EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS MEETING**
DATE:	**30 OCTOBER 2014**
SUBJECT:	**COMPLIANCE FRAMEWORK QUARTERLY SUBMISSION QTR 2 2014/15**
REPORT FROM:	**DIRECTOR OF FINANCE & PERFORMANCE MANAGEMENT AND INTERIM DIRECTOR OF OPERATIONS**
PURPOSE:	**Decision**

CONTEXT / REVIEW HISTORY

The *Risk Assessment Framework*, issued by Monitor in August 2013, sets out the approach by which they will assess the risks to the continued provision of NHS services. Monitor will use this framework to undertake an assessment of each Foundation Trust to identify:

- A risk to the financial stability of the provider of key NHS services which endangers the continuity of those services; and/or
- Poor governance at an NHS Foundation Trust.

The above will be assessed separately by Monitor and each NHS Foundation Trust will be assigned two ratings.

The Trust's annual plan was submitted on 3 June 2013 and the framework provides for quarterly monitoring. Monitor will use quarterly information to update its assessment of Foundation Trusts during the course of the year.

Continuity of services rating
The rating allocated by Monitor will be their view of the level of risk to the ongoing availability of key NHS services and the risk of a provider failing to carry on as a going concern. Main categories of in-year submissions are:

- Latest quarter financials;
- Year to date financials;
- Financial commentary;
- Forward financial events.

The rating incorporates two common measures of financial robustness: Liquidity; and capital servicing capacity. There are five rating categories:

- Rating 4: No action.
- Rating 3: Emerging or minor concern, potentially requiring scrutiny
- Rating 2*: Level of risk is material but stable
- Rating 2: Material risk
- Rating 1: Significant financial risk

Governance rating
NHS Foundation Trusts are subject to the NHS foundation trust condition 4 (the governance condition) in their licence. Monitor will use a combination of existing and new methods to assess the governance issues of NHS Foundation Trusts. Main categories of in-year submissions are:

- Performance against national standards;
- CQC information;
- Clinical quality metrics;
- Information to assess membership engagement.

There are three categories to the new governance rating applicable to all NHS Foundation Trusts:

- Green Rating: where there are no grounds for concern;
- Written description of concerns: where action is being considered but not yet taken; and
- Red: when enforcement action has begun

Exception Reporting
Monitor requires licence holders to notify them of any incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with their licence. This applies to all licence conditions, not just the conditions that are the focus of the *Risk Assessment Framework*. An exception report should describe:

- The issue that has arisen or will arise, the magnitude and when it occurred or will have an effect.
- Actions planned to address the issue.
- List of affected parties.
- How the licence holder plans to notify these parties of the issue.

The *Risk Assessment Framework* makes it clear that the role of the ratings is to indicate when there is a cause for concern at a provider. Ratings will not automatically indicate a breach of a Foundation Trust licence or trigger regulatory action. Monitor will use their ratings to consider when a more detailed investigation may be necessary to establish the scale and scope of any risk.

SUMMARY:

The report is divided into four sections outlining performance as at Quarter 2 and is summarised below:

Section 1 – Continuity of Services
It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that the Continuity of Services Risk Rating for Q2 is confirmed as:

- Rating 4: no action.
- The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

Section 2 – Governance Rating
It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that not all healthcare targets and indicators have been met.

Section 3 – Exception Reports
Exception reports are included for the following areas of non-compliance:

- *C.Difficile*
- *A&E 4 hour wait performance*
- *Cancer symptomatic breast*

Section 4 – Additional Information
Additional information has been included related to the following:

- Invited Review – Royal College of Surgeons/High Risk Surgery Update
- CQC Visit Update
- Radiology Information Systems

- Outpatients Consultation Update
- Board Changes
- Governor changes

RECOMMENDATIONS:

Section 1 – Continuity of Services

It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that the Continuity of Services Risk Rating for Q2 is confirmed as:

- Rating 4: no action.
- The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

Section 2 – Governance Rating

It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that not all healthcare targets and indicators have been met.

NEXT STEPS:

To incorporate any changes discussed at Board and arrange for submission to Monitor by the deadline of 31 October 2014.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Demonstrates the extent to which strategic objectives are being achieved.

LINKS TO BOARD ASSURANCE FRAMEWORK:

AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.

A09: Finance: Ensure strong financial governance, agree contracts with commissioners that deliver sufficient activity and finance and supports a comprehensive internal cost improvement programme where all divisions deliver cash releasing savings schemes to deliver Trust QIPP targets.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Exception reports are included for the following areas of non-compliance:

- *C.Difficile*
- *A&E 4 hour wait performance*
- *Cancer symptomatic breast*

FINANCIAL IMPLICATIONS:

No direct implications, although investment may be required where the need for corrective action is identified.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The *Risk Assessment Framework 2013/14* serves as guidance as to how Monitor will assess governance and financial risk at NHS foundation trusts as reflected by compliance with the Continuity of Services and governance conditions. NHS foundation trusts are required by their licence to have regard to this guidance.

Monitor's *Enforcement Guidance* sets out Monitor's approach to prioritising and taking regulatory action where a breach of a licence condition is likely or has occurred.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

Not applicable.

BOARD ACTION REQUIRED:

This report recommends that the Board of Directors declare that not all healthcare targets and indicators have been met during the quarter.

CONSEQUENCES OF NOT TAKING ACTION:

Monitor's *Enforcement Guidance* sets out Monitor's approach to prioritising and taking regulatory action where a breach of a licence condition is likely or has occurred.

MONITOR RISK ASSESSMENT FRAMEWORK 2014/15
QUARTER TWO (JULY 2014 – SEPTEMBER 2014)

SECTION 1 – CONTINUITY OF SERVICES

1. At the end of Quarter 2 the consolidated position for the Trust and its subsidiary is an EBITDA of £7.2m (£0.9m below plan) and a £0.4m net surplus – £0.8m below the plan.

2. Continuity of Services Risk Rating performance is shown in the following table:

CoSRR (Cumulative)	Target	Q1 actual
Capital service cover	3.26x	2.95 x
Capital service cover rating	4	4
Liquidity metric	9.5	9.2
Liquidity rating	4	4

3. Total Operating Revenue for the first quarter is £132.4m which is £1.6m above plan. NHS Clinical income was £0.9m above plan predominantly driven by over-performance in income for High Cost Drugs and elective day cases (variance analysis by point of delivery has been provided in the templates). Private patient and non-mandatory clinical income was £0.7m above plan.

4. Operating Expenses within EBITDA amount to £125.2m which is £2.5m above plan. The main drivers include £3.1m on pay due to excess agency, bank, locum and overtime costs linked to activity pressures. £1.7m of the overspend is due to drugs overspending (largely on pass through costs). Non-Clinical Supplies were underspent by £1.7m driven by slippage on service developments and are matched by an underachievement in income.

5. The £26.8m CIP target for the year comprises £6.1m of income opportunities and £20.7m for cost reductions. Actual performance against these targets was a short fall of £0.9M for the quarter. Income Opportunities are £0.4m above plan whilst Cost Reductions £1.3m below plan due to slower than expected starts to some workforce and supplies savings.

   The trust is currently reviewing delivery plans for all CIP's and has identified an executive board member to help focus the organisation on delivery. The Trust therefore expects to deliver the required CIPs or cover any shortfall from our contingency reserve.

6. Capital expenditure for the quarter was £6.3m, £1m below plan. This is primarily due to a Theatre scheme being postponed and changes have been agreed to the programme as a result.

7. Closing cash balances were £5.5m higher than plan, largely due to settlement of old year invoices by the Specialist Commissioning Group (SCG) and some risks within the plan not having materialised.

8. The Trust continues to work with Maidstone & Tunbridge Wells Trust on the Kent Pathology Partnership project, with the aim of setting up a Joint Venture (a non-legal entity) delivering high quality, cost effective laboratory services to our hospitals and GPs. Staffing reductions as a consequence of planned consolidation of disciplines will lead to some redundancies and other one-off project and implementation costs, possible contract penalties and impairment charges. There will be equal representation from both Trusts on the Partnership Board. East Kent hospitals will employ all the staff. No firm decision has yet been taken but it is assumed at this stage that formal arrangements would be in place by September 2014.

2. Summary and Conclusion

At the end of Quarter 2 the I&E surplus of £0.4m is £0.8m below plan. This is due to income over performance being matched by expenditure being over plan and savings targets being behind plan for the quarter. Unused general contingency was used to offset excess costs on a non-recurrent basis whilst alternative measures are developed. Divisions that are performing adverse to plan are now subject to fortnightly Executive performance review and increased focus is being given to driving through CIP schemes.

3. Recommendation

It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that the Continuity of Services Risk Rating for Q2 is confirmed as:

- Rating 4:
- The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

SECTION 2 – GOVERNANCE RATING

PERFORMANCE AGAINST STANDARDS AND INDICATORS

Referral to Treatment Waiting Times

This target is reportable to Monitor on a quarterly basis however the Trust is required to meet the target in every month throughout that quarter. Failure in any one month represents a failure for the quarter. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.

The following table sets out the Trusts quarter 2 performance;

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q2 Performance	EKHUFT Consolidated Spencer Wing Position
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	1.0	Quarterly	88.7%	Not available at time of writing
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	1.0	Quarterly	97.6%	Not available at time of writing
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	1.0	Quarterly	93.8%	Not available at time of writing

* Data will be incorporated prior to submission to Monitor.

Standard non-compliant.

A&E 4 Hour Achievement

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q2 Performance	EKHUFT Consolidated Spencer Wing Position
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	1.0	Quarterly	93.4%	n/a

Standard non-compliant.

Cancer Waiting Times

The Cancer position stated below is as at 22nd October 2014, this position is not yet signed off due to the national reporting timetable. The position is therefore subject to change until the final reporting date of 5th November 2014. July and August figures are as per signed off data on Open Exeter, September is provided using local data.

The table below shows the Trusts performance in each of the standards;

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q2 Performance	EKHUFT Consolidated Spencer Wing Position
All cancers: 62-day wait for first treatment from					
• urgent GP referral for suspected cancer	85%	1.0	Quarterly	82.28%	n/a
• NHS cancer screening service referral	90%			86.03%	n/a
All cancers: 31 day wait for second or subsequent treatment comprising:					
• Surgery	94%	1.0	Quarterly	93.58%	n/a
• Anti-cancer drug treatments	98%			100.0%	n/a
• Radiotherapy	94%			n/a	n/a
All cancers: 31-day wait from diagnosis to first treatment	96%	1.0	Quarterly	98.69%	n/a
Cancer: two-week wait from referral to date first seen comprising:					
• All urgent referrals (cancer suspected)	93%	1.0	Quarterly	93.33%	n/a
• For symptomatic breast patients (cancer not initially suspected)	93%			81.99%	n/a

Standard Non-Compliant (scores 1 point).

Clostridium Difficile

Monitor will score NHS Foundation Trusts for breaches of the *C.Difficile* objectives as follows:

- Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. The de minimis level for C.Difficile is 12.
- If a Trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied.
- If a trust exceeds both the de minimis limit and the in year trajectory for the national objective, a score will apply.
- If a Trust exceeds its national objective above the de minimis limit, Monitor will apply a red rating and consider the Trust for escalation.

Indicator	Monitor Threshold (at year end)	EKHUFT cumulative target	Monitor Weighting	Monitoring period	EKHUFT Q2 Performance		EKHUFT Consolidated Spencer Wing Position
					Qtr	YTD	
Total C Diff: (inc cases not deemed to be due to lapses in care & cases under review)	47	23	1.0	Quarterly	17	32	n/a
*C Diff: Due to lapses in care.	-	-	-	Quarterly	0	4	n/a
C Diff: Cases under review.	-	-	-	Quarterly	13	13	n/a

Standard non-compliant.

Access to Healthcare for People with a Learning Disability.

At the Annual Plan stage, NHS Foundation Trust Boards are required to certify that their Trusts meet the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in *Healthcare for All (DH, 2008)*.
A quarterly declaration regarding continued compliance is required there after.

The Trust is compliant with the six criteria for meeting the needs of people with a learning disability, based on the recommendations set out in Healthcare for All (DH 2008). A detailed report on the issue was produced by the Practice Development Nurse (for people with learning disabilities) and considered by the Clinical Management Board (CMB) on 11 June 2014. The report highlighted the significant overall progress made in supporting access for people with learning disabilities and in particular identified areas of recognised best practice in the Carers Checklist for use with learning disability patients and their carers in hospital, the Bright Future project and the Healthcare Passport. After discussion the CMB accepted the recommendation to declare compliance with this standard.

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q1 Performance	EKHUFT Consolidated Spencer Wing Position
Certification against compliance with requirements regarding access to health care for people with a learning disability*	N/A	1.0	Quarterly	compliant	**n/a**

Recommendation

It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that not all healthcare targets and indicators have been met.

SECTION 3 – EXCEPTION REPORTS

Referral to Treatment Waiting Times

As highlighted in the Q1 Monitor Report ('section 5 – Risks to Compliance Moving Forwards) the Trust was non-compliant with the admitted RTT standard in Q2 2014/15. This is in line with the utilisation of resilience funding from NHS England to treat long waiting patients. This scheme began in August 2014 and initially ran to the end of September, providing funding above contracted levels to enable additional premium capacity to be secured by the Trust. Further to this, and as a result of significant increases in demand from Primary Care, the Trust Board previously endorsed a plan for the Trust to remain non-compliant in this standard throughout Q3 2014/15, however this may need to be extended to Q4 at the whole health economy has not yet been able to influence the demand sufficiently. The biggest areas of concern are Orthopaedic Surgery and Dermatology, both of which have seen increases in demand from Primary Care at ~30% over contracted levels. Work is on-going with Commissioning colleagues to understand the demand across the health economy and put in place schemes to direct referrals to the most appropriate setting. Recruitment of sub-specialty consultants in Dermatology is creating a mis-match between demand and available capacity; however more recent recruitment will correct this. In the meantime work is currently being outsourced to external providers.

Infection Control – C. difficile

The C. difficile limit for 2014/15 is 47 cases (a rate of 14.7/100,000 bed days).

For the first quarter of 2014/15, there were 15 cases against a trajectory of 11, 4 cases above the NHS England Q1 limit. In Q2 the trajectory has also been breached, with 17 cases against a trajectory of 12 (5 cases over). This gives a YTD position of 32 cases against a trajectory of 23 (9 cases over). Although the Trust limit has been breached, this continues to represent a relatively low rate of infection for a Trust as large as East Kent Hospitals (>300,000 bed days).

Following one Period of Increased Incidence (PII) in Quarter 1, there have been two PIIs in quarter 2, with cases seen on Cheerful Sparrows Female ward at the QEQMH and Harbledown ward at the K&CH. All isolates are routinely ribotyped in order to identify whether cross-infection is likely to have occurred, and this has revealed no linkage between cases, in quarter 2. It is important to note that although the Trust is currently over trajectory, there have been no patients with severe C. difficile infection (i.e. pseudomembranous colitis), and we believe that the number of cases confirmed is a reflection of our robust Policy regarding stool specimen collection and testing.

We can confirm that the Trust *C. difficile Recovery Plan*, reported in previous Exception Reports, has been fully implemented (updated version attached) and is regularly reviewed. The current "Diarrhoea Assessment Tool" has been revised and has been issued, for full implementation by the end of October. A "Competency Assessment Tool for the Management of Patients with Diarrhoea" has also been developed and is being rolled out concurrently. The IP&C Clinical Nurse Specialists will be assessing all Infection Control Link Practitioners using this tool – they will then be required to assess all nursing staff working within their clinical area. The implementation of this competency assessment tool should address most of the issues being raised at Root Cause Analysis namely: patients not being assessed according to the Diarrhoea Assessment Tool; "Record of Stool Specimen Collection" label not being used and bowel actions not being recorded consistently on VitalPAC.

A six month pilot for the use of hydrogen peroxide vapour (HPV) for the high level disinfection of side rooms following discharge of C. difficile positive patients (antigen and/or toxin positive), commenced on the 28th July. In addition we are instituting a pro-active approach to the high level disinfection of whole wards and bays as appropriate. The pilot is currently being implemented at the WHH (commenced on the 6th October and will shortly be implemented at K&CH). The pilot will inform the business case with regard to the amount of machines and man power required to ensure a comprehensive reactive and proactive service is provided to all three hospital sites in the future. The IP&CT continue to review all reported cases of diarrhoea on VitalPAC IPC Manager within working hours, which includes supporting the assessment and management of patients.

Lapses of care

Since April 2014, each case of Trust attributed C.difficile is being assessed for 'lapses of care' in accordance with the agreed Kent wide 'lapses of care' assessment tool based on NHS England guidance on sanction implementation 2014/15. With regard to those that have been agreed to date there were 4 'lapses of care' agreed in quarter 1 and quarter 2's overall total is yet to be determined with CCG Commissioners. The majority of 'lapses of care' agreed to date have been associated with antimicrobial prescribing (choice, duration and documentation). It is anticipated that these lapses of care associated with prescribing, will be significantly improved with the implementation of the new prescription chart towards the end of the year, which requires 48 hour review of antibiotic prescribing.

A&E 4 hour wait standard

The Trust was non-compliant with the 4 hour A&E standard in Q2 2014/15 at 93.4%. A&E attendances levels are up ~2% on the same period last year, with an emphasis on September which was 4.2% up on last year. Growth has been seen particularly at the WHH (1.5%) and KCH (2%) sites. Growth has been observed across all Clinical Commissioning Groups (CCGs), although South Kent Coast remains a significant outlier in the terms of growth from last year. Variation in numbers of attendances, and profile throughout the day, is causing pressure in the departments, there has been a consistent peak in attendances around mid-evening (6-8pm) which the Trust are reviewing to see if rotas need to be amended to reflect this. The conversion rate from attendance to admission has not increased however this may be due to new pathways for emergency patients who are admitted directly to short stay areas on the emergency floor.

There is considerable variation in specialty response rates at all sites, particularly prevalent at the WHH site, in some instances the average waiting time can be up to three hours. Whilst not applicable to every patient the delays caused by this inevitably impacts on other patients' journeys through the department. All breaches are analysed at the monthly A&E performance meetings with representation from all clinical divisions. The Surgical Assessment Unit opened at WHH on 15th October 2014, it is envisaged that this will start to address some of the above issues.

The Urgent Care Pathway transformation model commenced on 6th October at WHH as planned. The model is being implemented in stages at the QE. Both sites are seeing an increase in admissions avoidance as a result. Further work is required at the QE due to current constraints in space which is partly due to the increased length of stay and consequential lack of bed capacity to enable protection of the area reserved for hot ambulatory care. A copy of the A&E recovery plan is attached with these papers.

Cancer Standards

It has been a very challenging quarter for cancer waiting times. With performance levels of July and August together with current positions in September the Trust will be non-compliant against the 62 day GP, 62 day Screening and 2ww Breast Symptomatic referrals standards. All other cancer standards are currently predicted to be compliant for Q3 based on current and future treatment numbers and breaches. The Trust's must re-focus on cancer waiting time at all levels of staff involved in the pathways and the delivery of the pathways. Without good efficient pathways, cancer waiting time will not be delivered for future quarters.

In Q2 2014/15 there were 78 breaches against the 2ww symptomatic breast standard and it will therefore be non-compliant at 81.95% against the 93% target. This performance mirrors that seen for the same period last year and is heavily impacted by patient cancellations over the holiday period. Patient cancellation of booked appointment account for more than half of all breaches and the Trusts intention to move to the electronic 'Choose and Book' system for two week wait referrals will have a significant impact on this issue for the target.

Other factors impacting on this target include the process of:

- Registration
- Triage
- Booking
- Capacity

The Surgical Division has set up a group, Improving Breast Pathway, to address each of the areas above, with robust actions, which will be monitored through the cancer compliance group. The first meeting of the group is scheduled for 24th October 2014.

Whist October remains a challenge in this area the actions being taken should ensure compliance in this standard for Q3.

Both 62 day GP and 62 day Screening standards will be non-compliant for quarter 2 2014. Achievement of these standards is reliant on effective processes to pull patients through their pathway.

- Patient pathways should be capable of delivering a short waits and clearly describe what should happen next and in what order
- The capacity must match demand for each key mile stone along the pathway
- Patients must be actively managed against the pathway for their condition and the relevant key milestones

In order to achieve compliance of these pathways Cancer Compliance has developed an overarching Recovery Action Plan based upon best practice highlighted by the Intensive Support Team (IST). This is a deep dive into our cancer performance, as outlined below, and reporting to the Divisional Director for Specialist Services at the monthly Cancer Compliance Meeting to ensure delivery of plan. Along-side this action plan the Cancer Compliance PTL meetings will continue to escalate individual pathway issues to support current performance.

- Understanding Principles and Rules by all staff
- Managing capacity and demand
- Governance
- Core functions of cancer teams
- Reporting Meetings & Process

- Diagnostics
- Scheduling of treatment and Operational Delivery.

The Trust is likely to fail the 62 day GP standard for October due to issues within Lower GI, Lung and Urology. However, pathways are being reviewed and actions being implemented to mitigate the risk in these areas.

The 62 day screening standard is anticipated to be compliant for October and for Q3 2014/15.

Other specific actions being undertaken include:

- Waiting list staff must inform operational management if they are unable to TCI a patient within breach, even if instructed by the clinician. Each case must be reviewed to see if alterative TCI with in breach can be arranged.

- To maintain good performance 31 days subsequent drugs Chemotherapy schedulers must inform operational management if they are unable to TCI a patient within breach, even if instructed by the clinician. Each case must be reviewed to see if alterative TCI with in breach can be arranged.

- All GMs will be cc'd into PTL meeting outcomes - actions required and escalation from Cancer Data Managers.

- Working with the Clinical Support, Surgical and ULTC Divisions to ensure waiting times for diagnostics for patient marked as Cancer Pathway must be 10 days max including TRUS Biopsy.

- The 62 day PTL 'backlog' must continue to decrease and clinic lead should review patient passed 55 days.

SECTION 4 – ADDITIONAL BRIEFINGS

Invited Review – Royal College of Surgeons
High Risk and General Emergency Surgery

The Trust's Surgeons have presented a model of care to the Trust which has been fully supported. This model complies with the recommendations made in the RCS review which took place in 2012.

The model required additional consultants and the Trust agreed the additional funding required which will result in 2 x 1:9 rota on the William Harvey and QEQM sites. Job descriptions for the additional posts are being produced by the clinical leads in surgery and will be advertised in October 2014. In addition a Surgical Assessment Unit for the William Harvey will be implemented from mid October 2014, with additional resources made available via winter resilience funding. The Trust plans to also provide an assessment area for surgical patients at QEQM before the end of the financial year.

CQC Visit

Further to report which formed part of the Quarter 1 submission, the Trust submitted its high level action plan to Monitor and the CQC by the required deadline of 23 September 2014.

The Trust has been placed into special measures. Monthly performance meetings have been scheduled with Monitor to review progress against implementation and to discuss other compliance challenges.

Radiological Information Systems

The agreement has been confirmed in principle and will be ratified by the four CEOs within the next couple of weeks together with final legal details from Beachcrofts with GE's solicitor.

Board of Director Changes

Jeff Buggle has resigned from his position as Director of Finance and Performance Management to take up a position in Barking, Havering and Redbridge University Hospitals NHS Trust. Jeff leaves the Trust at the end of November 2014.

Chief Nurse & Deputy Chief Executive
Julie Pearce will be the executive director responsible for leading the improvement plan required to address the issues raised through the CQC Inspection report. The emphasis of Julie's role will change to focus on her responsibilities as Chief Nurse and Director of Quality. She will have an important role as deputy chief executive in supporting the CEO and Chairman in the transition to a new CEO coming into post in the New Year.

Director of Operations
Jane Ely has been appointed on an interim basis as acting Director of Operations, she will be accountable for the Operational delivery and performance, working closely with Divisional leadership teams. She will be accountable to the deputy chief executive and will ensure that quality improvement features strongly in our priorities as an organisation.

Director of Human Resources
Sandra Le Blanc joined the Trust as our new Director of HR on 2 September.

Council of Governor Changes

Peter Jeffries, Nominated Governor (representing Christ Church University and University of Kent) retired from his post at the end of August and as a result has resigned from the Council of Governors. The Trust is pursuing a replacement representative with Christ Church University.

SECTION 5 – RISKS TO COMPLIANCE GOING FORWARD

The following areas of risk to on-going compliance have been identified for Q3

18 weeks – Referral to Treatment standard – the Board has endorsed a plan for the Trust to be non-compliant throughout Q3. This is to enable to Trust to address the main areas of concern at a speciality level including orthopaedics and dermatology in order to reduce the backlog in these specialities and to improve patient experience of their pathway. The current increases in demand from primary care mean that there is a risk that the Trust will not be able to reduce the overall waiting list and the backlog will continue to grow. Joint work with the CCGs to reduce the overall demand is a key part of the plan to ensure that demand and capacity are better aligned.

Infection control – c.difficile – the Trust is working hard to reduce the number of c.difficiles infections in Q3, however the risk to achieving the overall trajectory for the year remains very high. The Infection Control committee is overseeing the improvement plan and there will be increased focus on reducing the lapses of care related to antibiotic prescribing (choice and duration).

A&E 4 hour standard – the Trust is aiming to be compliant with the standard in Q3. The risk, however, remains high and is dependent on the whole system delivery of the improvement plan supported by the surge resilience funding received by the system. The main focus is to reduce the number of patients admitted to hospital, manage more patients through ambulatory and short-stay pathways, make the best use of step-down capacity and to reduce the number of delayed transfers of care.

Cancer waiting times – the Trust is aiming to be compliant with the cancer standards; however there is a high risk that the Trust will be non-compliant with 62 –day wait for first treatment from an urgent GP referral for suspected cancer. The colorectal pathway is the largest contributory factor to the non-compliance and includes the delays in diagnostic endoscopy procedures due to the current level of demand and capacity. The improvement plan is in place to address the risks and to improve the pathway and to speed up the decisions being made through the MDT.

The two-week referral to date first seen for symptomatic breast is at risk and a task and finish group has met to look at ways to increase capacity to address the shortfall and to ensure that the Trust is compliant for the Quarter. Further information will be available at the Board meeting.

Finance

The financial risks that could impact compliance would result from the costs associated with rectifying issues raised from the CQC report which will be made more acute given the current activity and delivery pressures.

Prepared on behalf of:

Jeff Buggle	Jane Ely
Director of Finance & Performance Management	Interim Director of Operations
October 2014	