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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

17 DECEMBER 2015

REPORT ON THE PROGRESS OF THE IMPROVEMENT PLAN FOR MEDWAY NHS FOUNDATION TRUST

Report from: Barbara Peacock, Director of Children and Adults

Author: Rosie Gunstone, Democratic Services Officer

Summary

This report is to inform the Committee of the latest position with regards to the progress against the Care Quality Commission's last report on Medway NHS Foundation Trust and an update on mortality rates at the hospital.

1. Budget and Policy Framework

1.1 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

2. Background

2.1. The Chief Executive of Medway NHS Foundation Trust was invited to this meeting to update on the August inspection by the Care Quality Commission (CQC). Unfortunately the report has not yet been received from the CQC so the attached report (Appendix 1) covers briefly the journey on the improvement plan generally.

2.2. Members of the Committee also requested regular (6 monthly) updates on mortality rates at the hospital at the point at which the Chief Executive was already programmed to attend the meeting. This is also covered in Appendix 1.

3. Risk management

3.1. There are no specific risk implications for Medway Council arising directly from this report.

4. Legal and Financial Implications

4.1. There are no legal or financial implications for the Council directly arising from this report.

5. Recommendations

5.1. The Committee is asked to consider the update from NHS Medway Foundation Trust in relation to the Improvement Plan and an update on progress on mortality rates.

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Appendices

Appendix 1 – response from Medway NHS Foundation Trust.
Appendix 2 – action plan for improving mortality rates

Background papers:
None.

Appendix 1

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REPORT ON THE PROGRESS OF THE IMPROVEMENT PLAN FOR MEDWAY NHS FOUNDATION TRUST

Report from: Chief Executive Officer
Medway NHS Foundation Trust

Summary

This report seeks to inform the Health and Adult Social Care Overview and Scrutiny Committee about the current status of the published mortality indicators and the work undertaken to date to reduce the Trust position within these indicators.

1. Summary

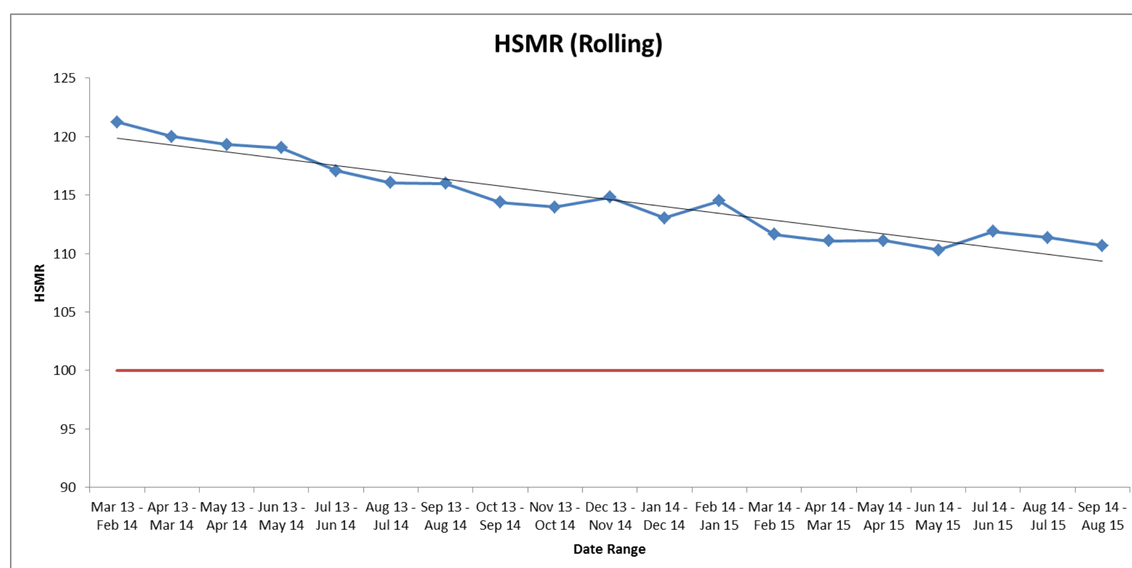
This report seeks to inform the Health and Adult Social Care Overview and Scrutiny Committee about the Trust's current position against all mortality indicators and the work being undertaken to further reduce mortality.

3. Background

Medway NHS Foundation Trust is one of four acute trusts within Kent, serving a population of over 400,000 in the Swale and Medway area. (Medway NHS Foundation Trust 2014). Following the Francis Inquiry (Francis 2010) in to the poor standards of care seen at Mid Staffordshire Hospitals NHS Foundation Trust, the Prime Minister requested a review in to the quality of care and treatment being provided by hospital trusts seen to be persistent outliers in either the Summary Hospital-Level Mortality Index (SHMI) or Hospital Standardised Mortality Ratio (HSMR) between 2010 and 2012, The Keogh Review (Keogh 2013). Medway NHS Foundation Trust was one of fourteen hospital trusts included within this review and as a result of the findings of the review was placed into special measures. As a result the Trust has been providing six monthly updates on mortality.

The HSMR (rolling year) from March 2013 to August 2015 shows a reduction from 121.22 to 110.68 (Figure 1).

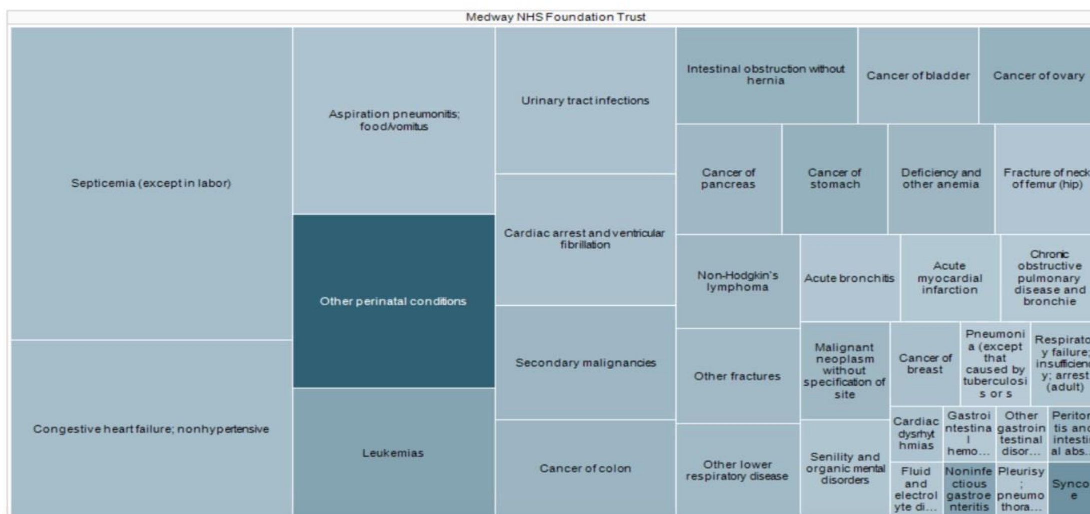
Figure 1: Rolling HSMR (March 2013 – August 2015)



Key: Red = target, Blue = Trust's results, Grey = Trend line

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups. The heat map in figure 2 shows the CCS groups that are having the greatest impact upon the Trust's HSMR; the larger squares on the heat map represent the CCS groups with the greatest number of excess deaths, the darker squares represent the CCS groups with the highest HSMR.

Figure 2. CCS Group Heat Maps



Data Source Healthcare Evaluation Data (HED), accessed 19th October 2015

The CCS group with the greatest number of excess deaths is Septicaemia. Septicaemia, a National CQUIN, remains a concern at Medway and is one of the strategic themes for improvement. Two recently appointed Quality Improvement project nurses are working to educate staff across the Trust to recognise the symptoms of Septicaemia and the importance of the Sepsis 6 Bundle. The implementation of the Sepsis 6 Bundle is being audited and measured as part of the Trust's local Safe to Care Initiative. As a result the Trust has seen a reduction in the crude mortality rate per 1,000 admissions (over the last three year period) from 340 to 254 for patients with a primary diagnosis of Septicaemia.

There has also been an improvement in the rolling year Standardised Mortality Ratio (SMR) for the diagnosis groups of Acute Kidney Injury (AKI), Pneumonia, Chronic Obstructive Pulmonary Disease (COPD) and Stroke since the Trust was placed in to special measures (Figures 3 – 6), this is a reflection of the Trust focus within the Patient Safety Strategy.

Figure 3: Rolling SMR AKI (March 2013 – August 2015)

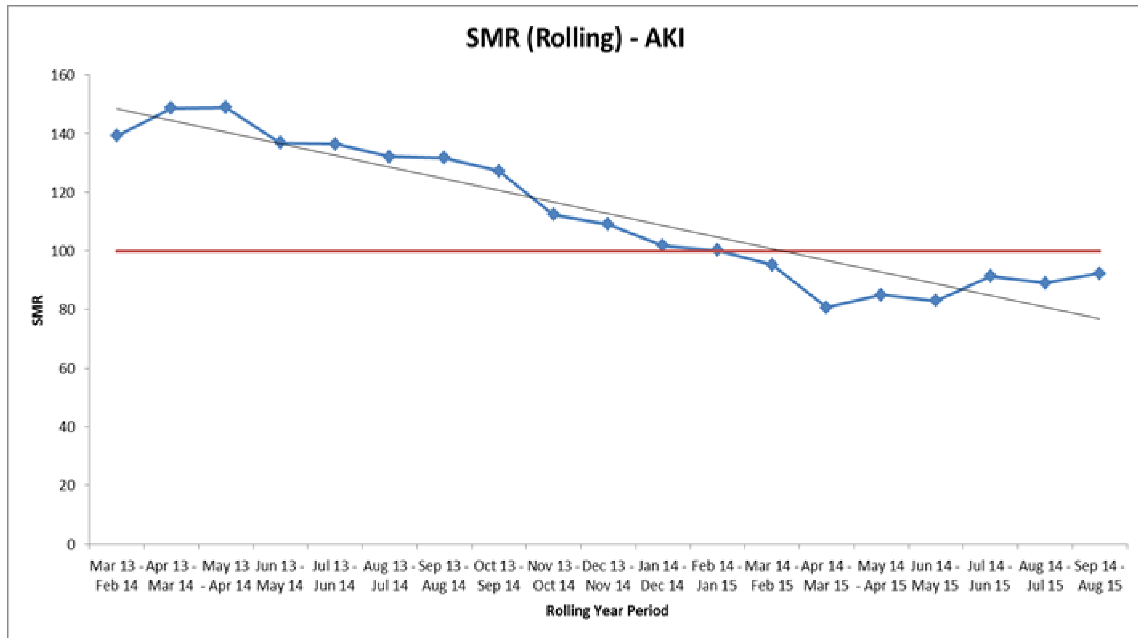
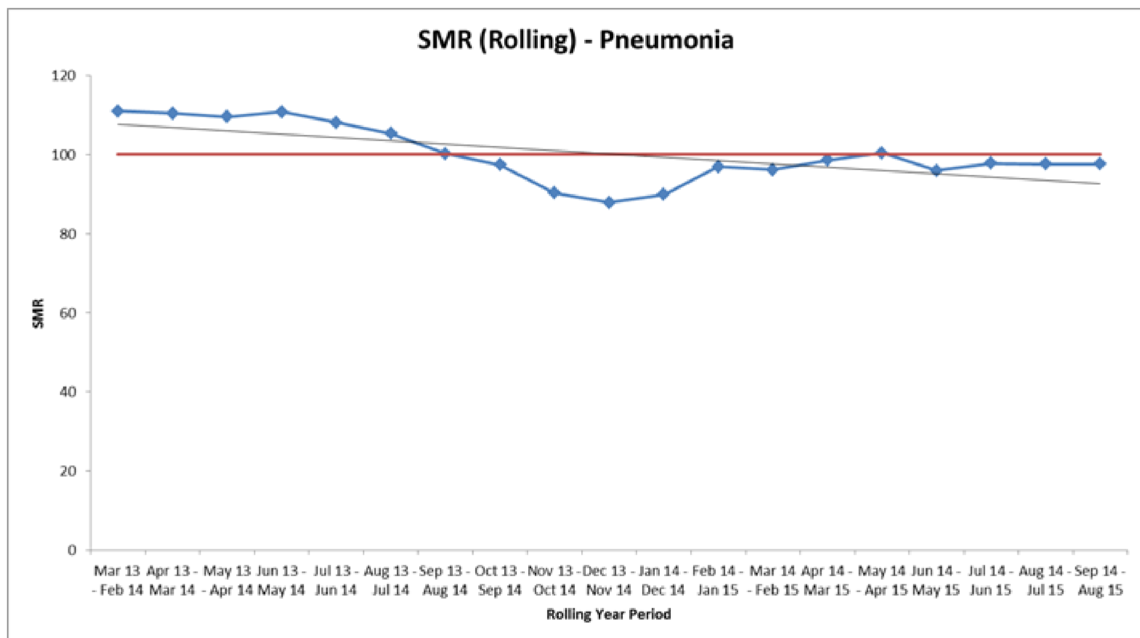


Figure 4: Rolling SMR Pneumonia (March 2013 – August 2015)



Key: Red = target, Blue = Trust's results, Grey = Trend line

Figure 5: Rolling SMR COPD (March 2013 – August 2015)

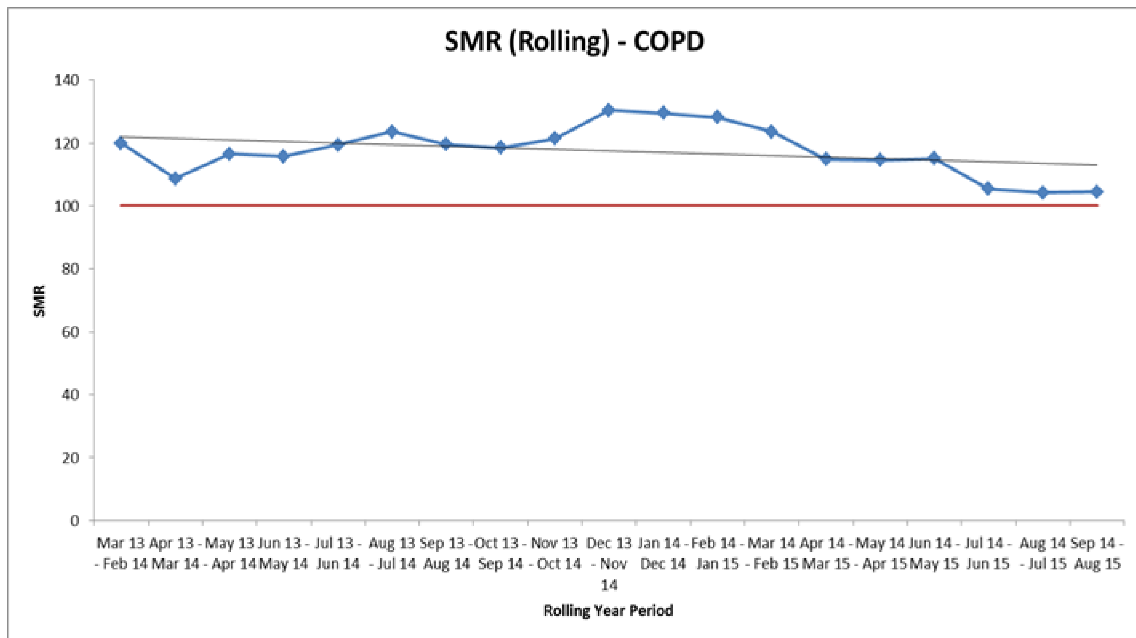
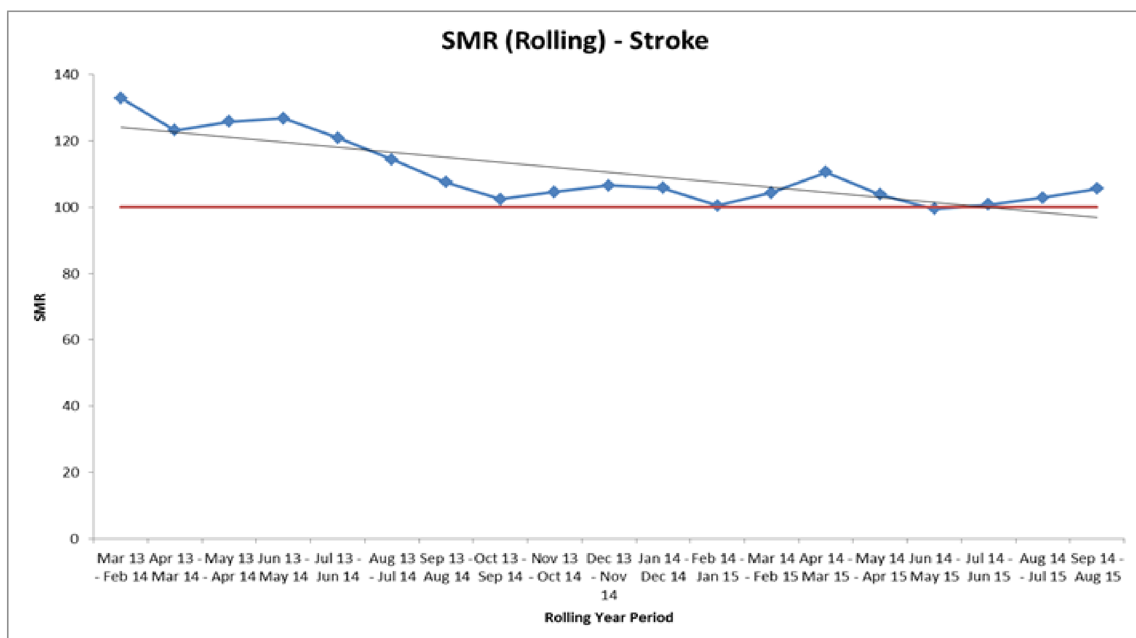


Figure 6: Rolling SMR Stroke (March 2013 – August 2015)



Key: Red = target, Blue = Trust's results, Grey = Trend line

Moving forward the Trust continues to focus upon optimising its medical pathways in order to improve patient outcomes. The Deteriorating Patient (including a continued focus on sepsis) is a priority programme of work for the Trust and a dedicated Project Management Office (PMO) is being created to support this. Congestive Heart Failure non- hypertensive mortality is the focus for improvement in 16/17. Other Perinatal Conditions is also a concern and will be the focus of improvement projects in the short term (we think with others that this is a coding/recording abnormality).

Harm Free Meetings

The Harm Free Meetings purpose is to undertake a weekly review of all incidents, claims and complaints with regard to potential harm to patients.

Responsibilities

• To review all information sources to identify early warning in relation to serious events, areas of concern with complaints, claims, inquests and infection control.

• To action and further communication to relevant areas over and above those already triggered via the Datix system.

• To ensure that all relevant actions are completed in a timescale proportionate to the issue

• To escalate relevant information to the Executive Team.

This relatively new meeting (since August 2015) has been an excellent forum to ensure focus and awareness of potential serious incidents is communicated effectively from Directorate level to executives. It has resulted in ownership of serious incidents and oversight of overarching work such as the increased training in the emergency department and formation of the deteriorating patient action group.

Mortality and Morbidity Meetings

The Mortality and Morbidity meetings are held monthly with good attendance from Specialities sharing learning and best practice. The group have agreed and developed mortality review and minute templates. Trust wide data from completed mortality review forms is shared at this meeting. The newly appointed Mortality Learning Coordinator is facilitating Specialty mortality meetings and has developed a monthly newsletter to disseminate the learning from these.

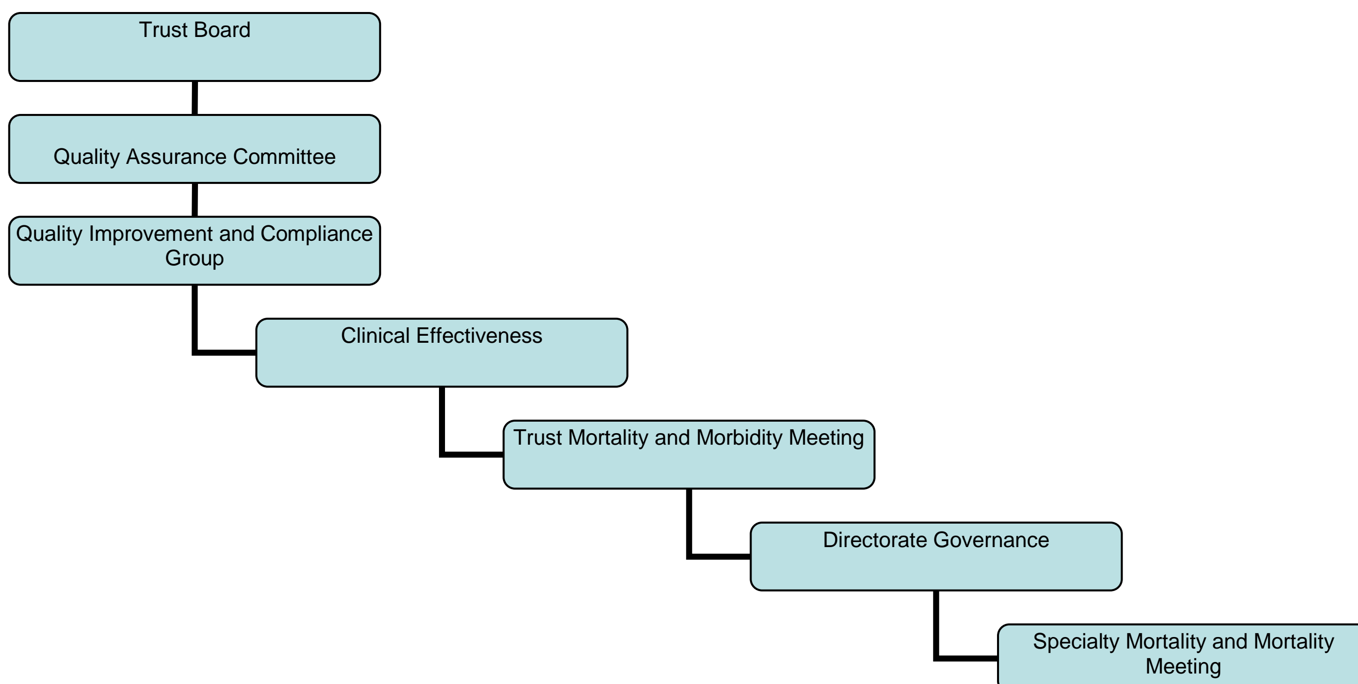
Mortality Working Party

This externally chaired meeting was set up to oversee the HSMR and SHMI at Medway NHS Foundation Trust and provide the Board of MFT and local health economy partners' assurance that all aspects of quality of care and factors that may affect or contribute to the current mortality rates are addressed. The group aims to:

- Develop a joint understanding of the HSMR/SHMI and reasons for MFT being an outlier.
- To review, if appropriate, a wider set of data and other information to identify issues which may contribute to MFT being an outlier.
- To agree an action plan to improve the hospital mortality indicators.
- To gain assurance that action is being taken to improve the quality of care and reduce the risk of death.

The last meeting was held on 6th November 2015.

The reporting pathway for mortality is presented schematically below:



4. Risk Management

The table below highlights the risks associated with the Mortality Action Plan as detailed in Appendix 1:

Risk	Description	Action to avoid or mitigate risk	Risk rating
Limited mechanism for co-ordinated review of themes and trends from Mortality and Morbidity reviews	The Trust is not responsive to common themes impacting upon the mortality of its patients	The Mortality and Morbidity Group explores common mortality themes and trends and escalates them as appropriate to the Quality Improvement and Compliance Group (QICG) and Deteriorating Patient Group	D2
Limited documentation of co-morbidities	The Trust does not have an accurate representation of the illnesses present within the local population, impacting upon both patient care and the Trust's position within published Key Performance Indicators	The Clinical Coding Department currently review documentation with clinicians. Co-morbidity checklist included in admission paperwork for clinicians to complete	E2
Multiple Finished Consult Episodes (FCE) used in general medicine	Multiple Finished Consultant Episodes impact upon the accuracy of primary diagnosis in the published mortality figures and consultant activity data	Plan to reduce number of FCEs in development and taken to Trust Board for approval in November 2015	D2
Clinical and nursing staff does not fully understand the published mortality figures	Staff across the Trust do not have a full understanding of the published mortality indicators and their implications	Establish regular education and awareness sessions to engage and educate staff	D3
Trust Incident Recording System (DATIX) not fully utilised	DATIX not fully utilised leading to silo working across the Trust and lack of shared learning	DATIX review undertaken in October 2015 and the Trust are working with DATIX Development and its peers to identify how the system can be developed.	C2

Limited shared learning across the Trust from specialty mortality reviews	The Trust is not responsive to common themes impacting upon the mortality of its patients	The Mortality and Morbidity Group is a forum for sharing learning from individual mortality reviews.	D2
Limited shared learning across the Trust from Serious Incidents	The Trust is not responsive to common themes impacting upon its patients	The Serious Incident Action Plan is discussed at the QICG and the new Serious Incident process will ensure that learning events are held across the Trust	D2

Appendix 2

Medway NHS Foundation Trust:
Action Plan for Improving Mortality Rates
December 2015 Update

Dr P Bain

Chief Quality Officer

Dr D Hamilton – Fairley

Medical Director

Karen Rule

Chief Nurse

1. Background: Mortality – Current Position

The overarching issues relating to the Trust mortality position relating to:

- Health of our population
- Quality of care
- Clinical coding including palliative care codes and co-morbidities
- End of Life care and cross healthcare support

Currently our HSMR for the latest period that can be reported (September 2014 – August 2015) is **110.68** which is statistically significant.

The SHMI for the latest period that can be reported (April 2014 – March 2015) is **118**, this was formally published on 28th October 2015.

It is critical that MFT starts to show some improvement in mortality rates, specifically for patients and also to enable the trust to remove enforcement actions currently in place from Monitor in relation to our higher than expected mortality rates.

1.1 MORTALITY ACTION PLAN

This action plan is intended to be a live document, and will be updated as the project progresses in agreement with the Mortality Steering Group, with progress against the plan reported within regular progress update meetings at Quality Improvement and Compliance Group and escalations to CEAG. All KPIs from each activity are included in the mortality scorecard – this will be reported to all groups and Board on a regular basis.

Key:

AB	Adrian Billington	CQO	Chief Quality Officer	KR	Karen Rule	SL	Sarah Leng
ADQI	Associate Director of Quality Governance & Improvement	DB	Debbie Brown	MD	Medical Director	SW	Sue Whiting
AH	Adrian Hopper	Dep CN	Deputy Chief Nurse	MDA	Margaret Dalziel	TB	Trisha Bain
CC	Chris Carter	GR	Ghada Ramadan	NJ	Neal Jackson	RL	Richard Leach
CEO	Chief Executive Officer	GSTT	Guy's & St Thomas'	PS Team	Patient Safety Team		
CN	Chief Nurse	KN	Kerry Nunn	RJ	Robert Johnson		

For M&M Group Review

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
A	**GOVERNANCE AND LEADERSHIP**					
B	**OPERATIONAL EFFECTIVENESS**					
	Mortality & Morbidity Group led by Dr G Ramadan (support GSTT Dr Richard Leach) Escalations/Quarterly progress report to Quality Improvement & Compliance Group	Now in place. June 2015 onwards	**Number of meetings held** **Number of members attending (Evidenced by meeting minutes)**	Discussed July QICG –Due back at September QICG. October 2015 – New Deteriorating Patient Group set up which will feed in to this group.	RL	MD
	All Mortality KPIS included in Board and divisional scorecards Mortality Alerts investigated, acted upon, activities included in Mortality Steering Group agenda and action plans Themes from Mortality Reviews fed into action plans additional KPIs consider from findings	Completed May 2015 In progress and on-going June onwards	**On-going reduction in:** **HSMR** **SHMI** **Crude death rate** **From June baseline**	Current position 119 (data June 2015). October 2015 – HSMR currently 112.6 (data July 2015) The IQPR contains Mortality KPI's. November 2015 – HSMR currently 110.68 (data August 2015). SHMI (April 14 – March 15) is 118.	SL/KN	CQO
	Review the templates for mortality review process, including the Mortality & Morbidity Form and the standardised M&M specialty meeting minutes template	Templates agreed June 2015	**Templates in place**	Draft template June 2015. October 2015 - review templates developed further. Draft minutes template created and agreed at M&M meeting 16.10.15. November 2015 – minutes template in place and being used. Form revised to GSTT format and sent to clinicians for feedback.	RL	MD

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
	Clearly articulate the Trust's interpretation of the roles and responsibilities of clinicians in mortality reviews	Awareness raising sessions throughout July to end of year.	**Number of specialities returning Mortality proformas**	Sessions started July 2015 – August 13th CG training clinical leads /GSTT. October 2015 – Approximately 200+ forms returned to date. Working with remaining areas to set up meetings/agenda/minutes to the agreed format. November 2015 – approximately 250 forms returned. Surgery and ED now the only remaining specialties not completing the forms. Meetings arranged.	RL	MD

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
	Review use of EDN'S by junior doctors in AMU/Admission areas to ensure that the correct co-morbidities are recorded on admission and also to aid junior doctors in making the correct diagnosis on admission. Co-morbidity checklist included in admission paperwork – clinicians to tick co-morbidities of patient on admission – coding to code from sheets.	July onwards July 2015	**Number of clinicians trained** **Coding improvement by speciality – feedback reports on Qlikview** **Number of completed EDN reviewed on admission** **Increase in co-morbidity recording from current level of 2.3 to 5 by April 2016** **Improved HSMR/SHMI by April 2016**	Coding currently reviewing recording with clinicians. Review EDN status and develop programme of improvement with junior doctors/A&E/consultants. Coding checklist agreed July 2015. Coding sheets in the notes week beginning 20.7.15. Reduction in Backlog from 600+ to 300 (Sept 2015) – weekly reports to all wards/specialties, now entered real-time. Qlikview report not working. Business Intelligence Team is investigating this. October 2015 – Coding Data Quality Auditor is providing training to FY1/2's in addition to a coding talk at induction days. October 2 week co-morbidity audit results: AMU 61% complete, SAU 52% complete. Moving forward, Stethoscope will be used to look at the mean Charlson co-morbidity score and to identify problem areas. Awaiting confirmation from lead anaesthetist for the form to be used in conjunction with 'safer sleep' forms. Discussions also taking place about a similar form for paediatrics.	CC	CQO
	Multiple FCEs used in general medicine	July 2015Datix	**Reduced FCE in GM specialities**	Meeting and message to leads in Medicine division given. October 2015 – to continue work, a meeting was set up for 27/10/15 but was cancelled. Meeting is to be rearranged. November 2015 – Plan to reduce number of FCE's taken to trust board for approval 26/11/15.	RL	MD

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
	Training of ward clerks in data quality relating to FCEs/recording on system	September onwards	**Increased training of ward clerks in Data Quality**	Training Packs received UHB. Analysis being conducted Sept 2015 re impact.	CC	CQO
	Feedback and monitoring process for coders reviewed to ensure disease specific coding is captured accurately - Qlikview to be further developed	July onwards	**Coding standards as per IG Toolkit met for 2015/16 quality account**	Coding expert meeting with team July 21-22nd to share systems and processes. New Head of Clinical coding interviews w/b 28.9.15.	CC	CQO
	Engage with medical and nursing staff to raise awareness and understanding of mortality	June 2015 ongoing	**Knowledgeable staff**	Clinical Grand Round. Senior nurse meetings.	CQO	MD
C	**PATIENT AND CARER EXPERIENCE**					
	Subject specific monitoring: Deteriorating Patient	First year of PS strategy	**Increased escalation of deteriorating patient** **Increased NEWS**	KPIS included in mortality scorecard. October 2015 - Deteriorating Patient Group initial meeting 12th October 2015. November 2015 – Deteriorating patient a focus of priority programme workshop 30/11/15. Deteriorating Patient database being created.	RL/AH	MD
D	**PATIENT SAFETY**					
	Reliable implementation of NEWS	August 2015	**Increased use of NEWs**	End of December 2015 – additional focus on ED (ED Action plan).	RL/AH	MD

For Information – Quality Improvement Compliance Group

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
A	**GOVERNANCE AND LEADERSHIP**					
	Review of clinical governance and improvement arrangements	June 2015	**Improved clarity of governance arrangements**	GSTT programme started – new committees in place. October 2015 - There is a new organisational structure, and recruitment to the new Clinical Director roles is under way. Interviews will take place next week. GSTT suggested a model for clinical governance structure, work is being done to finalise the model under four main work-streams: patient safety, patient experience, clinical effectiveness and research, regulatory and standards. This is expected to link in to the directorate work programme.	GSTT	CQO
B	**OPERATIONAL EFFECTIVENESS**					
	Commence programme of patient flow emergency and surgical pathways	July 2015	**Pathways changed**	Scoping agreed July 2015. Work underway.	GSTT/Clinical leads/RJ	CEO
	Continue development of frailty pathway	March 2015	**Recued LOS >80yrs**	Reduction seen. Reduction in admissions >80yrs.	MDA	CEO
C	**PATIENT AND CARER EXPERIENCE**					
	Training on handling complaints/DoC	May to Dec 2015	**Increased training**	Under review.	Dep CN	CN
	Review of complaints process	May to Dec 2015	**New process in place**	Under review.	Dep CN	CN
	Continued work on surgical and medical pathways	July 2015	**Pathways in place**	Scoping document signed off – work underway GSTT.	GSTT/RJ/MDA	CEO
D	**PATIENT SAFETY**					
	Complete and monitor Serious incident Action Plan	June 2015 to Dec 2015	**Action plan complete**	Target for end of December 2015 – This action plan is reviewed at the QIG monthly, some actions may require continual monitoring for a longer period for assurance.	DB	CQO
	Sepsis bundles implemented	Dec 2014 on-going	**Increased use of bundles**	Increased assessments and diagnosis (part of Safe to Care work stream).	SL/GR	MD

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
	Serious Incident and Patient Safety – enhanced learning from incidents/events	Nov 2015	**Event held**	Recruited new Head of Patient Safety August 2015. Launch of new process and training Nov 2015.	GR/SL/MD/CN/DB	MD/CQO
	Review of patient safety strategy outcomes	June 2015	**Strategy in place**	Part year Dec 2015.	DB	MD
	Clinical Governance and Patient Safety Programme	June 2015	**Leadership programmes and training sessions completed** **Action plan complete end 2015**	X 2 sessions completed.	GSTT/MD/CQO	CQO
	Review Datix system	Sept 2015	**Datix used by all – increased reporting**	Initial review planned October 2015. October 2015 - Initial meeting took place on 12th October 2015. Consultation day to take place 1st week in December. Patient Safety Team visited Chester Hospital 26th-27th October to see how they have developed Datix. November 2015 – Datix developer visiting 16/12/15.	PS Team	ADQI
	Handover to be included in bed management module	Dec 2015	**BM inc SBAR handover module**	Bed management – Dec 2015. November 2015 – Treatment escalation protocol to be added to standardised ward round.	NJ/AB	CQO
	Full roll out of 24/7 working	May on-going	**24/7 in place**	24/7 consultant cover at weekends and OOH.	GR	CEO
	Ensure consultant ward rounds occur	March 2015 on-going	**All ward rounds conducted with consultant lead**	Started – still needs consistent input consultants.	RL/MD	CEO
	Develop and implement trust wide RCA and human factors training programmes	Sept 2015	**Trust wide programme in place**	November 2015 start date. External training already completed in Acute & Continuing Care. Internal training sessions booked for January.	DB	CQO

Completed Actions

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
A	**GOVERNANCE AND LEADERSHIP**					
	Harm Free Review Group: Chair CQO Divisional Incident review Groups Chair Divisional Leads Escalations/Monthly progress report to Quality Improvement & Compliance Committee and CEAG/Board	Now in place. June onwards	**Number of meetings held** **Number of members attending** **Closure of overarching SI action plan** **Timeliness of closed SIs improved** **Evidence of learning from incidents, SI, mortality, inquests, complaints**	All groups met and Terms of Reference agreed. Standard templates for meetings and ToR July 14th evidence collated for SI action plan July 23rd closure of historical Sis October 2015 – New SI process being developed and new Patient Safety Team in post. Learning from incidents and themes from the overarching SI action plan to be included in training and trust-wide communication. This action will be monitored via QICG.	SL	CQO
	Development and implementation of Trust wide Safety Culture questionnaire	September 2015	**KPI'S TBA**	Start date October 2015.	GR	MD
	Executive walk arounds – using safety checklist	June 2015 and ongoing	**Number of walk-arounds**	Monitored via MD secretaries. Ward allocation to execs – currently 5 walk arounds per week each exec covering all wards (prior to CQC visit). October 2015 – Ongoing drop-in sessions for engagement with executives set up as well as 'Lunch with the Chief Executive'.	CN/MD/CQO	CN/MD/CQO
B	**OPERATIONAL EFFECTIVENESS**					

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
	Mortality themed database developed and themes agreed – learning fed into M&M meeting, directorate governance meetings and QICG	May 2015 onwards		In place and on-going development with Mortality Leads (including promotion of contributory factors).	SL	MD
	Reinforce timeliness of discharge letters/EDNs with co-morbidities	June 2015	**Improved coding and diagnosis** **Junior docs trained**	July 2015 complete – as above.	Clinical Leads	CQO
	Agreement on admission criteria Hospice	May 2015	**Increase admissions to hospice on patients EoLC**	Discussion with COO has taken place. Review of EoLC by Chief Nurse will feed into the EoLC Steering Group. Ongoing work required through this group.	KR	CN
C	**PATIENT AND CARER EXPERIENCE**					
	Monitoring of Quality metrics as part of strategy	Quality Metrics 2015/16	**Improved quality of care**	KPIs included in quality performance report at Board.	TB/SL	CQO
	Monitoring of Sign up to Safety metrics	Jan 2015	**Reports with progress**	Reports available.	GR/SL	CQO
	Drop in events CNO	May on-going	**Attendance at events**	Bi weekly drop in in place.	Dep CN	CN
	More formal analysis of themes	July 2015	**Themes in Board report**	Monthly report.	Dep CN	CN
	Review how compliments can be collated	August 2015	**Themes in Board report**	Monthly report.	Dep CN	CN
	Consult identified key stakeholders across healthcare setting regarding the review of policies and procedures in relation to End of Life Care	Consultation and feedback to be obtained in July/August 2015	**EoLC pathway and guidelines in place**	An End of Life strategy will be developed. Provided self-assessment for our quality of EoLC update was discussed at the October 2015 EoLC Steering Group. This work is to be monitored by the EoLC Steering Group.	Matron EoLC	CN

Ref	Action/TASK	Timescales Start/Finish	Outcome	Progress update	Lead	Executive Lead
D	**PATIENT SAFETY**					
	Sign off of historical SIs	July 2015	**Closure of SI'S**	End of July 2015.	SW	CQO
	Performance Management Meetings all relevant KPIs	May 2015 on-going	**All quality metrics discussed and actions completed**	X 3 meetings action points completed.	ALL	CQO

CF: POPULATION HEALTH: The Health of our population will be reviewed and addressed via our Trust wide strategy and in relation to our clinical service reviews and accompanying strategies – work will start on these August 2015 and be completed for April 2016

Care Quality Commission (CQC) Update and Progress against the Remedial Action Plans

The draft report from the CQC trust-wide inspection carried out on 25th – 27th August is still awaited, however we are expecting receipt of this imminently. The subsequent Quality Summit, originally planned for the 14th December, is likely to not now take place until early January 2016.

The Trust has 5 Remedial Action Plans (RAPs) in place which are related to Cancer, Imaging, the Emergency Department, Referral To Treatment (RTT) and Endoscopy.

Cancer

- Overall good progress has been made with the high level action plans within the RAP. The Trust had a mid-way review from the Intensive Support Team last month where the Trust received positive feedback on the progress made to date.

Imaging

- Overall good progress has been made with the RAP. The aim is to have the imaging RAP closed by the end of this month.

Emergency Department

- Work against the Emergency Department Improvement Plan continues with 4 actions from a total of 24 now closed and a further 17 actions having been completed, the impact of these are being monitored through a daily dashboard and a weekly conference call with Monitor, NHS England and the CQC.
- ED Education Plan (which sits underneath the ED Action Plan):
  Steady progress is being made with the 2 day ED Essentials Training for Nursing staff. Cohort three of staff completed the training on 20/11/15 – 18 trained Nursing Staff have now been through the formal training and evaluation. The Advanced Training Module is starting the accreditation process with Greenwich University in the new year.
- The Mutual Aid plan drafted in response to the CQC feedback has not resulted in significant support from neighbouring Trusts. The plan will be reviewed prior to closure with Monitor and NHSE in the coming weeks.

RTT

- A validation plan and trajectory has been developed to ensure RTT pathways are validated by end of January 2016
- There remains back log with 18week pathway and focus is given to prevent 52 week breaches
- Discussions are being held regarding outsourcing for areas of greatest capacity issues.

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Endoscopy

- The number of patients waiting for endoscopes is increasing. Urgent actions are being taken to identify additional capacityin order to achieve compliance by February 2016.