EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS MEETING – 25 APRIL 2014**
SUBJECT:	**COMPLIANCE FRAMEWORK QUARTERLY SUBMISSION QTR 4 2013/14**
REPORT FROM:	**DIRECTOR OF FINANCE & PERFORMANCE MANAGEMENT**
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 4 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 Q4 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:

- 62 Day Screening
- *C.difficle*

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

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

- Outpatients Consultation
- Board / Governor changes

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Demonstrates the extent to which strategic objectives are being achieved.

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 2013/14
QUARTER FOUR (JANUARY 2014 – MARCH 2014)

SECTION 1 – CONTINUITY OF SERVICES

1. At the end of Quarter 4 the consolidated position for the Trust and its subsidiary is an EBITDA of £29.7.4m (£1.8m below plan) and a £6.3m net surplus – £0.8m above the plan.

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

CoSRR (Cumulative)	*Target*	Q4 actual
Capital service cover		3.52 x
Capital service cover rating	*4*	4
Liquidity metric		11.2
Liquidity rating	*4*	4

3. Total Operating Revenue for the year is £524.8m which is £24.2m above plan. Patient-related NHS income was £21m above plan driven by over-performance in day cases, outpatients and other non-elective patients (variance analysis by point of delivery has been provided in the templates). The position takes account of provisions for known PCT disputes and challenges, and potential fines. Private patient income was £1.8m below plan. Services provided to Other bodies were above plan by £4.2m.

4. Operating Expenses within EBITDA amount to £495.1m which is £26.0m above plan. The main drivers include £12.2m on pay due to excess agency, bank and overtime costs mainly driven by the additional activity particularly in A&E. Divisions are reviewing agency staffing, to remove them or justify continuing use. £5.2m of the overspend is due to drugs overspending (largely on Pass Through and Homecare Drugs), £4.4m on Clinical Supplies (driven by high activity and supply savings not achieved), and £1.7m on Secondary Commissioning of Mandatory Services (largely T&O).

5. The £30m CIP annual CIP target comprises £6.7m of income opportunities and £23.3m for cost reductions. Actual performance against these targets was ; Income Opportunities £2.3m above plan, Cost Reductions £6.1m below plan due to operational pressures caused by excess non-elective demand. Planned bed closures (the Patient Pathway Scheme) took longer to implement than planned; alternative plans were agreed by Q2 when it was recognised that this scheme would not achieve planned levels in the current year. Other corporate schemes, notably procurement and workforce, have also not delivered in full this year. The shortfall has been mitigated in part through non-recurrent measures.
6. £1.2m of the £8.5m general contingency has been deployed on a one-off basis giving a £7.3m favourable variance at the end of December.

7. Capital expenditure for the year was £30.5m, £0.3m below plan and £0.7m above the Forecast Outturn

8. Closing cash balances were lower than expected by £4m, largely due to non-payment of invoices by the Specialist Commissioning Group (SCG). A settlement has now been agreed with SCG which will ensure payment for work done.

9. 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. One of the partner Trusts 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 July 2014.

2. Summary and Conclusion

At the end of the year the I&E surplus of £6.3m is £0.8m higher than plan. High demand for non-elective services has required excessive use of agency staff to maintain safe and effective services and has impacted on the savings position which is 13% below plan. Unused general contingency was used to offset excess costs on a non-recurrent basis whilst alternative measures are developed. Accounting adjustments to write back prior impairments on re-valued assets has driven a surplus below EBITDA

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 Q3 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 4 performance;

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q3 Performance	EKHUFT Consolidated Spencer Wing Position
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	1.0	Quarterly	**90.4%**	Not available* at time of report
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	1.0	Quarterly	**98.4%**	Not available* at time of report
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	1.0	Quarterly	**94.3%**	Not available* at time of report

* Data will be incorporated prior to submission to Monitor.

Standard compliant.

A&E 4 Hour Achievement

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q3 Performance	EKHUFT Consolidated Spencer Wing Position
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	1.0	Quarterly	**95.3%**	**n/a**

Standard compliant.

Cancer Waiting Times

The Cancer position stated below is as at 15th April 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 8th May 2014. January and February figures are as per signed off data on Open Exeter, March 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 Q3 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	85.2%	n/a
• NHS cancer screening service referral	90%			77.5%	n/a
All cancers: 31 day wait for second or subsequent treatment comprising:					
• Surgery	94%	1.0	Quarterly	96.7%	n/a
• Anti-cancer drug treatments	98%			99.4%	n/a
• Radiotherapy	94%			n/a	n/a
All cancers: 31-day wait from diagnosis to first treatment	96%	1.0	Quarterly	96.8%	n/a
Cancer: two-week wait from referral to date first seen comprising:					
• All urgent referrals (cancer suspected)	93%	1.0	Quarterly	95.8%	n/a
• For symptomatic breast patients (cancer not initially suspected)	93%			94.0%	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 Q3 Performance		EKHUFT Consolidated Spencer Wing Position
					Qtr	YTD	
Clostridium difficile – meeting the c.difficile objective	29	29	1.0	Quarterly	11	49	n/a

Standard non-compliant (scores 1 point)

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 08 May 2013. 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 Q3 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

C Difficile:

East Kent C difficile numbers by quarter for 2013-14 were:

Q1	18
Q2	10
Q3	10
Q4	11
Total	49

The excess of cases experienced in Q1 has been addressed in previous exception reports.

In brief we believed that the increase in cases reflected the exceptional stress that the NHS experienced during these months. Analysis of the cases and molecular fingerprinting of the strains isolated from patients indicated that there were no clusters of cases and therefore no evidence of an "outbreak" but rather an increase in the population of patients requiring broad spectrum antibiotics who are the group of patients susceptible to *C difficile* infection.

A *C difficile* recovery plan was successfully implemented and as anticipated, the numbers of cases in the remaining quarters of 2013/14 have fallen to the average quarterly rate seen in the previous year. As predicted the cumulative total for 2013/14 was 49 cases.

While a quarterly rate of 11 cases is above the EK DH quarterly target of 7 cases for 2013-14, it represents a low rate of infection for a Trust as large as East Kent (>300,000 bed days).

We can confirm that the recovery plan reported in previous exception reports has been fully implemented (updated version attached).

The implementation of VitalPAC Infection Prevention and Control Manager, (electronic near patient monitoring system), in the third quarter, has resulted in significant improvements in the management of patients with potentially infectious diarrhoea. The system allows for the notification of patients experiencing symptoms to be communicated to the Infection Prevention and Control Team, allowing timely review and management.

The planned external review of the *C difficile* control programme by Public Health England was undertaken on the 8th January 2014. We understand the written report is in the final stages of completion.

The EKHUFT objective for 2014/15 is 47, a rate of 14.7/100,000 bed days.

62-Day Screening Exception Report:

This investigation was carried out following a review of the January 2014 cancer performance by the Divisional Director and the Cancer compliance manager on 17th February 2014. This followed the monthly Cancer Compliance meeting that was held on 3rd February and in advance of the next meeting on 3rd March.

The compliance standard for 62 day screening is 90% and the Trust is performance managed against this target on a quarterly basis. The tumour sites that contribute to this screening standard are:

- Breast (breast screening)

- Lower GI (bowel screening)
- Gynaecology (cervical screening)

It was noted that in January alone there were 10 breach patients within a total of 24 treatments. 9 breaches were within Breast and 1 within Lower GI (colorectal). Based on the previous performance for the quarters, the highest number of breaches in the *whole* quarter was 8.5 (includes a shared breach) and therefore it was concluded that the Trust was almost certain to fail the whole Q4 for this standard.

Summary of contributing factors for delays in Breast Patients:

- Delays through the breast screening pathway with delays to breast screening MDT and surgical appointment.
- Appointments delayed from screening to first OPD with surgeon due to "unprotected" slots being used for other patients
- Delays in diagnostics MRI, bone scans etc
- Delays due to patients being booked for admission passed breach
- Cancelled surgical appointment by the hospital – (single incident)
- Delays in histology reporting (this may be due to complexity of cases) – (no further information at this time – this may not have been avoidable)
- Delays in escalation of key milestones along the pathway.

Recommendations:

1. Specialist Services Division to review cancer escalations process and policy – including re-confirming the agreed waiting times for diagnostics and reporting (in radiology and histopathology) and named individuals. This is to include contacts within breast screening.
2. Specialist Services Division to ensure that **all** breaches have a summary report and all specialities review and take action.
3. Specialist Services Division to review cancer compliance meetings –with greater emphasis on specialty input to breach reports and actions.
4. Clinical Support Division to review where cancer performance and in particular breast screening performance is monitored and discussed within the Division.
5. Clinical Support Division to produce a report on diagnostic (radiology) waiting times for cancer referrals (now that data can be extracted). (This requires some development in order to identify cancer referrals correctly). The current Clinical Support balanced scorecard may need to be adapted to capture these requirements for 4. and 5.
6. The Division and the Cancer Compliance Manager to review the screening booking of OPD surgical appointments in line with the capacity needed to meet the required milestones (linked patient choice) Also to ensure the slots are "protected".
7. Surgical Division to review the capacity for surgery in line with likely demand. In addition the actual booking of the admission is to be reviewed in line with the breach dates.
8. A joint clinical support and surgical division pathway mapping session to be set up so that the milestones for the 62 day screening target are confirmed and accountability for the milestones and the whole pathway is agreed.

Conclusion:
In March 2014, the 62 day screening standard has been met at 92.86% (90%). It is expected that the standard will be met each month and for each quarter in the future. The main areas of improvement have resulted from intense tracking of patients and ensuring that they meet key milestones along the pathway. This has been achieved by escalation when surgical appointment slots and capacity for surgery are not available. In addition the whole pathway is being review to ensure that all current staff involved are aware of the standard. A full report was sent to Monitor in April 2014.

SECTION 4 – ADDITIONAL BRIEFINGS

Invited Review – Royal College of Surgeons

The surgical division and particularly the colorectal surgeons have been working with one of the RCS reviewers to ensure that the surgical action plan is on track. The new surgical leads have implemented a programme of work to meet the required actions and one site lead (at QEQMH) has taken the lead in developing a unified Trust colorectal service. The HEKSS deanery re-visited on the 24th September and then subsequently on the 22nd November to review surgical training on the WHH site. A final report encompassing these visits was released on the 23rd December and concluded that adequate progress had been made.

A further meeting between the Trust medical director, the surgical division medical director, the 2 clinical leads and the external advisor will take place on the 23rd January to review future options for the delivery of emergency surgical services. This meeting will consider the possible models of surgical working, the existing surgical staffing resource, the pressures on the surgical service and the future demands of surgical training. Following this meeting it is envisaged that a recommendation for provision of emergency surgery within the Trust will be put to the Trust Board. All other actions are in progress as planned.

High Risk and General Emergency Surgery

Since January the future options for the delivery of emergency surgical services have considered various possible models of surgical working, taking into account the existing surgical staffing resource, the pressures on the surgical service and the future demands of surgical training. During this process additional pressures were placed on delivery of surgical services through loss of additional senior surgical staff and following representation from the surgical divisional medical director, supported by the Trust medical director, in February 2014 the Board of Directors came to a decision, in principle, to centralise high risk and emergency surgery, with the aim of achieving an interim solution for safe surgical services by May 2014.

The Trust's Surgeons have presented their alternative proposal for sustaining safe high risk general surgical services in our hospitals. The proposal aims to replicate the QEQMH model at WHH. This would involve the Trust recruiting two permanent replacements, currently covered by locums and creating a further three new posts.

The proposed new option has yet to be tested with the Royal College of Surgeons to see whether it is an acceptable solution and we also need to understand the risks that may be involved. The Clinical Strategy Implementation Board (CSIB) met last week and considered the surgeon's proposals the Board raised a number of points including: The Trust's ability to recruit to Emergency Surgeons roles to undertake on call outside of the General Surgical on call rotas; the impact on middle grades; the implications for training and the support for surgical assessment units.

In parallel with this work, the original interim solution agreed by the Board continues to be thoroughly examined by 13 separate work streams whose members are drawn from all specialties that could be impacted by changes to high risk surgery provision.

It is anticipated that all of this highly detailed and complex will be drawn together into a report to be considered at the April Board of Directors meeting.

CQC Visits

The Trust was inspected under the new CQC inspection regime week commencing 3 March 2014 as reported as part of the Quarter 3 submission. The inspection team

(consisting of 55 inspectors) were on site for a period of 4 days. An additional team was on site looking at the Trust's complaints processes.

High level feedback has been received from the CQC and a response has been sent together with additional evidence where this was felt to be necessary.

A draft report is scheduled to be with the Trust by 17 April 2014. The wave 2 inspection reports are currently running behind the planned publication periods and the date of 17 April may need to be revised. A quality summit has been confirmed for May 2014 when the final report will be shared together with the Trust's action plan.

Radiological Information Systems

The Consortium continues to work with GE to resolve the on-going system issues with PACSRIS. Monthly meetings are taking place chaired by the EKHUFTs CEO and GE's appropriate team to agree the level of outstanding costs incurred due to the delay in go live and the subsequent sub optimal performance of the system which required additional workforce support to be put in place to mitigate operational risk of patient scans being delayed. The Consortium has confirmed to GE that these outstanding costs are non-negotiable.

The Consortium and GE are also working together to agree a Gap Analysis document which will highlight those areas where functionality has either been fully achieved, partially achieved or not achieved. The Consortium has stated that no payment will be made to GE for the managed service until full reimbursement has been paid by GE for costs incurred from June to December 2013.

The Consortium will then only pay GE the % of the managed service that has been fully achieved. The Consortium has confirmed to GE that it will not pay for any partially or not delivered functionality.

Board of Director Changes

There have been no changes to the Board of Directors during Quarter 4.

Council of Governor Changes

Public and staff Governor elections to one third of the elected seats on our Council of Governors were held in February 2014. During 2013/14, two Governors resigned from our Council. In line with our Constitution, these positions remained vacant and the seats were included in the February 2014 elections. All vacancies were filled with terms commencing from 1 March 2014.

The overall percentage of votes based on the number of members who were balloted was:

- 1 Shepway position - 25% - *John Sewell (Re-elected)*
- 1 Ashford position - 20.09% - *Junetta Whorwell (Re-elected)*
- 3 Staff positions – Uncontested – *Mandy Carliell, David Bogard (Re-elected), Vikki Hughes (Elected)*
- 1 Canterbury – Uncontested – *Philip Wells (Re-elected)*
- 2 Dover positions – Uncontested – *Carol George, Martina White (Elected)*
- 2 Thanet positions – Uncontested – *Marcella Warburton, Roy Dexter (Elected)*

Outpatients Consultation Update

The outpatient consultation has now closed. All responses received as part of the consultation have been sent to the University of Kent for analysis and an independent report will be produced for review by the Trust and Canterbury and Coastal CCG in early May. An initial discussion will be undertaken at the Trust's May Board meeting, with a view to attending the HOSC on 6th June and making a final decision at the Trust's public Board meeting in June.

Prepared on behalf of:

Jeff Buggle
Director of Finance &
Performance Management

Julie Pearce
Chief Nurse and Director
of Quality & Operations

January 2014