a focus on transformation and innovation. This includes work to improve the advice and guidance and patient initiated follow up metrics.

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.

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

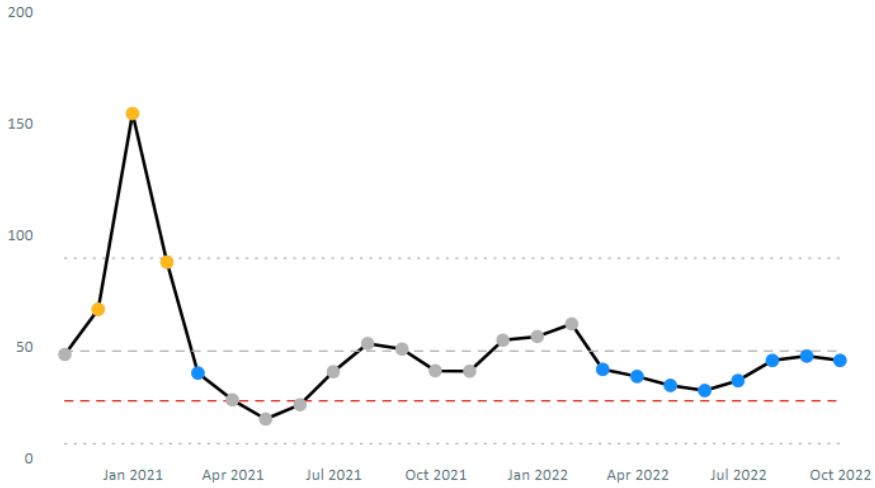
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



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 slight improvement in our performance; this is particularly positive in light of a sustained pressure on the emergency/inpatient pathway with all services facing increased demand and changes to the bed base.

Intervention and Planned Impact

- Elective Orthopaedic Centre (EOC) has focused on increasing productivity by holding a multidisciplinary 6-4-2 booking meeting. This has improved both booked and actual performance. The planned booking for the EOC has increased during the month from 87.7% to 93.5%. The actual performance has improved from 81.4% to 87.8%.
- Implementation of 6-4-2 booking commenced from 3rd October which enable specialities to focus on booking ahead to maximise opportunity and improve patient experience.
- To facilitate further improvement there are a number of measures that have been implemented, with further actions:
- The Trust is optimising scheduling opportunities with the booking teams. This includes awareness of individual targets and discrepancies between planned and actual utilisation. October booking performance Trust-wide was 87.6% which was an increase of 0.5% on last month. Actual theatre occupancy was 79.4%.which was an increase of 1.3% on the previous month.
- Late starts were a focus for General Surgery in September where it was identified that delays were due to ITU bed confirmation. The action was to add a small case first on the list; as a result there has been a 1% improvement in October.
- Urology and General Surgery are focusing on creating standby patients to reduce cancellations on the day by increasing pre assessment pool.
- 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.

Risks/Mitigations

- Theatre staff shortages continue mainly at WHH Active recruitment is on going.
- Daily review of staffing across all sites to mitigate reduction of lists.
- Theatre Business case (pending CEMG approval) would provide increased substantive 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.

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

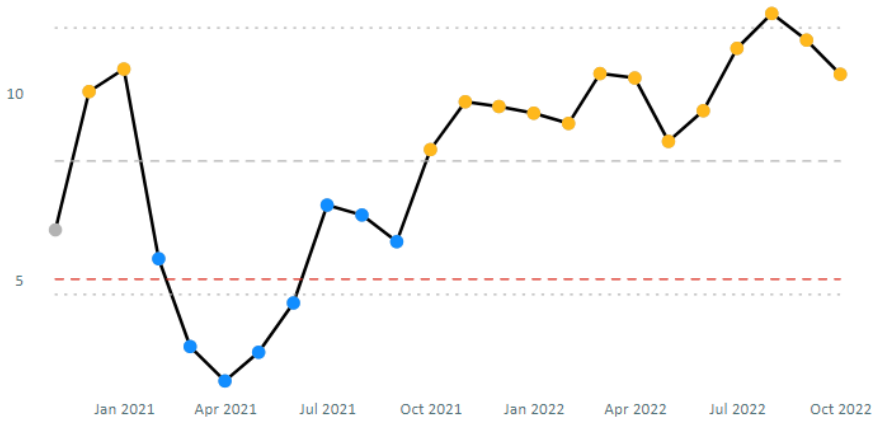
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The new national standard is for no more than 2% of patients to spend longer than 12hrs in the emergency department, from arrival to admission, transfer or discharge.

The number of patients reported as waiting more than 12 hours in the Trust's EDs saw an improvement in October (10.5% in Oct v 11.4% in September).

The 12 hour trolley wait numbers have reduced in October to 1,028 v 1,126 in September.

There were 29.7k attendances (all types) in October, the highest number recorded over the last 12 months with the number of DTAs in the departments waiting for beds was also the highest (ave. 55.4) reported in the last 12 months. The number of >21 days for October was 291 v 283 in September, again the highest number of cases recorded in the last 12 months.

Intervention and Planned Impact

The key interventions below key aim is to improve the total times in ED, through the development of direct access pathways:

- The UEC improvement delivery plan is focussed on enhancing and developing pathways to reduce patients attending the ED and includes the enhancement of the SDEC model. This work includes both the acute and the community
- SECAMB/111 pathways to support the direct access to the right service first time.
- Front Door Frailty service – implementation of a roving model to support the frailty cohort across the front door over winter whilst an established dedicated unit can be released once the ED build has completed.
- The Internal Professional Standards, launched earlier this year are being supported and monitored via the UEC workstream programme to support timely access to decision making from clinicians, reduce waits for referrals and response to impact positively on the overall total time in ED.
- Children's ED (CED) - Paediatrics will be providing an extra Night Paediatric Registrar to support the waits for children in the CED waiting to be seen/for decisions to reduce the overall total time in ED.
- Mental Health have commenced a pilot in November to provide a front door assessment nurse to support suitable patients direct to alternative services.

Risks/Mitigations.

- A review of all the areas across the EDs was completed in October with a paper to EMT to approve the use of the SAL lounge as a dedicated area for patients who are managed within a 'ward type environment'.
- Identification of space to support the mental health safe haven initiative.

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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
2,288	2,017	2,144	1,940	2,302	1,945	2,076	1,972	2,032	1,793	2,007	1,909

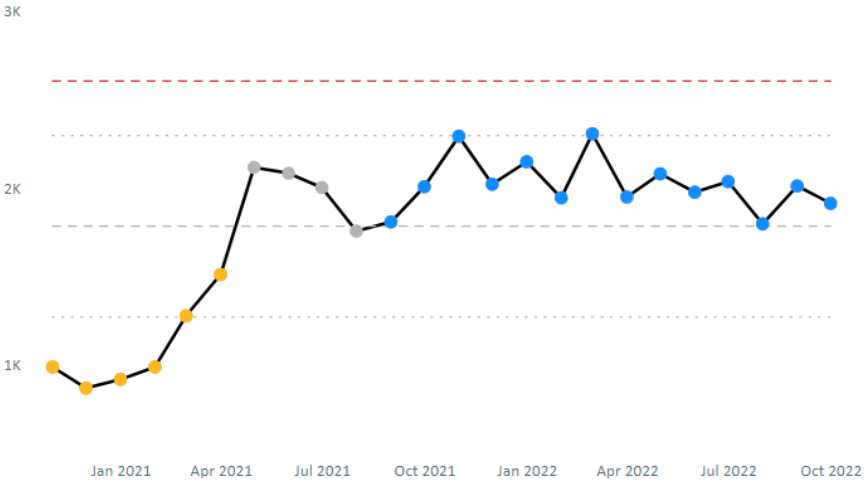
Variation indicates consistently falling short of the target

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 a decrease in the number of attendances in October 2022 (1,909 v 2007 September 22). SDEC remains an area that is not used for escalation inpatient beds . The principle of using the same day emergency care space for direct access and same day care exclusively enables patient access and flow to be maintained. 75% of patients who use the SDEC service are not admitted.

Intervention and Planned Impact

- The Direct Access Pathway/SDEC workstream, is working on delivering an extended SDEC model for winter Patients with long term conditions attending ED require the support of an integrated approach with community clinicians and acute hospital specialists. This opportunity is being developed as part of the winter planning programme with KCHFT.
- Using the Acute Emergency Care (AEC) directory and analysing further opportunities to increase numbers through the SDEC medical pathway has been completed and plans are in progress to extend the WHH SDEC to 23.00 hours 7 days a week from the 1st December.
- Work in place to review the changes to the hours of the QEQM service to maximise the opportunity for more patients to access the service.
- Due to the OPEL 4 status at WHH, the extended hours SDEC model has been delivered from the 14th Nov. Tracking and monitoring of activity and benefits in place as part of the wider UEC workstream
- The creation of 4 'Hot Slots' for referral into SDEC the next day commenced from 14th November. The aim is to provide the ability for clinicians to discharge patients who attend out of hours to return to a booked slot the next day. Monitoring is in place.
- Integrated SDEC pathways pilot commenced in October for 111 to direct SECAMB to ensure patients can access to the SDEC service. The aim is to increase the slots to maximise the use of the ambulatory pathways
- Work progressing on the development of the Medical Day Unit at Canterbury to realise further opportunity to manage more patients from across the sites reducing the impact on capacity.
- The focus for this month is to extend SDEC at WHH until 23.00 hours 7 days a week 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. This is highlighted in the winter plan

Risks/Mitigations

Maintain non admitted pathway in SDEC areas and increase opportunity for access to meet demand

- Work is in progress to scope out the QEQM SDEC service to move the hours of service from 08.00-17.00 to 10.00 -20.00 to manage a wider number of patients identified for the ambulatory pathway
- Review of the streaming function at the front door – work commenced to develop processes to directly send patients to SDEC , bypassing the ED.

Our patients

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.

Rebecca Carlton

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
84.3%	78.0%	75.6%	71.0%	74.5%	66.1%	61.7%	73.2%	78.0%	71.7%	65.8%	65.2%

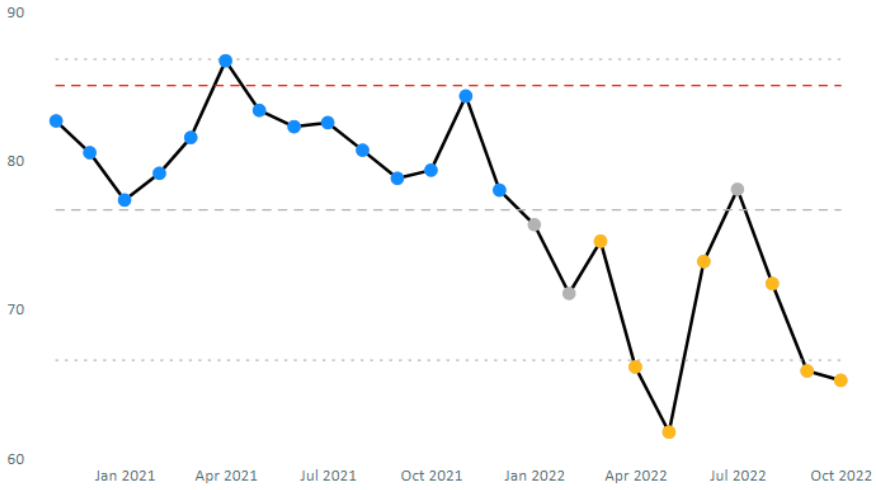
Variation indicates inconsistently passing and falling short of the target

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

Performance has reduced in October with a lower number of overall treatments than the previous months and higher number of breaches treated in month. An increase of 10% in the referrals for cancer services has resulted in a 5% decrease in performance at 62 days. The Trust remains in the top 3 performers nationally for 2 week wait access.

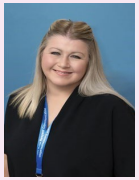
Intervention and Planned Impact

- Due to reduction in performance and competing challenges for all tumour sites, new daily/weekly early escalation implemented, with lead CNS's involved to ensure prioritisation of most vulnerable patients and greater support and guidance.
- 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 pathways have been contacted to ensure they are fully supported and are aware of next steps. The total number of patients waiting for treatment has reduced.
- 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. A new pilot is due to start to secure faster chemotherapy prescribing and reduced risk/stress within teams.
- Lower GI straight to test (STT) implementation continues with PGDs for bowel cleansing approved end of September. Faster Diagnosis Manager has commenced escalation meetings with the endoscopy booking team, along with clinical support and nursing lead. qFIT project facilitator to discuss complex patients and improve booking times.
- Lower GI Pathway reduced to 1,000 waiting from 1,500.

Risks/Mitigations

- Delays to diagnostics booking remains a risk due to teams challenges and increased demand
- Theatre capacity and skill set for Urology, Head & Neck and Lower continues to be a risk
- Tertiary capacity for diagnostics and treatments remains challenging, working with the Alliance to support improvements.

Our patients



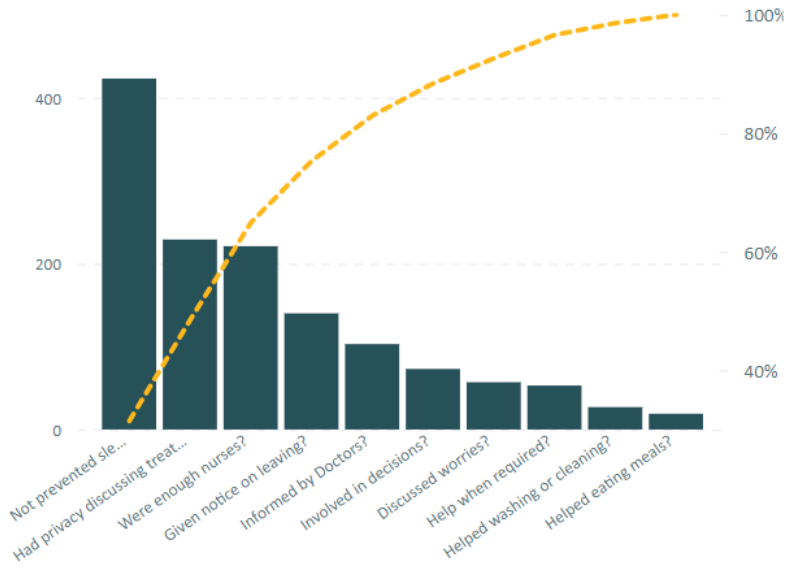
Sarah Shingler

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 - Oct 22



Stratified By	Num	Den	Value	Thresh.	Pareto Value	Pareto
Not prevented sleeping by noise?	911	1,334	6.8	7.7	423	31.4%
Had privacy discussing treatment?	1,187	1,416	8.4	7.7	229	48.5%
Were enough nurses?	1,228	1,449	8.5	7.7	221	64.9%
Given notice on leaving?	776	916	8.5	7.7	140	75.3%
Informed by Doctors?	1,288	1,391	9.3	7.7	103	83.0%
Involved in decisions?	1,297	1,370	9.5	7.7	73	88.4%
Discussed worries?	1,332	1,389	9.6	7.7	57	92.6%
Help when required?	1,376	1,429	9.6	7.7	53	96.6%
Helped washing or cleaning?	1,088	1,115	9.8	7.7	27	98.6%
Helped eating meals?	841	860	9.8	7.7	19	100.0%

What the chart tells us

There were 1,459 patient Experience surveys completed in October via Tendable across 52 wards, this failed to meet the target of 2,050. 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 across the Trust inpatient wards. The accreditation team are supporting ward areas who are not currently reaching their target of 50 surveys per month and this is monitored daily for each site. 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 have been implemented to counteract the noise disturbances at night with the frontline teams. The guidelines for ward night duty staff have been produced and ratified at the FOC committee and 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. Procurement have shared the order number for these items to all areas. An in-patient information booklet has been developed and ratified to help meet expectations whilst in hospital and provide information in the flow of a ward over a 24 hour period. The dementia working group have contributed 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 from the inpatient questions. The finalised booklet is being sent to the printers w/c 21st November.
The Head of Patient Voice and Involvement is working with the Associate Director of Nursing for Quality and FOC. An anticipated key role of the patient volunteers and champions will be to support the wards in the completion of the surveys but currently this has been placed on hold due to a challenge with information governance and access to tendable without an NHS email. A patient champion/member of the public has now joined the monthly FOC committee and it is hoped they will become a regular and active participant.

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.	Jul-22	Aug-22	Sep-22	Oct-22
Cancer 62d			Cancer 2ww Performance		93.0%	95.5%	94.6%	95.7%	95.7%
	W4		Cancer 28d Performance		75.0%	67.7%	68.3%	68.0%	69.9%
	W4		Radiology Diags vs Plan		Traj.	17.6K	17.7K	17.5K	18.5K
	W4		Endoscopy vs Plan		Traj.	1,419	1,439	1,309	1,396
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	480	448	396	380
	W4		DM01 Compliance		75.0%	70.1%	65.8%	64.0%	65.1%
	W4		RTT OP Booking Breaches		14,000	24.3K	26.6K	27.2K	27.0K
	W4		OPA vs Plan		Traj.	71.1K	71.9K	75.0K	71.8K
	W4		Elective Admissions vs Plan		Traj.	8,502	9,200	8,827	8,493
ED Compliance	W4		ED Compliance		90.0%	68.1%	65.0%	68.1%	68.8%
	W4		Clinician First Seen within 1h		50.0%	40.2%	42.0%	48.4%	45.3%
	W4		A&E Atts vs Plan		Traj.	23.9K	22.0K	22.1K	24.1K
	W4		Unplanned Re-attendance ED		10.0%	14.5%	14.1%	14.2%	13.7%
	W4		Super Stranded >21D		107	247	271	283	291
			Pathway 0 Patients >7 Days		Sigma	139	135	134	149
	W4		NEL Admissions vs Plan		Traj.	7,184	7,097	6,691	6,629

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	68.8%	84.0%	62.0%	73.2%
Cancer 62D	*65.8%	*73.6%	*85.7%	*71.2%
DM01	65.1%	89.9%	77.9%	84.3%
18w RTT	56.4%	66.4%	61.5%	69.7%

RTT 18 Weeks

In all three categories of wait the Trust is seeing improvement and a reducing admitted patient waiting list. The Elective Orthopaedic Centre is applying for Elective Surgical Hub accreditation and will aspire to meet the best practice standards set out by the GIRFT programme. Planning is in progress to have super surgical weeks underway that will support increased throughput of admissions.
DM01, with focus on the most challenged diagnostic services, continue to optimise capacity where workforce allows.
Focus to improve the volume of patients scheduled for first out patient appointments continue, through reducing DNA and cancellation rates with further focus required to increase the utilisation of clinics where we are seeing short notice cancellations.

ED Compliance

A gradual improvement is being seen, a focus is on driving up the UTC performance at the WHH where it has been below the 95% target since March 2022, and often below 90%. A UTC improvement plan is in place and being monitored weekly within UEC.
The system Summary Acute Provider Indicator Table (SAPIT) data shows that for both hospitals in EK the percentage ambulance arrivals against attendances is above 28% and indicated high against our system partners.
The dwell time in ED against the 4 hour standard reports a mean time of 3.5 hours for non-admitted patients (an improvement against the previous month of 3.7 hours) and 25.4 hours for admitted patients (a deteriorating position against September 22.1 hours).

Unplanned reattendance

The adjusted number when planned activity is removed is less than 10%. The BI team are automating this activity to reflect in the dashboard. For clarity, the reattender categories are:

1. Patients who arrive in ED and then are streamed to UTC who are recorded by the IT system as two episodes on the same day (about 3%)
2. Patients who return for diagnostic results but attend the ED and not a speciality pathway, impact current unknown.
3. Frequent attenders (3 or more attendances) who are managed by the frequent attender program (these few patients are a disproportional impact on our performance, again impact unknown).
4. Those who attend within 7 days but for a different reason.

Super stranded over 21 days

In response to increased pressure we have introduced patient by patient review with key decision makers and enablers from within the Trust and from our community partners.

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.	Jul-22	Aug-22	Sep-22	Oct-22
FFT	W4		FFT Maternity Response Rate		18.0%	13.8%	13.4%	7.7%	16.6%
	W4		Complaint Response		90.0%	10.3%	20.3%	54.5%	18.9%
	W4		Duty of Candour - Verbal		100.0%	80.0%	75.9%	81.8%	68.8%
	W4		Duty of Candour - Written 15wd		100.0%	77.8%	64.3%	55.0%	73.7%

Duty of Candour (DoC)

With the new DoC dashboard, the Care Groups are able to monitor, on a daily basis with real time data, what elements of their DoC are outstanding prior to it breaching. There continues to be a challenge within the Care Groups in compliance with the DoC deadlines that have been set. The dashboard monitors both current DoC, Recent breaches (Since April 2022), and the Backlog. The recent breaches have significantly reduced which demonstrates that although the 10-day compliance has not improved, the breaches since April 2022 have reduced by approximately a third in October 2022. In addition, the number that are being completed within a month has also increased. It is anticipated that the November 2022 figures on compliance with be much improved due to an additional available resource. With the improved figures expected in November, confidence remains that a >90% compliance rate will be achieved in December 2022.

Complaints

During the month of October 2022, the care groups have maintained a good level of compliance, but the corporate complaints team have continued to experience a significant reduction in their staffing levels which has affected their ability to maintain high levels of managing complaints. A new starter left the role within the first week, one of the externally funded members of staff was unable to work for much of October and has now left and one member of staff has been supporting the maternity information line full time. The other factor that has impacted the compliance this month was the time Executives had to review and sign off complaints and the need to prioritise work supporting the publication of the investigation report and Maternity Services. There are currently approximately 35-40 complaints per week sent to the executive to be signed off. With the staff returning from sickness, the midwifery information line now reduced and a new externally funded support person, it is expected that compliance will improve next month.

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.

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

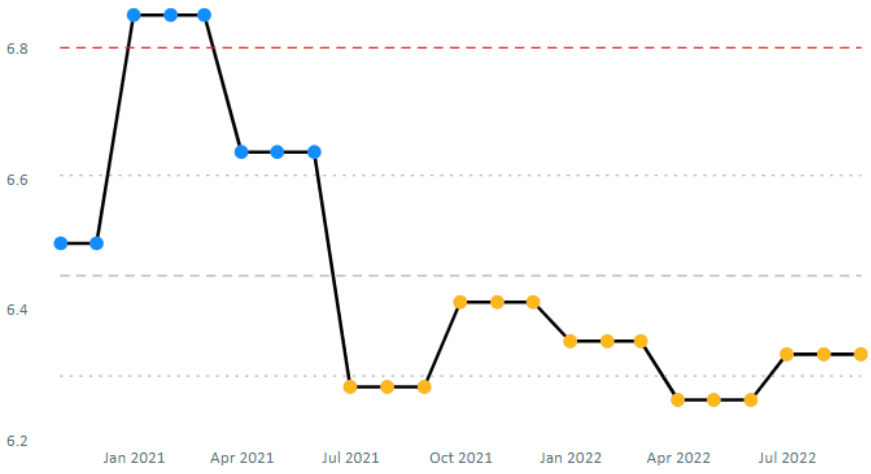
L

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 almost complete, the results of which will populate a revised Staff Engagement position. Following conclusion of the NSS on 25th November, these results will not become available until January 2023.

Staff Engagement remains at 6.33. The Trust is currently benchmarked 120th out of 187 Trusts nationally, in quartile 2 – and 0.3 from the national average (6.6).

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 was 38.2% (3,459 respondents) which is 1% ahead of the national average (37.1%).

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 (19%), Obstetrics & Gynaecology (21%) and Acute Medicine Wards (23%). By contrast, response rates are highest in Rheumatology (81%), Audiology (80%) and Medical Physics (79%).

Risks/Mitigations

The timing of publication of the investigation into our maternity services has impacted on the overall response rate, with communications necessarily being directed toward the publication of the report. The response rate appears to be similar to MTW (37%) and Medway (32%), but is about 7% behind last year at the same time-point despite tracking ahead until this time. There is a risk that the report also has an impact on all of the NSS results, specifically advocacy and therefore engagement.

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.

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

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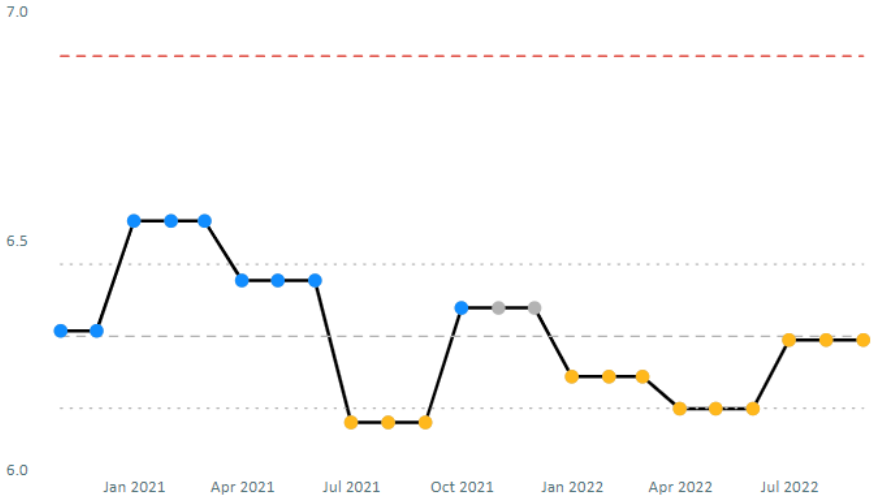


What the chart tells us

National Staff Survey fieldwork is now complete for 2022 and a new staff involvement score will be available in January 2023. Model Health indicates that Staff Involvement is currently benchmarked 109th out of 187 Trusts nationally for staff involvement. This is in quartile 2 (25-50%) and means we are <0.1 away from both the national average (6.4) and that of our benchmarked peers (also 6.4).

There have been subtle improvements against a backdrop of national decline against staff involvement. Whilst the score is improving (by 2-4% in July), it needs to do so consistently over each of the next quarters in order to achieve the desired position.

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 18 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) have completed the KENT Fundamentals programme
- The new staff intranet 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
- The Kirkup 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.	Jul-22	Aug-22	Sep-22	Oct-22
Staff Engagement	W4		Appraisals Compliance		80.0%	67.4%	69.4%	69.9%	69.8%
	W4		Safeguarding Children Training		90.0%	89.5%	88.2%	87.0%	86.2%
			Staff Turnover Rate		11.5%	10.8%	10.8%	10.8%	10.5%
	W4		Safeguarding Adults Training		90.0%	89.0%	87.9%	86.3%	85.0%
	W4		Vacancy Rate		10.0%	12.7%	13.6%	12.3%	10.9%
	W4		Staff Turnover: HCA		13.5%	14.4%	14.9%	14.3%	13.9%
			Premature Turnover Rate		25.0%	23.1%	22.9%	23.5%	23.6%
	W4		Medical Job Planning Rate		90.0%	32.9%	34.0%	31.5%	33.3%

Appraisal

Overall appraisal compliance had been on an upward trend during the last few months. As usually happens in May and June each year, the appraisal rate fell back and dropped significantly to 66% in June. However, July to October have seen an increase, with compliance at 69.8% in October. The metric is below the reviewed alerting threshold of 80%. The compliance by Care Group ranges from 89% for Surgery HNBD to 63.5% for UEC. The Corporate areas are the lowest of the groups at 54.8%. Teams are working to book appraisals in during the next two months to improve compliance. Non-compliance is highest within the N&M 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, this will now be supported through the Trust objective of Staff Involvement, which is a Driver for some Care Groups.

Staff Turnover

Staff Turnover currently stands at **10.50%.** This is below the desired threshold (11.5%) and has improved in October, falling below 10% for the first time in-month since June. Total turnover stands at just **8.28%** in-month. This has helped the largest net growth of WTE this year (n=181).

Healthcare Assistant turnover fell to 8.89% in-month in October - the lowest it has been in over a year. The HCSW headcount is now at a record high (n=1098).

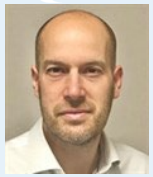
Nurse turnover remains below the alerting threshold of 10% and fell to just 9.23% in-month in October. This has now been below the alerting threshold for 10 of the last 12 months.

Vacancy Rate

The overall vacancy rate has improved, decreasing from 12.3% to 10.9% in October, largely due to an increase in nursing staff through the IEN recruitment plan and a reduction in the number of trainee doctor vacancies. There is also a rolling programme of recruitment in place for HCSW posts plus a marketing campaign supported by the East Kent Healthcare Partnership which is having a smaller positive impact on the vacancy rates.

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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
-0.996	-0.941	-0.090	1.307	0.076	-3.700	-6.624	-6.604	-7.795	-11.453	-13.015	-15.313

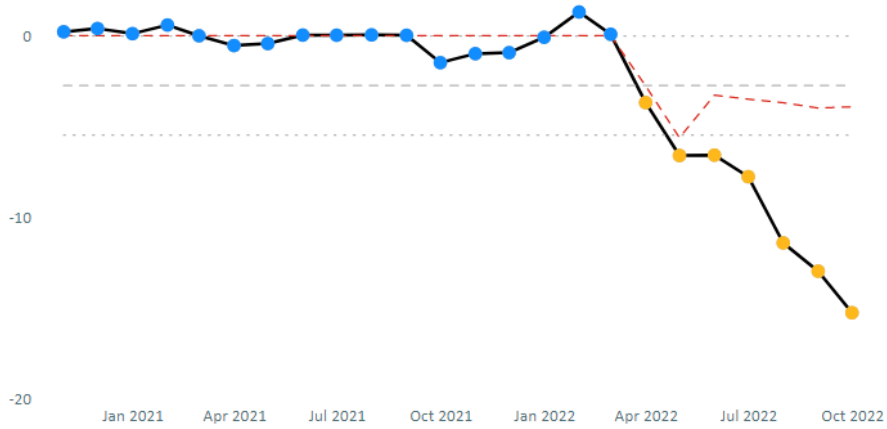
Variation indicates inconsistently passing and falling short of the target

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

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 October which is a £15.3m deficit against a plan of £4.0m deficit. The key drivers behind the deficit are: £1.3m behind plan on CIPs, £4.8m on escalation areas (additional 60 beds), £1.9m bank and reductions not seen, overspends on work permits £1.0m, drugs overspend £1m and not charging for parking £1m. The Trust is currently reforecasting the position to a potential £30m deficit in year.

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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
7,255	6,441	7,168	7,403	9,148	7,890	7,497	8,894	8,702	8,809	9,618	9,178

Variation indicates inconsistently passing and falling short of the target

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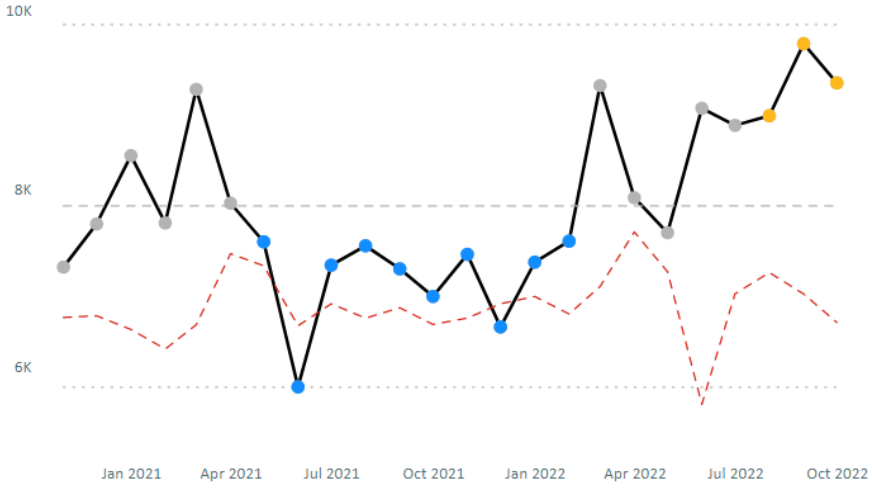
Flag Description

Two Out Of Three Beyond Two Sigma Group

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 October 2022 premium pay spend has decreased by £0.4m. The drop is mainly related to the pay award back pay being paid in September.

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

- 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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
8.06	8.60	9.55	7.65	7.97	6.12	6.63	2.44	4.22	4.63	4.11	

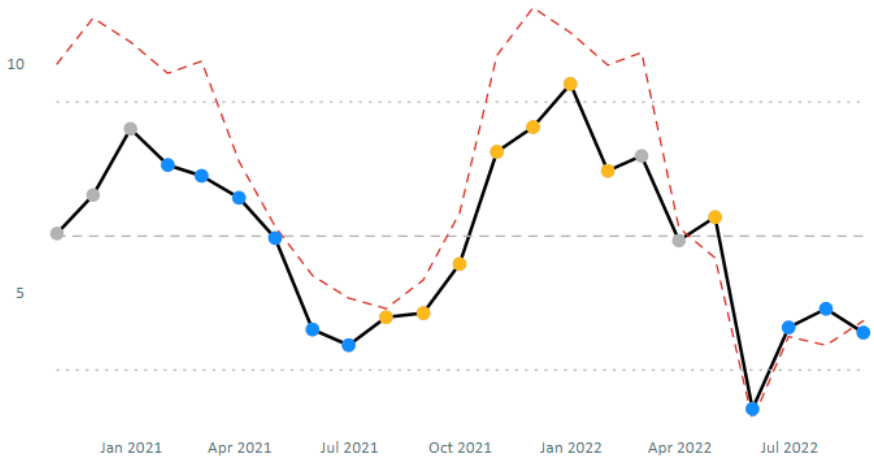
Variation indicates inconsistently passing and falling short of the target

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. The position is reporting below the monthly trajectory of 4.37 at 4.11 kgC02e per m2 and is below the same period last year (which reported at 4.53). The Trust has increased its m2 during 2022 (ie, new ITU build at the William Harvey Hospital) and this, plus the installation of combined heating and power (CHP), will have an impact on the Trust's energy usage. CHP in particular will have an impact on the amount of gas used. 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 and confirmation has been received that the bid has passed through to the second stage. 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.	Jul-22	Aug-22	Sep-22	Oct-22
Financial Position	W4		Total Pay		0.0%	-3.6%	-4.0%	-6.6%	-6.9%
	W4		Efficiencies YTD Variance (£M)		0.0	-2.7	-3.2	-1.1	-1.3
	W4		Efficiencies FOT Variance (£M)		0.0	-4.7	-6.2	-5.3	-3.4
	W4		Efficiencies Green Schemes		90.0%	32.8%	41.5%	53.6%	58.9%
	W4		I&E Monthly Variance Trust (£)		0	-315.6K	-3.1M	-1.4M	-2.4M
	W4		I&E YTD Variance (£)		0	-4.0M	-7.1M	-8.5M	-11M
			I&E FOT Variance (£)		0	0	0	0	-30M

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 £27m 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.

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

The key drivers behind the deficit are: £1.3m behind plan on CIPs, £4.8m on escalation areas (additional 60 beds), £1.9m bank and reductions not seen, overspends on work permits £1.0m, drugs overspend £1m and not charging for parking £1m. The Trust is currently reforecasting the position to a potential £30m deficit in year.

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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
332.0	346.2	314.3	320.4	336.2	351.1	352.9	354.9	402.6	385.9	358.3	362.2

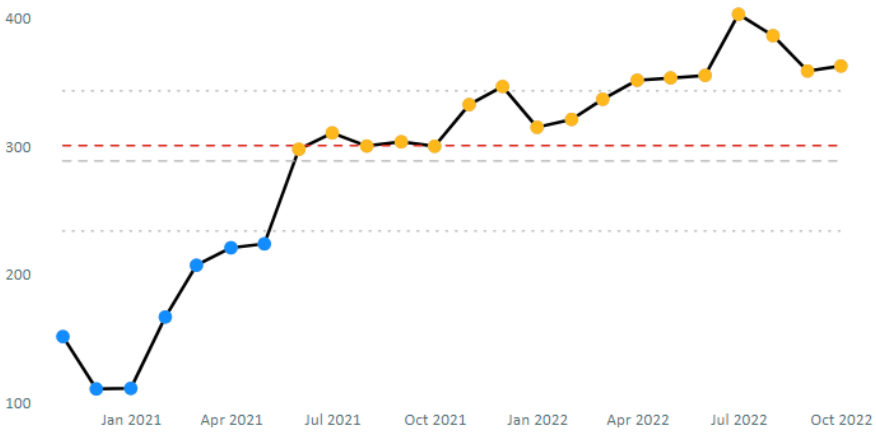
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group
Astronomical Point
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.

The SAPIT data shows EK growth is substantial in comparison to system partners in long stay patients in each category of 7, 14 and 21 day stay, with over 100% growth in 21 days for both QEQM and WHH compared to Medway with second highest growth in this area of 59%.

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.

The Trust is working with partners from ICB, KCC, RTS and Primary Care to run a multi-disciplinary discharge event. This builds on work at the WHH which involved a patient-by-patient review with key decision makers supporting patient on-going care. As part of a wider collaboration this event will cover all the Trust's hospital sites and is supported by the external improvement lead working with the East Kent system.

Our work continues with Pathway 0 patients who have onward care or rehabilitation needs to ensure we minimise these patients length of stay.

Themes from both of these reviews are influencing and shaping the Trust's evolving winter plan.

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.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
303	198	116	91	246	129	162	430	82	161	190	111

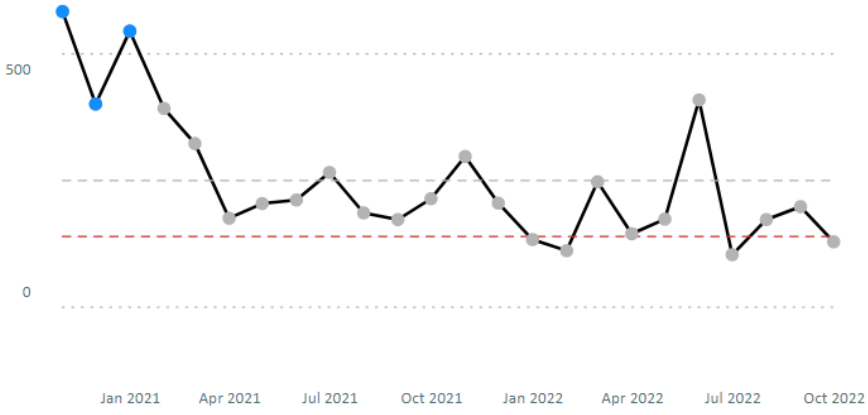
Variation indicates inconsistently passing and falling short of the target

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 October position of 111 participants is slightly below the threshold of 123. However the April – October cumulative position is 1,265 patients recruited to trials, which is above the year to date trajectory of 861 (47% above plan). A total of 10 studies opened in October (4 commercial and 6 non-commercial), which will generate additional recruits and income over the coming months. Key successes include recruitment to the MIDI project which trains a deep learning algorithm to recognise abnormalities on Head MRIs and the MINDARISE study of mindfulness in response to NHS staff. These two studies account for a third of the month's recruits. In addition, the Trust is the chief investigating site for the SILVER commercial surgical study into wound treatment, which opened in October and has already recruited 3 of the 15 recruits required over an 8 month period.

Intervention and Planned Impact

- The Trust is a member of the Trinetx (a collaborative international platform which connects Trusts with sponsors and provides real world data to investigators). The Trust attended the recent annual summit, providing the scope for EKHUFT to use global data in developing homegrown studies.
- Three new expressions of interest have been made to three big commercial studies.
- An expression of interest has been submitted to host the Central Research Network and the Trust has been successful in moving to the next stage of the process. Hosting the Central Research Network would bring significant reputational benefit and status within the region as the 'go to place' for research.
- The Harmonie trial (looking at how strongly babies can be protected from serious illness due to RSV) commences in November.
- Further studies in maternity are currently in the pipeline.

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 move to the original metric.
- Completion of East Kent data integration.

Appendix 1
Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Harm Events	W		Falls		Sigma	148	143	154	152
	W		IPC: EColi Infections		10	9	8	9	8
	W		IPC: Klebsiella Infections		6	8	5	4	7
	W		IPC: Pseudomonas Infections		3	1	2	2	2
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	232	222	216	183
	W		Medication Errors; Severity C+		1	1	1	1	1
	W		Nutrition Incidents		Sigma	47	60	60	63
	W		Pressure Ulcers: Cat 2		Sigma	40	35	30	40
	W		Pressure Ulcers: Cat 3 & 4		Sigma	2	0	0	1
	W		Pressure Ulcers: DTI		Sigma	8	11	11	7
	W		Pressure Ulcers: Unstageable		Sigma	8	12	10	15
	W		IPC: Audits Composite		85.0%	86.5%	85.7%	85.1%	86.8%
	W		Safeguarding Incidents		Sigma	18	19	21	21
	W		IP Spells with 3+ Ward Moves		Sigma	496	507	459	494
	W		Clinical Incidents		Sigma	2,237	1,995	1,876	2,116
	W		Serious Incidents		Sigma	25	14	21	24
	W		Overdue Incidents		Traj.		6,698	6,531	6,532
	W		Never Events		0	0	1	1	1
	W		Maternity Serious Incidents		2	6	1	3	6

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Mortality	W		Extended Perinatal Mortality		5.93	4.26	4.12	4.43	4.61
Staff Engagement	W		Sickness		5.0%	6.0%	5.0%	4.8%	5.5%
	W		Statutory Training		91.0%	91.9%	91.7%	91.1%	90.2%
	W		Staff Turnover: Nursing		10.0%	9.4%	9.4%	9.5%	9.7%
Financial Position	W		Non Pay		0.0%	1.8%	0.7%	0.9%	-0.4%

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Cancer 62d	W		Cancer 31d Performance		96.0%	98.3%	98.3%	96.2%	98.2%
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,652	1,718	1,626	1,646
	W		RTT 52w Breaches		Traj.	3,419	3,453	3,386	3,602
ED Compliance	W		Discharges by Midday		15.0%	13.9%	13.6%	15.1%	12.8%
	W		NEL Readmissions		15.0%	9.6%	9.7%	9.2%	8.9%
	W		Stroke Ward within 4 Hours		50.0%	55.7%	59.4%	56.0%	69.2%
FFT	W		FFT IP Response Rate		15.0%	19.2%	18.1%	20.9%	19.5%
	W		FFT DC Response Rate		27.0%	30.3%	30.5%	29.5%	29.8%
	W		FFT ED Response Rate		12.0%	14.5%	14.3%	15.1%	14.4%
	W		FFT OP Response Rate		17.0%	20.0%	20.2%	20.5%	19.2%
	W		Complaints Number		Sigma	85	72	72	67
	W		Mixed Sex Breaches		Sigma	69	46	69	108
	W		Duty of Candour - Findings		100.0%	75.0%	66.7%	50.0%	100%

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
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 incorporated into the Emergency Care Delivery programme (Same Day Emergency Care SDEC, Break Through Objective.
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022 New date Sept 2022	• Clinical Guidelines Governance Policy is fully approved and published on the Policy Centre. • Details of the Policy and Clinical Guidelines Template (contained therein) are now available on Staff Zone. • Initial specialties for MicroGuide roll-out have been approached and preparations have begun. • The use of specific document stores for Clinical Guidance and SOPs has been discussed within Trust-wide steering groups with actions to take forward.	• Further analysis of current MicroGuide Content and usage to inform roll-out procedures. • MicroGuide documents highlighted for re-location to alternative storage to be discussed with relevant specialties. • Review of clinical guidelines from initial specialties selected for MicroGuide roll-out, in preparation for upload. • Clinical Guidelines Approval Group (CGAG) Terms of Reference to be finalised following presentation at the Patient Safety Committee.
Improving End of Life Care	Sarah Shingle r	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	• Work with 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	• Project incorporated into the Emergency Care Delivery programme (Same Day Emergency Care SDEC, Break Through Objective.

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	• 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.	• Working with therapies resolving prompt mobilisation at QE • Improving alerts to trauma co-ordinators when patients arrive in ED • Working with the site teams to ensure patients are admitted to the right ward at the right time .
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	• Review the 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	• Away day with Team completed • Reviewing 12 and 20 week scanning pathway • Developed and agreed action log and working through the documents. • To schedule whole antenatal pathway work shop with lead consultants, midwives and radiology looking at Multiple births, Pre-term and Twin pathways

Appendix 2
Completed Trust Priority Improvement Projects

NHS
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
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.	Complete BAU Oct 22
Trust wide Job Planning	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	Complete BAU Oct 22
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)	Complete BAU Oct 22

Appendix 3: Glossary of Terms

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

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

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

Appendix 3: Glossary of Terms

NHS
East Kent
Hospitals University
NHS Foundation Trust

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