East Kent Hospitals University NHS Foundation Trust

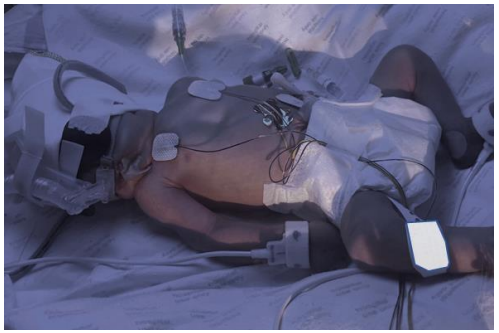
Integrated Performance Report

August 2022







We care

Our vision, mission and values

We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our focus centres on five "True North" themes. These are the Trust-wide key strategic objectives which it aims to significantly improve over the next 5 years:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**

True North metrics, once achieved, indicate a high performing organisation.

What is the Integrated Performance Report (IPR)?

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

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

We have chosen these five objectives using data to see where focusing our efforts will make the biggest improvement. We'll use data to measure how much we're making a difference.

Frontline teams will lead improvements supported by our Improvement Office, which will provide the training and tools they need. Our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

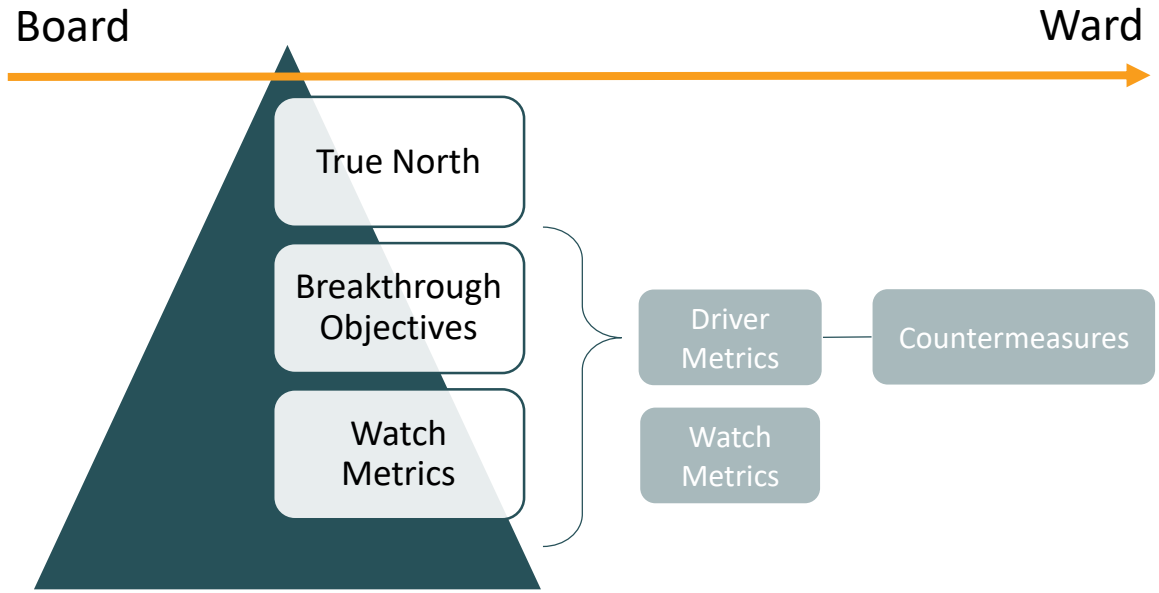
We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our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

Integrated Performance Report

IPR

Performance Review Meetings

PRM



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2022/23. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them

What are the Business Rules?

East Kent Hospitals University NHS Foundation Trust

Breakthrough objectives will drive us to achieve our "True North" (strategic) goals, and are our focus for this year.
These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen.

Metrics that are not included in the above are placed on a watch list, where a threshold is set by the organisation and monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate.

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
99.1	100.0	98.3	93.4	90.7	89.3	87.9	89.0	89.8			

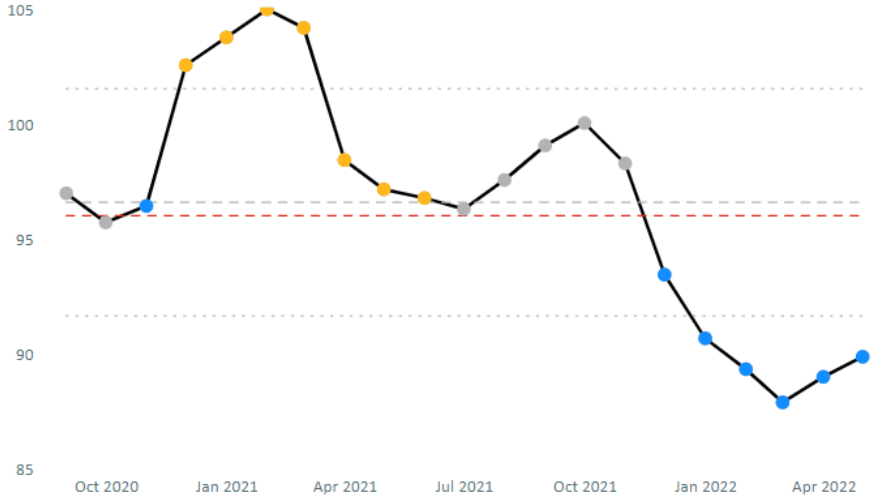
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

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

This translates into the Trust lying 19th out of the 121 acute non-specialist Trusts on the Telstra Health platform.

Intervention and Planned Impact

- The fracture Neck of Femur pathway is our focus for 2022/23 to improve outcomes for this group of patients and time to theatre had been a driver metric for Surgery and Anaesthetic Care group. A Trust Priority Improvement Project (TPIP) is underway for 2022/23 to support driving this at WHH and QEQM sites
- Current 12 month rolling HSMR for fractured neck of femur patients is 90.7 (to May 2022) and is now 'as expected'.
- Mortality metrics continue to be reported and discussed at Mortality Surveillance Group and intelligence used to drive deep dives into pathways where indicated. There were no new alerts at the time of writing this report.

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk with the national baseline not stabilised.

Our quality and safety

Sarah Shingler

Incidents with Harm

The True North target is to achieve zero patient safety incidents of moderate and above avoidable harm within 5 years. We want to reduce harm caused to patients, to improve their experience and outcomes. **Our target for the next 12 months is to reduce avoidable harm incidents of moderate harm and above to no more than 26 incidents per month by March 2023 (5% reduction).**

The breakthrough objective will be to reduce all patient safety harm incidents with a harm severity score of moderate and above, this will be achieved through the Fundamentals of Care and Patient Voice and Involvement workstreams.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
21	43	15	31	27	31	28	21	16	25	33	35

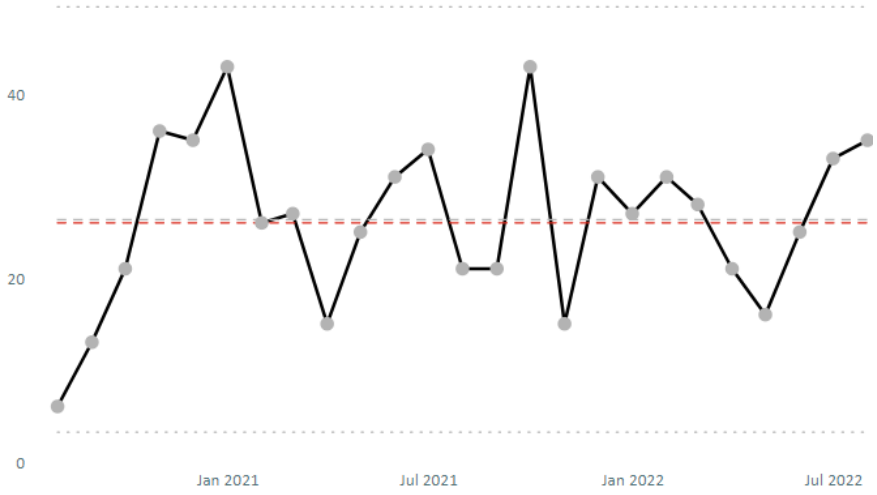
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 35 incidents in August, which is above threshold but a reduction from July. The highest contributors to harm were falls with 6 harm incidents, which was a decrease from the previous month and care/treatment also with 6 harm events. The third highest contributor was delay/failure with 5 harm incidents. This is the second month that falls are the top contributor to harm and for the last 5 months care/treatment and delay/failure have both featured in the top the highest contributors.

Intervention and Planned Impact

Safe staffing is a major factor contributing to patient harm, we are seeing a direct correlation between low staffing levels and harm and this was exacerbated in August. Our full capacity policy has continued to be initiated and we remained in OPEL 4 escalation for extended periods. Length of stay in our EDs increased and we reported significant 12 hour trolley breaches. Escalation areas continued to be utilised due to a significant high number of patients being cared for in corridors and other non-clinical areas. The inability to provide enhanced support and care to our patients was a contributory factor in most of the 6 harm incidents resulting in a fall. A deep dive has been undertaken which identified that staffing levels resulted in delays and inconsistencies with risk assessments especially in relation to the use of bed rails, inability to perform lying and standing blood pressure and general visibility of patients. However, unwitnessed falls reduced in August and the total amount of repeat fallers overall has improved (6 in August compared to 17 in July) which is a direct result of some targeted work by the specialty nursing teams who continue to have an increased presence in both EDs, escalation areas and high contributing wards to support clinically and educationally. The teams are working closely with the therapy teams to increase visibility and promote intentional rounding to ensure patients are hydrated and have their toileting needs met in a timely manner. Safe staffing escalation processes remain in place, audits are being undertaken to provide assurance that safer staffing policy is being followed, refresher training has been taking place in August led by the Associate Director of Nursing for Workforce.

The Deputy CMO and corporate governance team are supporting with reviewing care/treatment and delay/failure incidents as some of these were recorded in August but are a result of mis diagnosis and delays to treatment in patients on a cancer pathway and have resulted in a complaint or documented as a result of the SJR process. Focused improvement work is taking place in Maternity with oversight through MNAG and Board.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where enhanced care is required and could be managed with co-horting patients and increasing visibility in the bays. Ward leaders, Matrons and Therapy teams are on the floor supporting ward teams, increasing oversight that risk assessment and falls reduction strategies are being used. GSM/UEC/S&A care groups developing driver A3s for the Harm TN.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	May-22	Jun-22	Jul-22	Aug-22
Harm Events	W4		IPC: CDiff Infections		6	10	13	13	9
	W4		VTE Assessment Compliance		95.0%	92.5%	92.4%	92.0%	92.0%
	W4		Serious Incidents Breached		0	114	103	99	52

IPC: C diff Infections

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

VTE Assessment Compliance

VTE compliance remains below threshold and is driven by under performance across three out of the six Care groups impacting on this metric. Two of those care groups have seen a small improvement in month but remain below threshold and the Clinical Directors have improvement plans in place. For the third there has been an in month deterioration and this is being addressed by the new Clinical Director.

The overall compliance is sitting at 93.3% in month to date.

Serious Incidents Breached

Declared Serious Incidents (SIs) must be investigated and closed within 60 days, to ensure timely understanding of issues, address gaps and provide learning to avoid repeated incidents. There has been a significant reduction in the number of serious incident breaches, and there is a plan to close all remaining breaches by October 22. Additional support to write reports has been secured, and many reports are open but have been submitted to the ICB. All Care Groups closed a majority of cases, with GSM and UEC, previously the biggest contributors, reducing to under 10 breaches each this month. Women's health remains challenged and additional support has been provided.

Regional IPC position: Cdiff

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

Target/Trust	Apr to Aug 22	Threshold 22/23	% of Threshold to date
D&G	22	21	105%
EKHUFT	54	82	66%
MTW	41	62	66%
Medway	20	34	59%

Our patients

Our patients

Rebecca Carlton

Trust Access Standards: 18wk Referral to Treatment

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

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the 'sustaining access' Strategic Initiative early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
63.3%	61.4%	61.8%	61.3%	59.6%	59.6%	60.1%	60.1%	61.1%	59.2%	59.5%	58.8%

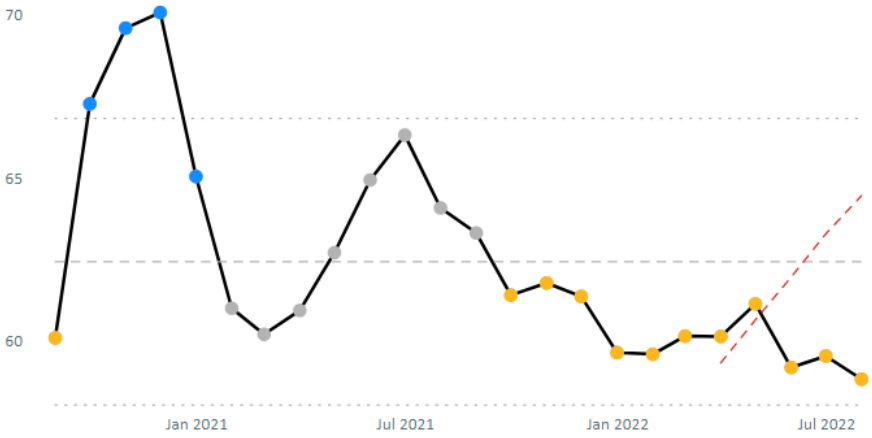
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

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

Intervention and Planned Impact

- Focused recovery actions in ENT and Urology are showing positive improvements in the volume of patients dated who are waiting longer than 78 weeks for treatment.
- Enhanced recovery actions have been implemented in General Surgery and Orthopaedics (with bespoke actions to increase the productivity within the Elective Orthopaedic centre).
- Non-admitted PTL validation commences in September focusing specialities who have the greatest volume of undated patients in out patient pathways to ensure patients receive a first out patient appointment date as a priority.
- DNA task and finish groups implemented in outpatients and radiology, utilising health inequality data, to maximise patient engagement and reduce wasted activity.
- Cardiology diagnostic (ECHO, CT Cardiac and Cardiac MRI) demand and capacity modelling completed with short, medium and long term recovery plans articulated.
- 104week patient breaches are still featuring in our admitted position but this is due to patient choice, treatment delays due to patients having COVID and patients returning to EKHUFT from Independent Sector Providers not treated.

Risks/Mitigations

- Theatre workforce constraints remain the greatest issue effecting care groups ability to run their theatre sessions aligned to their activity plans. Late cancellations of theatre lists due to insufficient staffing levels, particularly at WHH, remains a risk to our activity plan recovery in quarters three and four.
- A revised theatre timetable has been launched, commencing in September, aligned to care groups with the greatest volume of 78 week breaches/risks.
- A new Theatre Optimisation Group has been established, reporting to the Elective Delivery Group to improve the performance of our theatre suites trust-wide.

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.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
48	39	38	52	54	60	39	36	32	30	34	43

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Common cause (no significant change)

Flag Description

No Special Cause Flags

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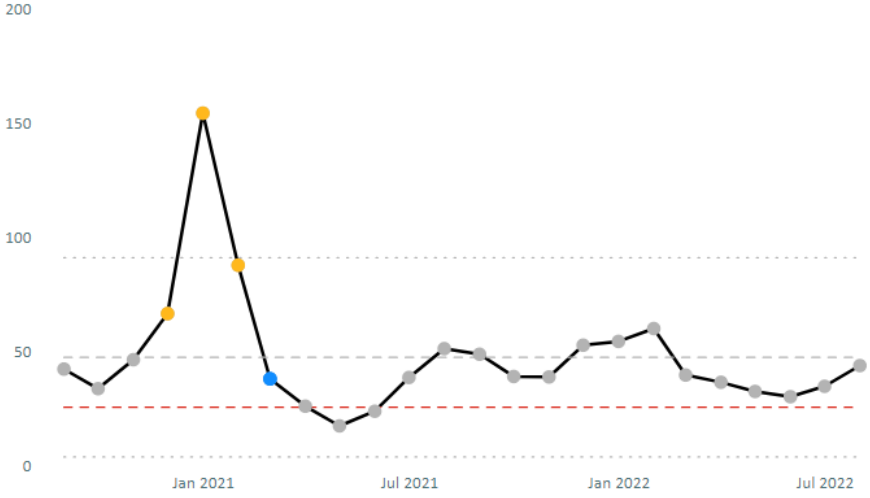

What the chart tells us

Current performance shows an opportunity of 43 sessions which is an increase. Cancellations on day also had a slight increase from 147 in July to 167 in August.

Intervention and Planned Impact

Utilising all of our available theatre sessions and returning to pre-covid cases per session (2.8) will enable us to treat more patients and reduce waiting times for patients waiting for surgical treatment. The current cases per session is at 2.3.
To facilitate this there are a number of measures that have been implemented, with further action required:
We are optimising scheduling opportunities with the booking teams. This includes awareness of individual targets and discrepancies between planned and actual utilisation; August booking performance at 85.2%, with actual theatre occupancy at 78.4%.
The 2022/23 elective activity plan has been translated into weekly sessions required, and has been used in the development of the revised theatres timetable which went live on 5th September. As such, theatre time will be proportionate to the activity required by each speciality.
The theatre staffing business case will be presented at CEMG in October, recruitment at risk is underway.
The theatre optimisation group was established in August and meets fortnightly and is drawing up plans and SOPs regarding Implementation of 6:4:2 and theatre utilisation meetings, led by the Surgery & Anaesthetic Leadership team.
There has been a focus on aligning sub specialities within orthopaedics to the theatre timetable and an away day with the consultants has concentrated on work to increase cases per list and efficiencies through the Elective Orthopaedic Centre.

Risks/Mitigations

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

Our patients

Rebecca Carlton

ED 12h Total Time in Department

There is a nationally proposed new set of Emergency Department Access Standards which will focus on 12 hour Total Time in Department. This measures from arrival to either discharge, transfer or admission.

ED performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
6.0%	8.5%	9.8%	9.6%	9.5%	9.2%	10.5%	10.4%	8.7%	9.5%	11.2%	12.1%

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Astronomical Point
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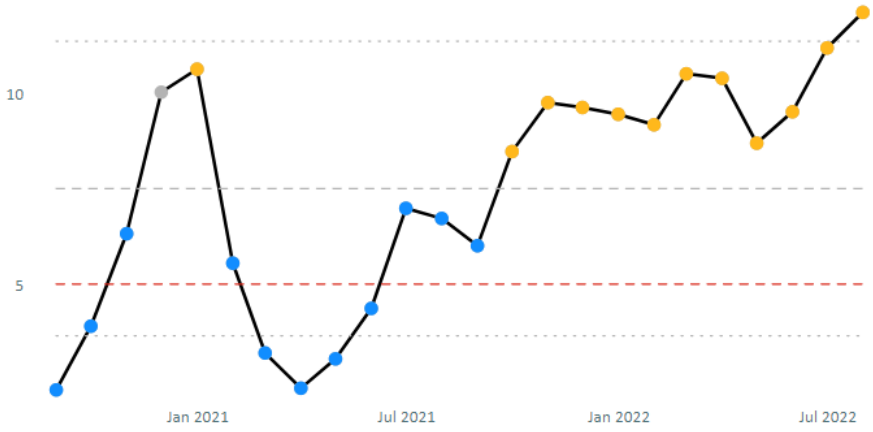


What the chart tells us

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

The number of patients reported as waiting more than 12 hours in the EDs saw an increase for August (12.1% v 11.2% in July) with a corresponding increase in the number of DTAs in the departments at 08.00 hours each day. This deterioration has been driven by a corresponding increase in the number of patients over 48 hours in the AMUs; increase in the medical outliers (64 Aug v 53 July): bed occupancy 103% and patients over 21 days increased to 271 v 247 in July. Overall time to see clinician in ED improved despite the pressures within the department (42.1% v 40.2% in July)

Intervention and Planned Impact

- The refocus of the SDEC services has a planned clinical summit on the 29th September to agree the medical model (Road Map) and use the intelligence data to understand the opportunity to optimise this pathway across all sites. Direct Access Pathways including acute medicine, surgery assessment pathways will form part of the discussions with the clinical directors.
- The 'Amber Pick' pilot commenced in September 2022 with a focus on a pull model to increase use of the SDEC. This will be monitored and reported through the Emergency Care Board. The number of patients reported through the SDEC services deteriorated in August to 1,875 v 2,032 in July . The focus is to increase throughput to SDEC as part of the winter plans, undertaking a capacity and demand analysis to ensure the service serves the greatest number of patients combining the integrated service development. System partnership work on supporting the complex patients discharge pathway in place with a focus on the development of Virtual clinics, step/down community capacity , integrated SDEC. As part of the daily rhythm, the OCC will undertake a daily review with the ward teams on all pathway zero patients to support earlier safe discharge

Risks/Mitigations.

- The OCC WHH commenced a pilot to align operational delivery focus to clear actions from the teams representing the groups to better support whole hospital responsiveness to improve patient flow
- The WHH triumvirate to undertake a review of all the patient areas across the EDs using the National Sit-rep guidance to maintain ambulance off load times and ensure the environment for patients is safe. Findings and Recommendations to be taken to CEMG

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.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
1,804	2,003	2,288	2,017	2,144	1,940	2,302	1,945	2,076	1,972	2,032	1,875

F

Variation indicates consistently falling short of the target

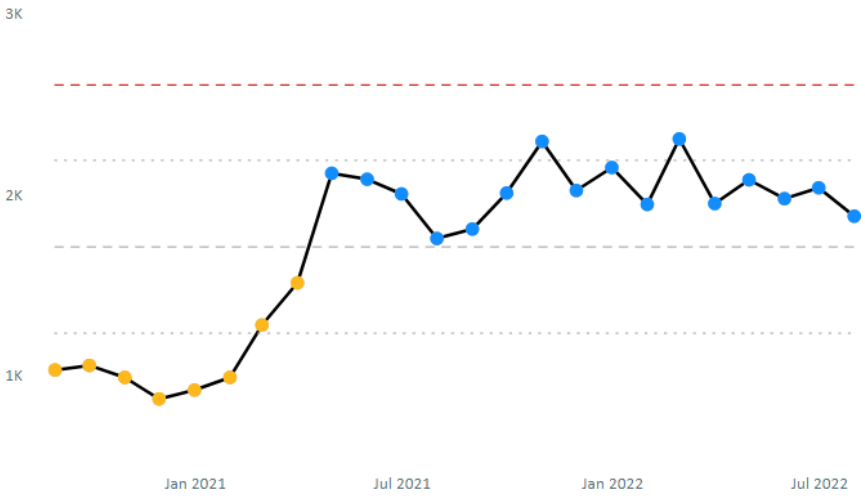
H

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

Flag Description

Above Mean Run Group

XMR Run Chart



What the chart tells us

The SDEC activity across all services deteriorated in August 2022 (1875 v2032 in July), with Paediatrics reporting 116 seen in August v 181 in July. Medicine also reported a reduced footfall accessing the service (73% against the activity seen in March 22) though remains above trajectory with no deterioration in the % of patients discharged. Frailty also remains above trajectory but further analysis on LoS, discharge % is to be undertaken now the QEQM has established its frailty unit at the front door in September 22

Intervention and Planned Impact

A clinical forum with clinical leads delivering SDEC was held with community partners and identified next steps to progress the SDEC services :-

- A clear ambition to work this through to fully realise the opportunity
- To consider joint SDEC models of care
- Equitable across all sites
- Planning ahead of the ED build completion
- Establish an away day with clinical leads for both SDEC/Integrated SDEC and Direct Access pathways to be planned (29th September confirmed)
    - This will provide the opportunity to agree the medical model for the alternative pathways (the road map) : BI team to present data to design the best use of the estate to develop the services.
    - Working groups to be established to agree actions to work towards the model ahead of winter (do more, right patient: right place: first time in line with the medical take plan.)
    - A review of the pilot – Amber Picks once completed end of September

Risks/Mitigations

- Current long waits in ED before accessing SDEC services – plan to develop direct access pathways for GPs to Medical SDEC – UEC team leading
- To review paediatric SDEC activity reduction with the Team to understand the drivers and work on actions to improve numbers seen through the service
- To work up the SDEC road map, evolve working groups to support the delivery plans and align with the community pathway developments for the SDEC services

Our patients

Rebecca Carlton

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patients are seen, diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
78.8%	79.3%	84.3%	78.0%	75.6%	71.0%	74.5%	66.1%	61.7%	73.2%	77.0%	69.6%

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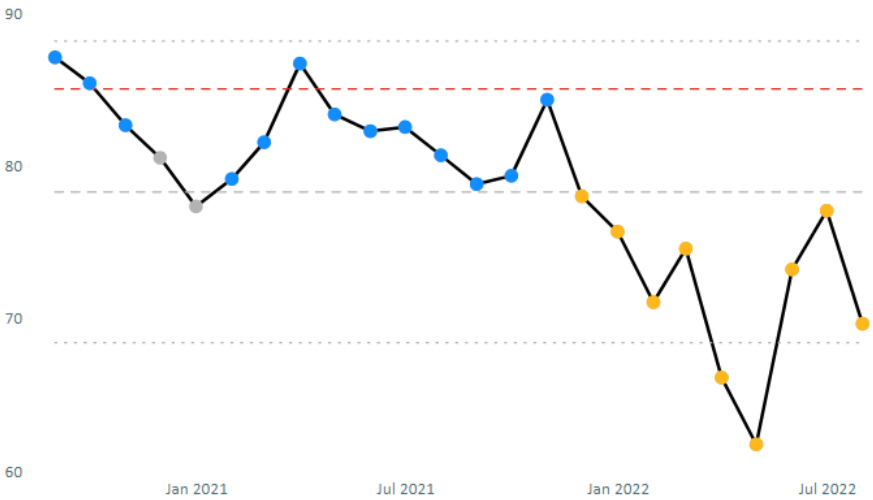


What the chart tells us

Performance has dipped in August due to increased demand, delays with capacity within outpatients, annual leave and delays with Diagnostics delays. K&M Cancer Alliance continued to record the lowest back log of all Alliances, East Kent Hospitals is the largest contributor to this.

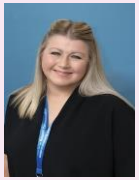
Intervention and Planned Impact

- Utilising slots at BHD Community Diagnostic Centre continues to drive improvement in the diagnostic pathway. The services are working at a patient level to ensure timely diagnostics.
- Lead Clinical Nurse Specialists are following up with patients who do not attend to support access and treatment. Contacts with patients are being monitored via the cancer reporting system, with actions including arranging transport to enable patients to access timely diagnostics across sites.
- Shared learning across tumour groups for support with 28 days and implementation of template letters to update patients where a cancer has been excluded, aiming for timely patient communication and improving compliance.
- Engagement with care groups regarding backlog of 28 day letters for patients – Urology and Gastro making significant inroads in to the backlog.
- Further development of 2ww information of trust page to support patients and their relatives on suspected cancer pathway, to include useful numbers to aid communication and support
- Exploring options to provide walk in / drop in session for patients requiring urgent cancer pathway blood tests prior to recommended investigations. Cancer and CSS care group working in partnership to develop this potential service.

Risks/Mitigations

- Radiology reporting delays have increased. MDM radiology cover consistency continues to be a risk for August and September.
- Urology surgical capacity – securing mutual aid has not been possible and teams are booking patients but significant delays remain.
- The volume of patients on the PTL who will need to access lower GI pathways and diagnostics is high and there has a sudden decrease in Biopsy capacity which has also increased the risks/delays
- Tertiary Centre delays have also increased over this period. Raised with the Alliance to help support urgent improvement.

Our patients



Sarah Shingler

Patient Experience: Inpatient Survey

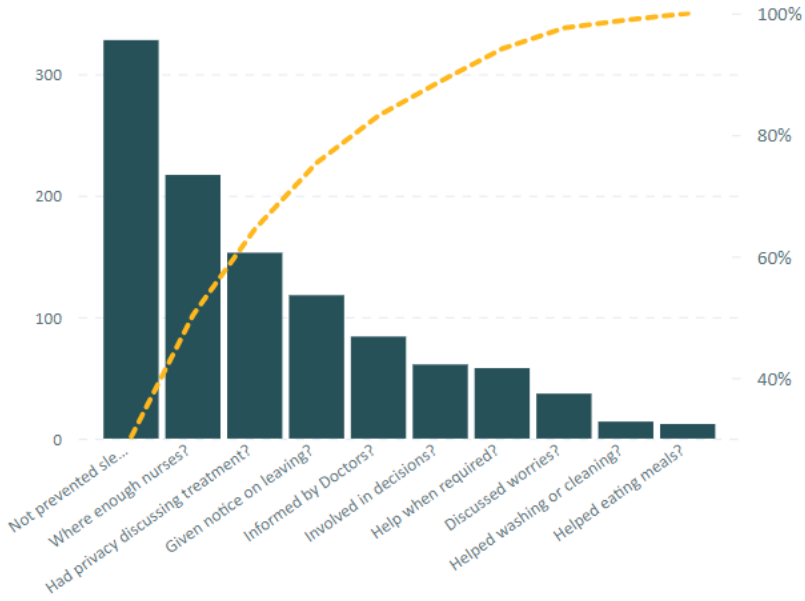
The National In Patient Survey published in October 21 (surveyed patients discharged in November 2020), completed responses for the trust were received from 515 patients (1,250 invited) with a response rate of 43%. The survey consists of 45 questions and the trust scored below the national trust average 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 - Aug 22



Stratified By	Num	Den	Value	Thresh.	Pareto Value	Pareto
Not prevented sleeping by noise?	605	933	6.5	7.7	328	30.3%
Where enough nurses?	812	1,029	7.9	7.7	217	50.4%
Had privacy discussing treatment?	835	988	8.5	7.7	153	64.5%
Given notice on leaving?	514	632	8.1	7.7	118	75.4%
Informed by Doctors?	897	981	9.1	7.7	84	83.2%
Involved in decisions?	876	937	9.3	7.7	61	88.8%
Help when required?	952	1,010	9.4	7.7	58	94.2%
Discussed worries?	940	977	9.6	7.7	37	97.6%
Helped washing or cleaning?	772	786	9.8	7.7	14	98.9%
Helped eating meals?	585	597	9.8	7.7	12	100.0%

What the chart tells us

There were 1035 Inpatient Experience surveys completed in August via Tendable across 47 wards, this exceeded the target of 750 set for August. 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 65% (6.5) score is reflecting those patients that had a positive experience.

Intervention and Planned Impact

CNMO has set trajectory over the next 3 months for all wards to be completing 50 surveys per month to achieve the 2050 surveys per month: August: 750, September 1200, October 2050. HONs and DONs 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 action plans to address poor responses. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FOC), measures are being explored to counteract the noise disturbances at night with the frontline teams. The guidelines for ward night duty are in the process of being reviewed, this will provide support to our newly qualified nurses and IENs. An in-patient information leaflet is also being developed to help meet expectations whilst in hospital and provide reassurance in the flow of a ward over a 24 hour period.

The accreditation team are supporting ward areas who are not currently reaching their target of 50 surveys per month and this is monitored daily.

The Head of Patient Voice and Involvement is working closely with the Associate Director of Nursing for Quality and FOC. A key role of the patient volunteers and champions will be to support the wards in the completion of the surveys and also support in the development of the action plans. A priority is to identify a patient champion/member of the public to become an active member of the monthly FOC committee.

Risks/Mitigations

If culture and behaviours do not change and the patients voice continues not to be heard, there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	May-22	Jun-22	Jul-22	Aug-22
Cancer 62d			Cancer 2ww Performance		93.0%	97.3%	97.0%	95.4%	94.5%
	W4		Cancer 28d Performance		75.0%	66.4%	66.1%	67.6%	67.6%
	W4		Radiology Diags vs Plan		Traj.	18.0K	17.5K	17.6K	17.7K
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	642	527	480	448
	W4		DM01 Compliance		75.0%	67.6%	69.6%	70.1%	65.8%
	W4		RTT OP Booking Breaches		14,000	22.8K	24.1K	24.3K	26.6K
ED Compliance	W4		ED Compliance		90.0%	69.4%	69.4%	68.1%	65.0%
	W4		Clinician First Seen within 1h		50.0%	39.2%	41.7%	40.2%	42.0%
	W4		A&E Atts vs Plan		Traj.	24.8K	23.9K	23.9K	22.0K
	W4		Unplanned Re-attendance ED		10.0%	13.7%	14.6%	14.5%	14.0%
	W4		Super Stranded >21D		107	221	221	247	271
	W4		Discharges by Midday		15.0%	13.6%	14.3%	13.9%	13.6%
	W4		NEL Admissions vs Plan		Traj.	7,789	7,400	7,184	7,084

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 for July as this is the latest national data available

Target/Trust	EKHUFT	MTW	Medway	Dartford
A&E 4 Hour	65.0%	86.3%	76.3%	76.1%
Cancer 62d	*77.0%	*85.1%	*82.3%	*62.3%
DM01	65.8%	*94.9%	67.4%	83.0%
RTT 18w	58.8%	*70.4%	61.9%	69.5%

RTT 18 Weeks

Reducing our backlog remains our focus which is reflected in our performance in August. We continue to receive support from our national and regional colleagues. Cardiology (ECHO/Cardiac MRI/CT Cardiac) remains the high risk area with options developed to recover in the medium and long term. Diagnostic demand is increasing generally and opportunity to enhance community provision is being considered by our commissioners.

ED Compliance

August 2022 reported a deterioration in the 4 hour performance against 68.1% for July, with a downward trajectory since May 2022.

The number of patients admitted (NEL) was 100 below the reported July position against the increased number of reported > 21 day stays (271 in August v 247 in July) overall an deterioration since May 2022.

Unplanned reattendance

August reported a slight improvement against the July data with 14% of patients reattending v 14.5% in July. Focused work reviewing data will support conversations with our primary and community service partners to ensure the service model best fits patient need. Addressing these issues would bring the Trust back in line with national average.

Super stranded over 21 days

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

Pathway 0

These are patients who have no complex needs or additional services that are required on discharge. The number of pathway 0 patients remains static despite growth in other pathways. Each hospital has now commenced medical, therapy and nursing lead 'Pathway 0' board to stem the growth of patients in this cohort and effectively manage their length of stay.

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

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	May-22	Jun-22	Jul-22	Aug-22
FFT	W4		FFT Maternity Response Rate		18.0%	14.9%	14.7%	13.8%	13.4%
	W4		Complaint Response		90.0%	5.1%	0.0%	9.2%	19.8%
	W4		Duty of Candour - Verbal		100.0%	70.0%	60.9%	51.7%	50.0%
	W4		Duty of Candour - Written 15wd		100.0%	50.0%	60.0%	48.4%	48.5%

Complaint Response

The month of August remains impacted by addressing the complaints backlog. This has resulted in continued reporting of low compliance for resolving complaints. GSM, UEC and S&A had the largest backlog, and are the highest contributors to breaches. The backlog will be resolved by next reporting period so the reported compliance is expected to achieve the 90% threshold by the following month.

Duty of Candour

Improvement in recording has not been significant over the past month as governance teams focused on addressing incident and complaints backlogs. The DoC dashboard is now complete and will be live in September. This will form the basis for the discussions between the Care Group and Corporate Governance at weekly meetings to monitor compliance. Trajectory for improvement sees >90% compliance by December 2022.

Our people


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

Our people

Andrea Ashman

Staff Engagement (score)

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

The National NHS Staff Survey (NSS) is used to give an indication of staff engagement, providing an overall Staff Engagement Index to the Trust. In order to monitor this more regularly, we are also measuring this at quarterly intervals through the National Quarterly Pulse Survey (NQPS). Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

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

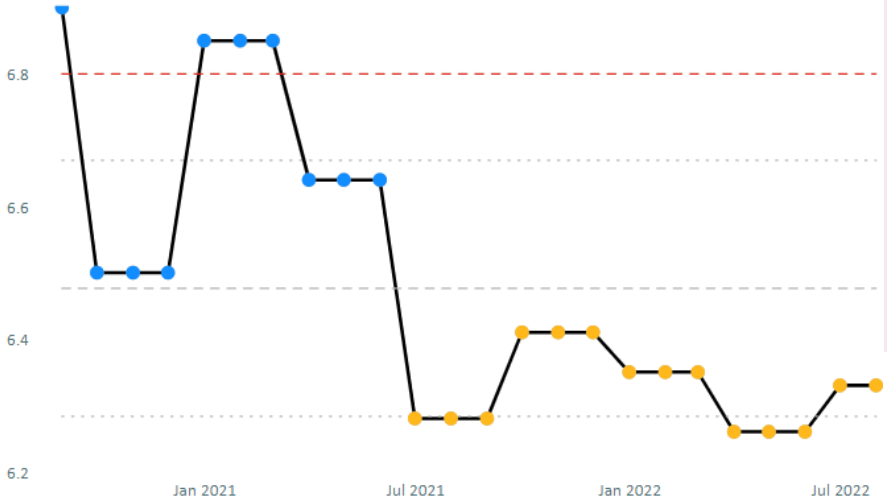
F — Variation indicates consistently falling short of the target

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

The National Quarterly Pulse Survey which took place in July showed a 7-point improvement in Staff Engagement (from 6.26 to 6.33), returning the Trust to Q4 levels. The survey demonstrated improvements in 7 of the 9 engagement questions. The 15-point improvement in involvement was quite pronounced, however responses to two questions deteriorated. This is particularly concerning as they both relate to advocacy; care being our top priority was down 1.5% and recommending as a place for treatment was down 0.6%.

Interventions and Planned Impact

Each Care Group has shared their NSS & NQPS results (from Q1). Discussions around this data and information has enabled greater understanding of challenges and areas of good practice. These have been captured through action plans which are now reported to PCC. The NQPS gives the first insight into these action plans beginning to demonstrate an impact as their focus has been on involvement – the area we have seen the most pronounced improvements (15 points) quarter on quarter.

Staff engagement has also been analysed by We Care wave to explore the impact of the programme. With the exception of Women's Health (Wave 3) which is a known outlier (5.7), the data appears to indicate that the longer an area has been involved in/embedded We Care, the better the overall staff engagement score; from 6.2 in Wave 4 to 6.4 in Wave 2 and 6.6 in Wave 1.

Plans are underway for the National Staff Survey which launched w/c 12th September. This acts as the primary barometer of staff engagement and a Comm's plan encouraging a majority response rate is in place, which should give the most accurate picture of staff engagement.

Risks/Mitigations

There is a risk that the Independent Investigation into Maternity Services Report will have a significant impact on the NSS, particularly in relation to staff advocacy. The Trust has been preparing by providing and promoting wellbeing support. We Care, TED and an interactive engagement toolkit are in-place, being developed or extended to drive staff involvement in particular as part of the True North for Staff Engagement and BTO for staff involvement.

22/23 breakthrough objective

Staff Involvement Score

The Trust'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.

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

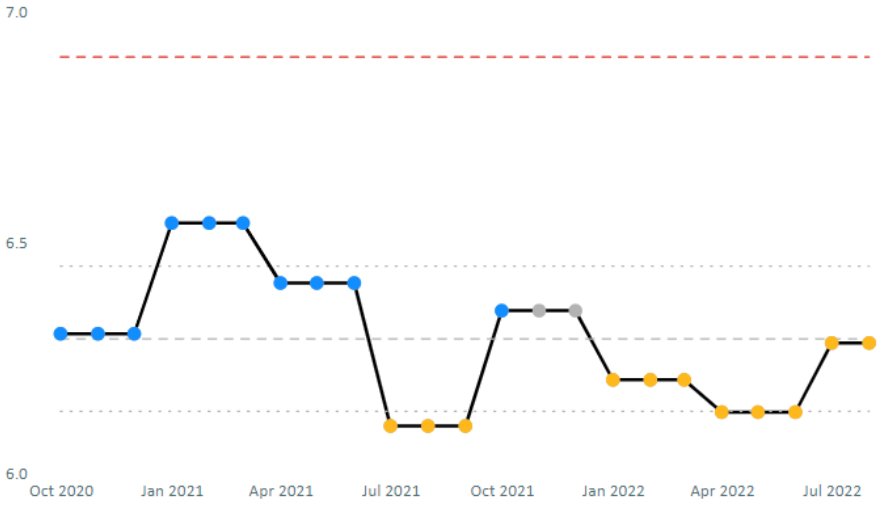
F — Variation indicates consistently falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

The National Quarterly Pulse Survey in Q2 demonstrated a 15-point improvement in Staff Involvement, from 6.13 to 6.28. The most pronounced improvement in engagement overall were seen in involvement, with each of the three related questions improving significantly as follows:

Opportunities to show initiative frequently in my role	↑1.7% to 62.2% (from 60.5%)
Able to make suggestions to improve the work of my team/dept	↑2.2% to 64.4% (from 62.2%)
Able to make improvements happen in my area of work	↑4.1% to 51.4% (from 47.3%)

Intervention and Planned Impact

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

Risks/Mitigations

- Nationally, levels of staff involvement in the NHS have been on a downward trend for the last 3-4 years and there has been a pronounced fall in recent quarters
- The Independent 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.	May-22	Jun-22	Jul-22	Aug-22
Staff Engagement	W4		Appraisals Compliance		80.0%	72.3%	66.4%	67.4%	69.4%
			Staff Turnover Rate		11.5%	10.9%	10.8%	10.8%	10.8%
	W4		Vacancy Rate		10.0%	12.6%	12.4%	12.7%	13.6%
			Staff Turnover: HCA		13.5%	13.2%	13.7%	14.4%	14.9%
			Premature Turnover Rate		25.0%	23.6%	23.9%	23.1%	22.9%
	W4		Medical Job Planning Rate		90.0%	37.1%	40.5%	32.9%	34.0%

Appraisal

Overall appraisal compliance had been on an upward trend during 2021 and 2022. July and August saw an increase, with compliance at 70% in August. The compliance by Care Group ranges from 89% for Surgery HNBD, to 52% for UEC. Teams are working to book appraisals in during the next two months to improve compliance. Non-compliance is highest within the Nursing & Midwifery and A&C staff groups. Appraisal compliance is an area of concern as it is a good indicator of staff engagement and personal development planning. In addition, Health & Wellbeing conversations and updated Covid Risk Assessments form part of the appraisal process.

Whereas previously, Appraisal Compliance was a driver for many Care Groups, this will now be supported through the Trust objective of Staff Involvement, which is also a Driver for some Care Groups.

Care Groups are identifying line managers who have not uploaded appraisals, or have not accessed ESR Self Service to ensure that true appraisal compliance is recorded

Staff Turnover

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

Total turnover, when measured as a rolling 12-month average, now stands at 10.80%. This is well within the current threshold, but it is recommended that this be revised following the calculation change. In-month turnover has risen from 10.69% in July to 12.31% in August. This appears largely related to a concerning rise in HCA turnover.

This is being monitored closely and is subject to more in-depth analysis.

Vacancy Rate

The overall vacancy rate has deteriorated with an increase from 12.7% to 13.6% in August, reflecting an increase in budgeted establishment and slight decrease in staff in post. A plan is in place to recruit nursing staff through 22/23. There is also a rolling programme of recruitment in place for HCA posts plus a marketing campaign supported by the East Kent Healthcare Partnership

Recent improvements to medical staff recruitment marketing and incentives are showing early signs of success in previously hard to fill areas.

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.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
0.021	-1.494	-0.996	-0.941	-0.090	1.307	0.076	-3.700	-6.624	-6.604	-7.7...	-11.4...

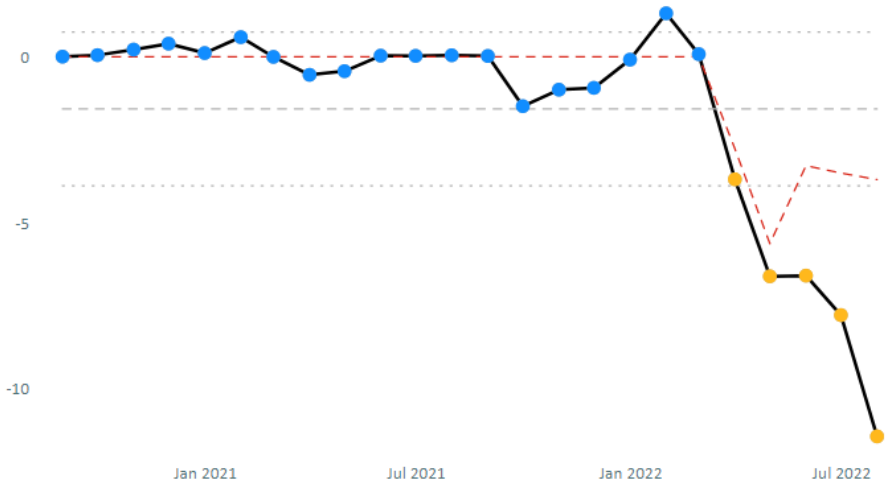
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The first two years of the graph show the monthly financial performance of the organisation which has resulted in both years being breakeven. The final graph point shows position in August which is a £11.4m deficit against a plan of £3.7m deficit. The key drivers behind the deficit are: £1.6m behind plan on CIPs, £2.9m on escalation areas, £0.9m bank and reductions not seen, overspends on work permits £0.8m and Covid overspend £0.4m.

Interventions and Planned Impact

The largest interventions for the plan are:

- Delivery of the £30m CIP programme, the largest pillar of this is the reduction of premium pay which is a breakthrough objective. Fortnightly meetings being held with clinical and corporate areas, use of national benchmarking data, plus detailed budget reviews underway.
- Premium pay deep dives are being held with care groups to test plans and review further actions to be taken.
- Away day held in September which had a focus on efficiencies, the PMO are working through the outputs to identify key areas of development.

Risks/Mitigations

For 2022/23 the key risk and mitigations are:

- Efficiency target of £30m, PMO team working with care groups and executive directors
- Covid-19 spend reductions £9m, DIPC working with finance to release costs
- ERF delivery £19m, 104% of 19/20 activity to be delivered, care groups have plans and weekly oversight by COO.
- Non-pay inflation. Procurement is working closely with NHS England procurement and supply chain to minimise impact.

22/23 breakthrough objective

Premium Pay Spend

Premium pay spend consists of agency (circa £36m per annum), bank (circa £32m per annum) and overtime/ locums (circa £19m per annum) across the Trust. The total value is around £87m per annum (18% of total pay bill). These costs are amongst the most influenceable by the management of the organisation and therefore a good area for a breakthrough objective that will positively impact the finances of the Trust.

The objective is to reduce the spend by 10% or £8.7m in 2022/23 but may be refined once the full project plan is developed.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
7,092	6,783	7,255	6,441	7,168	7,403	9,148	7,890	7,497	8,894	8,702	8,809

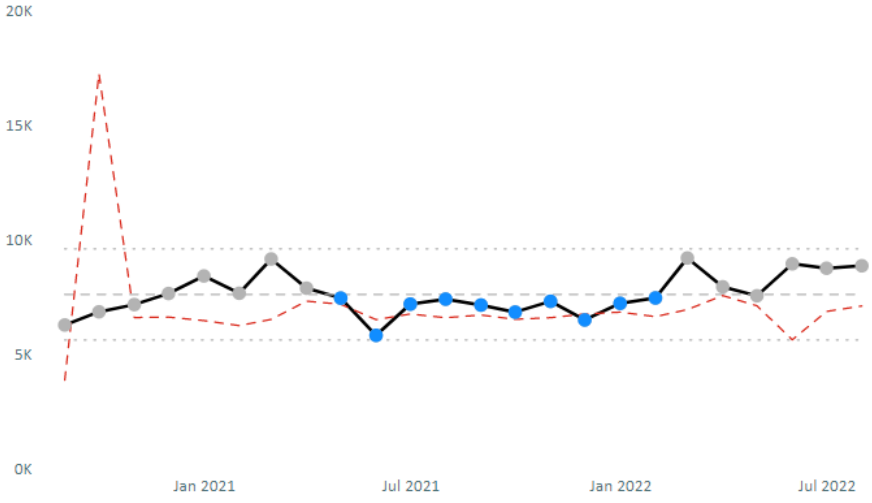
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart tracks premium pay spend in £'000 across the last two years. There are two points in March 2021 and March 2022 where a spike is seen above the usual control limits, historically this is caused by the Trust ensuring that all costs for that financial year are captured and will include unpaid claims that are due in year.

This information is the baseline for which we will measure improvement over 2022/23. In August 2022 premium pay spend has increased by £0.1m.

Intervention and Planned Impact

- The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all care groups to help deliver.
- The working up of an A3 project plan is complete and will be reported through EMT and PRMs and subsequently Board each month.
- Key Interventions include:
- Formalising and strengthening the weekly premium pay meeting.
- Detailed focus by care groups on drivers of premium pay. Premium pay deep dives occurring through September.
- Review of bank, agency and overtime rates across all staff groups.
- Ensure improved sign off processes and governance across the Trust.
- Recruitment to key clinical posts to reduce the need for temporary staffing.

Risks/Mitigations

- The temporary staffing team has formed but is in its infancy,
- Most Care Groups have identified premium pay as a driver and will need support to align and focus on the biggest opportunities for reduction
- A significant proportion of premium pay is caused by vacancies and will need targeted recruitment support to fill
- The remainder of spend is caused by sickness and operational demand. The former should reduce but work is required to control and reduce the latter.
- 60 escalation beds opened increasing need for temporary staff

Our sustainability

Liz Shutler

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North. The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. It is these areas we will be focussing on improving over the coming five to ten years. We also plan to add in other measures such medicines waste, NHS fleet and leased vehicles and staff travel, as we develop these metrics in the future. Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
4.53	5.61	8.06	8.60	9.55	7.65	7.97	6.18	6.70	2.46	4.27	

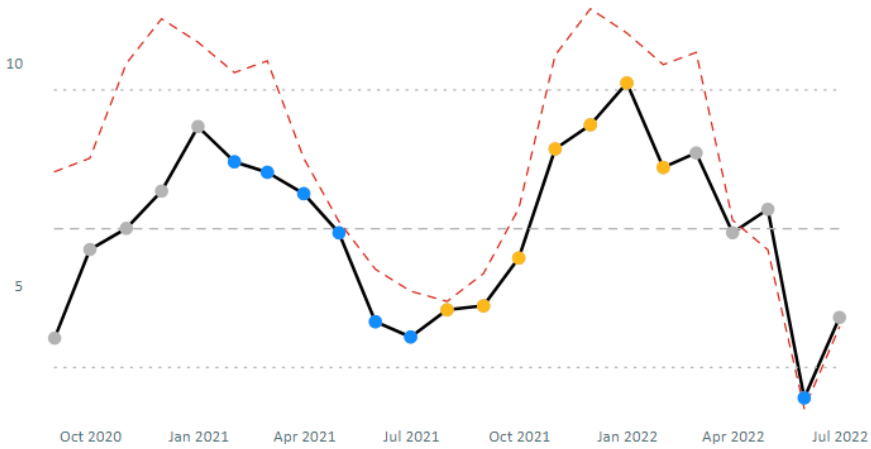
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's carbon footprint as demonstrated in the chart. However, the position is reporting above the monthly trajectory of 4.06 at 4.27 kgC02e per m2 and is above the same period last year (reporting at 3.83). It should be noted that the increase in 2022 will be in some part due to the increase in m2 in 2022 (new ITU build at the William Harvey Hospital). In addition the installation of Combined Heating and Power (CHP) equipment has increased the amount of gas used this year. The annual 10% reduction is a fixed value and the reduction is phased across the year and is based on seasonal phasing and on historic assumptions. While this allows greater tolerance in the winter months, it also increases the potential for missing the trajectory in month, because seasonal predictions can be difficult. We are, however, currently reporting that we will be within the annual 10% reduction for the end of the year. The trajectory now compares performance against historical data to a trajectory of systematic carbon reduction in line with NHSE/I's 'Delivering a Net Zero NHS'. This allows the measurement of carbon used to be proportionate to the size of the Trust's estate. An increase in our site footprint will, as a consequence, increase the use of carbon and therefore the new metric allows for appropriate contextualisation.

Interventions and Planned Impact

The Trust is working with Breathe Energy to recommend opportunities for a continuing programme of carbon reduction and to bid, on the Trust's behalf, for central monies to enable long term carbon reduction as part of the Public Sector Decarbonisation Scheme. The business case, which promotes the installation of heat pumps on each acute site has been submitted to the Strategic Investment Group (SIG) in September 22. The business case will be taken forward through internal governance in September/October. Schemes focus on carbon reduction, rather than financial savings, although financial reductions will be part of the programme of work. The application process for the grant is expected to be announced in October 22. 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.	May-22	Jun-22	Jul-22	Aug-22
Financial Position	W4		Total Pay		0.0%	-2.3%	-3.1%	-3.6%	-4.0%
	W4		Efficiencies YTD Variance (£M)		0.0	-1.0	-1.0	-1.4	-1.6
	W4		Efficiencies Green Schemes		90.0%	13.2%	22.8%	32.8%	41.5%
	W4		I&E Monthly Variance Trust (£)		0	-212.7K	-2.5M	-315.6K	-3.1M
	W4		I&E YTD Variance (£)		0	-1.1M	-3.7M	-4.0M	-7.1M

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.

Efficiencies YTD Variance/ Efficiencies Green Schemes

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

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

The key drivers behind the deficit are: £1.6m behind plan on CIPs, £2.9m on escalation areas, £0.9m bank and reductions not seen, overspends on work permits £0.8m and Covid overspend £0.4m. To mitigate the position the care groups and clinical areas have fortnightly meetings with the CFO and financial improvement director. In addition we are having premium pay deep dives for key areas.

Our future


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

Our future

Rebecca Carlton

Not fit to reside (patients/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. This allows us to easily identify the ongoing support and care patients need to leave hospital.

Patients are delayed in hospital awaiting a supported discharge which may be a care package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works in partnership with the local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
303.0	299.5	332.0	346.2	314.3	320.4	336.2	351.1	352.9	354.9	402.6	385.9

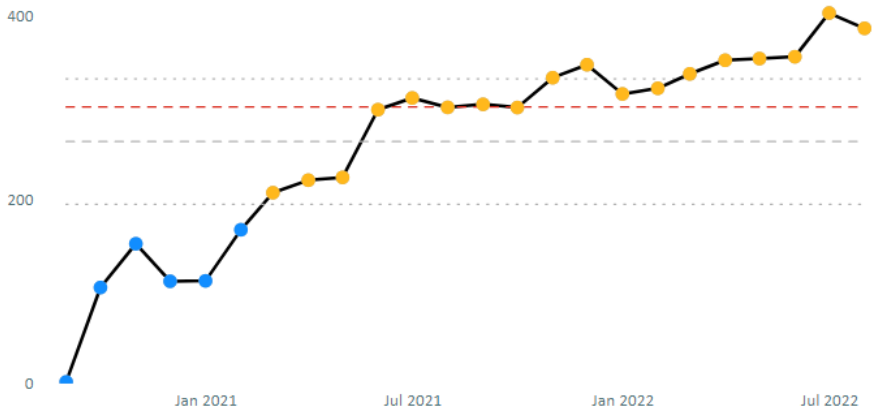
Variation indicates inconsistently passing and falling short of the target

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

The number of patients who no longer meet the criteria to reside (C2R) in hospital has fallen after 7 months of continuous growth. The sustained pressure on the hospital bed based is primarily related to a lack of external capacity to enable patients to be discharged on the correct pathway when they no longer need acute hospital care. 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.

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:

1. The enhancement of SDEC services and access with an Integrated SDEC led by KCHFT which works with patients with long term conditions and seeks to avoid full admission to hospital. This work aims to reduce admissions/bed days.
2. Virtual Ward – this is part of a national roll out of out of hospital provision for patients who need specialist support but who can remain at home or leave hospital for home earlier because o virtual ward. It seeks to provide 200 'beds' when pathways are fully deployed but we hope to focus delivery on 2 or 3 pathways 40-50 beds for this winter
3. Bridging arrangements that help people leave an acute hospital bed prior to care at home or long term residential care being available

These three areas of work and an integrated team working at both WHH and QEQM will focus our collective efforts on ensuring that where possible residents in East Kent are supported to leave hospital and patients who need emergency care as an inpatient will be admitted in a timely way. This work is vital as we know that residents who experience delay being admitted or leaving are not having a positive patient experience and can deteriorate waiting to go home or waiting to come in via our Emergency Departments.

Risks/Mitigations

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

Our future

Liz Shutler

Recruitment to Clinical Trials

In order to deliver outstanding care for patients, we need to provide and promote access to clinical trials and innovative practice for all our local population. Research, education and innovation are not yet embedded in our organisation at the heart of everything we do. We need to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence. The preferred measurement of success is the number of staff participating actively in research and innovation. However, at present the total number of staff involved in research and innovation is unclear and work is being undertaken to enable this metric to be measured and used going forward. Data does, however, enable us identify the number of patients recruited to trials within the Trust and this metric will be used initially.

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

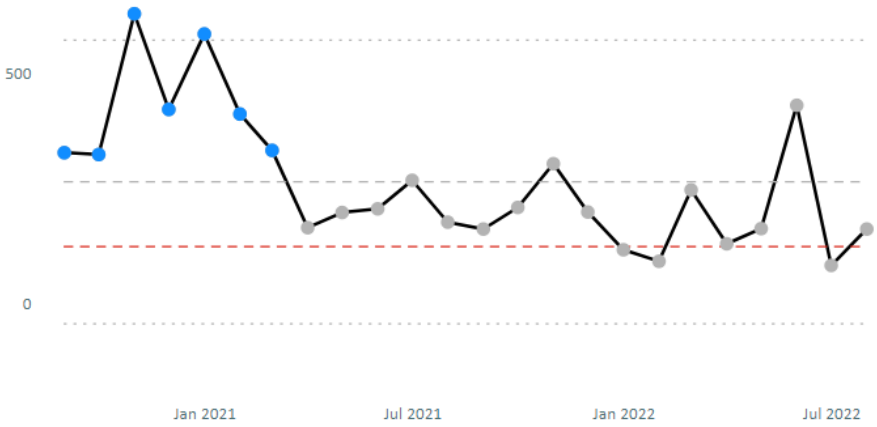
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

In 2020/21, 5,132 patients were recruited into trials. This number is significantly higher than usual as it included 3,000 Covid patients. In 2021/22, the Trust recruited 2,285 patients (including 240 Covid patients) across 22 specialities. By specialty, the number of patients recruited ranges from 1 (ENT) to 742 (Reproductive Health and Childbirth). The August position of 161 participants is above the threshold of 123 (positive). The biggest recruiting study in August was a new Anaesthetics study that is running at both the WHH And QEQM sites. The study opened on 3rd August 2022 with a target of 30 participants per site and recruitment has already achieved 42 by the end of August. The April – August cumulative position is 964 patients recruited to trails, which is above the year to date trajectory of 615.

Intervention and Planned Impact

- The Clinical Trials Unit at QEQM opened in June and studies are now running through the CTU. Studies have now commenced in the bedded area.
- 20 additional studies are already in the set-up phase or are due to start set-up imminently.
- DOLPHIN, our first multi-site study (3 sites across the UK), is ready to open in September. The study focuses on children with Haemophilia and through the use of technology, including AI, establishes physiotherapy programmes to get children up and moving. The Trust is the lead site and the other sites include GOS.
- Funding of additional Clinical Fellow posts continues to be discussed with Surgery, Cardiology, Haematology and Vascular and the Job Description for the Anaesthetics post is now out to advert.
- Work continues to identify ways to capture staff numbers across all healthcare professionals. Whilst this is expected to be via the new research database being produced, the publication of this has been delayed and the expected date is currently unknown.

Risks/Mitigations

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

Appendix 1
Non-Alerting Watch Metrics

NHS
East Kent
Hospitals University
NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	May-22	Jun-22	Jul-22	Aug-22
Harm Events	W		Falls		Sigma	171	134	148	143
	W		IPC: EColi Infections		10	10	5	9	8
	W		IPC: Klebsiella Infections		6	5	3	8	1
	W		IPC: Pseudomonas Infections		3	2	2	1	2
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	225	243	232	217
	W		Medication Errors; Severity C+		1	0	2	1	4
	W		Nutrition Incidents		Sigma	61	73	47	59
	W		Pressure Ulcers: Cat 2		Sigma	32	27	40	35
	W		Pressure Ulcers: Cat 3 & 4		Sigma	1	1	2	0
	W		Pressure Ulcers: DTI		Sigma	8	3	8	11
	W		Pressure Ulcers: Unstageable		Sigma	6	1	8	12
	W		IPC: Audits Composite		85.0%	86.2%	85.3%	86.5%	85.7%
	W		Safeguarding Incidents		Sigma	19	14	18	20
	W		IP Spells with 3+ Ward Moves		Sigma	547	538	496	507
	W		Clinical Incidents		Sigma	2,178	2,192	2,228	1,972
	W		Serious Incidents		Sigma	19	17	26	14
	W		Never Events		0	0	2	0	1
	W		Maternity Serious Incidents		2	2	5	6	1

True North Domain	BR	Flag	KPI	SPC	Thres.	May-22	Jun-22	Jul-22	Aug-22
Mortality	W		Extended Perinatal Mortality		6.32	4.30	4.41	4.25	4.11
Staff Engagement	W		Sickness		5.0%	4.7%	5.2%	6.0%	
	W		Statutory Training		91.0%	92.8%	92.4%	91.9%	91.7%
	W		Safeguarding Children Training		90.0%	91.5%	90.0%	89.5%	88.2%
	W		Safeguarding Adults Training		90.0%	90.8%	90.3%	89.0%	87.9%
	W		Staff Turnover: Nursing		10.0%	9.5%	9.4%	9.4%	9.4%
Financial Position	W		Non Pay		0.0%	2.6%	1.0%	1.8%	0.7%
	W		Efficiencies FOT Variance (£M)		0.0	0.0	-4.7	-2.3	-3.1
	W		I&E FOT Variance (£)		0	0	0	0	0

True North Domain	BR	Flag	KPI	SPC	Thres.	May-22	Jun-22	Jul-22	Aug-22
Cancer 62d	W		Cancer 31d Performance		96.0%	98.5%	98.7%	98.0%	97.8%
	W		Endoscopy vs Plan		Traj.	1,559	1,348	1,419	1,376
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,675	1,681	1,652	1,718
	W		RTT 52w Breaches		Traj.	3,560	3,605	3,419	3,453
	W		OPA vs Plan		Traj.	78.9K	73.8K	71.0K	68.0K
	W		Elective Admissions vs Plan		Traj.	9,319	8,637	8,491	8,638
ED Compliance	W		Pathway 0 Patients >7 Days		Sigma	142	158	139	135
	W		NEL Readmissions		15.0%	10.3%	10.3%	9.8%	9.6%
	W		Stroke Ward within 4 Hours		50.0%	56.0%	47.5%	54.6%	58.6%
FFT	W		FFT IP Response Rate		15.0%	19.8%	16.7%	19.2%	18.1%
	W		FFT DC Response Rate		27.0%	30.3%	28.1%	30.3%	30.5%
	W		FFT ED Response Rate		12.0%	15.2%	12.7%	14.5%	14.3%
	W		FFT OP Response Rate		17.0%	19.8%	18.8%	20.0%	20.2%
	W		Complaints Number		Sigma	63	65	87	73
	W		Mixed Sex Breaches		Sigma	54	37	69	46
	W		Duty of Candour - Findings		100.0%	12.5%	100%	25.0%	96.2%

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	Meeting is pending to review the A3 and dates	• Residential modelling is completed and used to manage high demand • Review of training room booking process continues. • Project lead continues to engage with care groups to identify office usage following new agile working policy	• Finalisation of Accommodation Management Policy • Feedback compiled by project lead on agile working with key stakeholders • Residential modelling forward view to be developed.
Job Planning (Trust wide)	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	Date to be confirmed	• Job planning project manager attended NHSEI LoA conference • Job planning included in the KCDP for the next cohort • e-JobPlan (allocate) added to the Trust application launcher for ease of access • CMO information web pages updated with current job planning information and FAQs • Digital CEA platform developed by CMO team to improve application rates and encourage job planning • Trust visited by the Higher-Level Responsible Officer team to review RO processes with good feedback (although not strictly aimed at job planning, some of the discussions covered the importance the role job planning plays in regards to RO responsibilities) • A draft recruitment and selection of consultants SOP was drafted which includes procedures for advertising posts with template job plans and Royal College/Faculty support	• Continue with PDSA cycles testing the new 3rd sign-off process • Continue with introduction of Impact/Effort matrix for all IP actions to improve action/counter-measure selection/targeting • To standardise the medical change form and governance process (as we were unable to confirm a date for all of the stakeholders could meet in the previous month) • Confirm the construction and timeline for the next round of job planning workshops • To begin a review of the e-jobplan platform to ensure it is fit for purpose for the current needs of the organisation • To receive and review the job planning trajectories from the care groups at the Medical Workforce Deployment Group • To finalise/approve draft policy/SOP for CEA and consultant recruitment.
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Dates will be reviewed at next A3 meeting	• Focus on examining Clinician engagement and ownership to determine where progress and improvement will best supported	• Operational issues have delayed the meeting with SRO and Leads to review the future direction of the project and update the A3. • A number of We Care front line wards are looking at improving discharges from their wards

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022 New date Sept 2022	• Clinical Guidelines Policy has been reviewed and presented at CEMG on 14th September • Clinical Guidance Manager appointment has been announced in Trust News • Preparing transition into wider implementation of MicroGuide before business as usual	• Submission of finalised Clinical Guidelines Policy to Policy Authorisation Group (PAG) • Review of current MicroGuide Content and Structure • Wider implementation of MicroGuide before business as usual
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	TBC at next meeting	• Mapping of stakeholders towards specific workstreams is complete • Establishment of workstream action plans ongoing • Develop a training program to increase staffs knowledge and skills in EoLC – complete	• Mandatory training video is in production. • No update
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	TBC	• Project currently on pause • Useful feedback from table top exercises completed at a QGD Away Day and a Consultant Development training.	• Senior team have met and will be reviewing and redrafting A3

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
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	• Writing to the 2 Hospital Management teams at WHH and QEQM for their support in getting patients to the right ward but Chris Hamson the interim Head of Nursing has been invited to the QEQM hip fracture meetings. • The clinical lead at the WHH is Mr Alex Chipperfield but he is retiring so I have requested that a replacement is sought. • We had a good meeting with the T&O Clinicians yesterday 15th September to talk about the hip fracture pathway. We did come away with a number of actions which will form part of the progress for the next 30 days. • QEQM continue to hold their meetings but WHH have cancelled Septembers so I am going to ask that it must go ahead for next month.	• Meet Claire on 20th September – appointment in the diary. • Liaise with the trauma co-ordinators to ensure patients are ready for theatre and not listed on "theatreman" without being optimised (16/9/22) • Liaise with the Hospital site teams and share the KPI data regarding this pathway and compliance for getting our patients to the right ward (16/9/22) • Getting our hip fracture cases onto the lists first and ensuring the there is dedicated time every day for our patients with hip fractures. • Review time to theatre and where there are delays to look at the days of the week where patients haven't being able to get to theatre due to capacity.
Maternity Ultrasound Booking	TBC	Provide a booking service for Ultrasonography that is linked to the patients pathway Improve the link between appointments team and clinicians Ensure PACs connects to the maternity systems Develop a robust workforce with clear roles and responsibilities to ensure a sustainable service Ensure capacity is available to meet the demand of the service	TBC	• Daily frontline discussions to review emerging issues and agree priorities for the day. • Monthly Operational meetings in place to identify any issues and working as a multidisciplinary team to resolve them • Review Booking processes and identify opportunities to improve efficiency	• Operational meetings working • Start reviewing Ultrasound Datix's to identify themes • New issues will be triaged by clinical management team to see where issues are and how they can be resolved • Review anti-natal risk assessment guidelines and align to future pathway.

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

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

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

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

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

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

Appendix 3: Glossary of Terms

NHS
East Kent Hospitals University NHS Foundation Trust

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