ENFORCEMENT UNDERTAKINGS

LICENSEE:

Countess of Chester NHS Foundation Trust ("the Licensee")
The Countess Of Chester Health Park
Liverpool Road
Chester
Cheshire
CH2 1UL

DECISION

On the basis of the grounds set out below, and having regard to its Enforcement Guidance, NHS Improvement has decided to accept from the Licensee the enforcement undertakings specified below, pursuant to its powers under section 106 of the Health and Social Care Act 2012 ("the Act"). In this document, "NHS Improvement" means Monitor.

BACKGROUND

The Licensee's expected financial position for 2021/22 is break-even, however, the finances have been distorted due to additional financial support provided by the government during the COVID-19 pandemic. The Licensee still has a significant underlying deficit that requires addressing once the system returns to normal funding arrangement. Draft plans for 2022/23 indicate a £28m deficit.

The Licensee has been subject to a series of escalating concerns relating to maternity care, urgent and emergency care, elective waiting times, data timeliness and quality, mortality, and serious incident management.

The CQC conducted a full inspection in December 2018 and rated the Licensee as Requires Improvement overall. All domains were rated Requires Improvement apart from Caring, which was rated Good.

The Neonatal Service has remained on enhanced quality surveillance since 2016 following concerns related to the higher than expected mortality and the subsequent police investigation. In October 2021 a Single Item Quality Surveillance Group was established to focus on the following quality concerns:

- Increasing Hospital Standardised Mortality Ratio (HSMR)
- 52+ week and 104+ week Waits
- Cancer 62-day backlog and endoscopy backlog
- Serious Incident Management and Reporting
- Issues with pathways
- Issues with Clinical Information Systems (Cerner)
- Waiting List Issues
- Impact of flow on patient safety and quality.
- Maternity – Continuity of Care for Women, Elective/Emergency Caesarean Sections and Improving Care and Outcomes of Women and Babies.

The CQC performed an unannounced inspection during February 2022 and a Well -Led inspection was completed in March 2022.

On the 18th March 2022, the Licensee was served with a 29a Warning Notice in relation to Post-Partum Haemorrhage (PPHs) in Maternity Services.

On the 8th April 2022 the Licensee was served with a section 29A Warning Notice in relation to:

1. Suitable governance systems and processes to effectively manage patient referral to treatment waiting times performance.
2. Effective systems and processes to identify, assess and mitigate key risks associated with the implementation of a new electronic patient record (EPR) system.
3. Effective governance systems and processes relating to the management of incidents, complaints, and patient death reviews.

The CQC report is pending.

GROUNDS

1. Licence

The Licensee is the holder of a licence granted under section 87 of the Act.

2. Breaches

NHS Improvement has reasonable grounds to suspect that the Licensee has provided and is providing health care services for the purposes of the NHS in breach of the following conditions of its licence: FT4(4)(a) to (c), FT4(5)(a) to (d), FT4(5)(e) to (f), FT4(6)(a) to (d) and (f), FT4(7) and CoS3.

3. Financial Sustainability

3.1 The Licensee has reported annual deficits of £12.7m in 2018/19 and £8.0m in 2019/20 (excluding Provider Sustainability Fund).

3.2 The Licensee's financial position for 2020/21 was a deficit of £1.4m, however, the finances have been distorted due to an additional system financial support provided by the Government during the COVID-19 pandemic.

3.3 The Licensee's expected financial position for 2021/22 is breakeven. However, the finances have been distorted due to additional system top-up funds made available to Trusts via ICB allocations during the financial year.

3.4 The draft 2022/23 financial plan is reporting a deficit of £28m and has a significant underlying deficit of concern.

3.5 The matters set out above demonstrate a failure of governance and financial management by the Licensee, including, in particular:

3.5.1 a failure by the Licensee to adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

(a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

3.5.2 a failure to establish and effectively implement systems and/or processes:

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively; and

(b) for effective financial decision-making, management, and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)

4. <u>Quality</u>

4.1 The Licensee:

4.1.1 Has been subject to a series of escalating concerns relating to maternity care, urgent and emergency care, elective waiting times, data timeliness and quality, mortality, and Serious Incident management.

4.1.2 Has been subject to a Single Item Quality Surveillance Group, established to focus on the above quality concerns: Noting that some improvements have been made.

4.1.3 Was inspected by CQC during February 2022 and a Well-Led inspection was completed in March 2022. The Licensee has been issued with two section 29A Warning Notices by CQC related to:

- Maternity and Midwifery Services - Post-Partum Haemorrhage (PPHs) in Maternity Services; not effectively or appropriately, assessing, recognising, and managing the risks to service users including management of Post-Partum Haemorrhage and hysterectomy.

- Treatment of disease, disorder or injury- provision of suitable governance systems and processes to effectively manage patient referral to treatment waiting times performance: effective systems and processes to identify, assess and mitigate key risks associated with the implementation of a new electronic patient record (EPR) system: effective governance systems and processes relating to the management of incidents, complaints and patient death reviews.

  Specifically:

(a) The Licensee could not provide assurance that it recognised and addressed incidents that were significant in relation to PPH and Hysterectomies.
(b) There was one maternity theatre on the central labour suite and a separate room used as a backup theatre in an emergency. The Licensee could not provide assurance that either of these areas were equipped with the appropriate equipment or staff were competent in its use.
(c) Managers did not consistently investigate incidents. Women and their families were not involved in these investigations.
(d) Whilst the Licensee had a Postpartum Haemorrhage Policy in place, there was evidence from the SBARs that clinicians were not always following the trust guidance.
(e) The Licensee had not undertaken appropriate actions to maintain the safety of service users.
(f) The learning identified was not always sufficiently or appropriately actioned.
(g) The classification of incidents was not always appropriate to assist in the recognition of risk.
(h) The Licensee does not have suitable governance systems and processes to effectively manage patient referral to treatment waiting times performance. Clinical validation of patients on the referral to treatment pathway waiting lists was not complete across a number of specialties; not all patients on the waiting list had been assessed to determine any risk factors associated with the extended waiting times for their treatment.
(i) There is a lack of assurance that the Licensee has effective systems and processes to identify, assess and mitigate key risks associated with the implementation of a new electronic patient record (EPR) particularly a staff lack of training or understanding of the EPR system in order to effectively complete patient records, including care plans and patient risk assessments (such as for falls or pressure care).
(j) For medicines management, there are a lack of controls or restrictions within the EPR system. This poses a potential risk of patient harm if medicines are prescribed or administered incorrectly.
(k) The Licensee could not demonstrate effective systems and processes in relation to the timely reporting and investigation of serious incidents.
(l) The Licensee could not demonstrate an effective and consistent approach to undertaking patient death reviews using the structured judgement review methodology.
(m) Complaints were not always acknowledged or responded to within the timelines stated in the trust's policy for listening and responding to concerns and complaints.

4.2 The matters set out above demonstrate a failure of governance arrangements including, in particular a failure to establish and implement:

4.2.1 effective board and committee structures

4.2.2 clear responsibilities for the Board, committees reporting to the Board and staff reporting to the Board and those committees

4.2.3 clear reporting lines and accountabilities throughout the organisation

4.2.4 systems and/or processes:

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively
(b) for timely and effective scrutiny and oversight by the Board
(c) to ensure compliance with healthcare standards specified by the CQC
(d) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making
(e) to identify and manage material risks to compliance with licence conditions
(f) to ensure the matters relating to quality of care specified in FT4(6)(a)- (d) and (f).

5. Performance

5.1 A Section 29A Warning Notice was issued by the Care Quality Commission on 8th April 2021 subsequent to an inspection which found that the Licensee does not have suitable governance systems and processes to effectively manage patient referral to treatment waiting times performance.

5.2 The total number of patients on the Licensee's referral to treatment (RTT) waiting list has increased from 25,051 patients in July 2021 to 44,446 patients in January 2022, and weekly 104-week reporting data showed the Licensee had 858 patients on the 104-week waiting list on 18 March 2022.

5.3 In January 2022, only 63.29% of patients were seen by a specialist within two weeks of an urgent GP referral, compared to the national target of 93%.

5.4 The inspection found insufficient assurance that senior leaders had ensured a sufficient pace of change or timely implementation of an effective recovery plan.

5.5 The inspection found that clinical validation of patients on the referral to treatment pathway waiting lists was still on-going across a number of specialties, with the result that not all patients on the waiting list had been assessed to determine any risk factors associated with the extended waiting times for their treatment.

5.6 The delayed implementation of an effective recovery plan increases the risk of potential risk of harm to patients experiencing long delays for their treatment.

6. Need for Action

NHS Improvement believes that the action, which the Licensee has undertaken to take pursuant to these undertakings, is action to secure that the breaches in question do not continue or recur.

7. Appropriateness of Undertakings

In considering the appropriateness of accepting in this case the undertakings set out below, NHS Improvement has taken into account the matters set out in its Enforcement Guidance.

UNDERTAKINGS

NHS Improvement has agreed to accept, and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act:

1. Quality of care

1.1. The Licensee will take all reasonable steps to rectify the concerns which are set out in the two CQC 29A warning Notices, in such timescales to be agreed with NHS Improvement (except where otherwise specified), such that the Licensee will:

1.1.1 Within the timeframe required by the CQC and the System Improvement Board finalise and submit to the CQC and to the System Improvement Board, a Quality Improvement Plan detailing actions which the Licensee will take to address Concerns raised by CQC in the two 29A Warning Notices specifically:

1.1.2 Demonstrate through the Quality Improvement Plan that robust governance processes in relation to Post-Partum Haemorrhage and Hysterectomies are in place, demonstrating timely identification and management of risk including processes for shared learning.

1.1.3 Ensure theatres used for maternity are appropriately equipped and staff are competent in its use.

1.1.4 Demonstrate through the Quality Improvement Plan that robust governance processes in relation to the identification and management of Serious Incidents and processes for shared learning, are in place.

1.1.5 Ensure that staff have the required training to use the EPR system (Cerner) in order to effectively complete patient records, including care plans and patient risk assessments (such as for falls or pressure care).

1.1.6 Manage the risks associated with the lack of controls or restrictions within the EPR system. This poses a potential risk of patient harm if medicines are prescribed or administered incorrectly.

1.1.7 As part of an overarching Mortality Improvement Plan, demonstrate an effective and consistent approach to undertaking patient death reviews using the structured judgement review methodology and bring together all elements of mortality improvement in one overarching plan.

1.1.8 Provide a recovery trajectory to ensure complaints are acknowledged and responded to within the timelines stated in the Licensee's policy for listening and responding to concerns and complaints.

1.2 The Licensee will implement all the recommendations from the NHS England and Improvement Governance Review in a timeframe agreed with the System Improvement Board.

2. Performance

2.1 The Licensee will take all reasonable steps within its control to:

2.1.1 Eliminate 104+ week waits for elective treatment and eliminate waits in excess of 78 weeks in line with operational planning guidance for 2022/23. In support of this, an improvement trajectory should be set and agreed with the System Improvement Board.

2.1.2 Rapidly improve performance against the 14 day cancer waiting time standard (% patients seen within 2 weeks of referral 93% standard). In support of this, an improvement trajectory should be set and agreed with the System Improvement Board.

2.1.3 Ensure that an effective elective recovery plan is put in place and implemented at pace, with evidence of appropriate ongoing oversight at Board level. This will be monitored through the System Improvement Board.

2.1.4 Ensure completion of the clinical validation of patients on the referral to treatment pathway waiting lists to determine any risk factors associated with the extended waiting times for their treatment. This will be monitored through the System Improvement Board.

3. Financial planning

3.1 The Licensee will deliver the Licensee's 2022/23 Financial Plan once it has been agreed with the Cheshire and Merseyside ICS, as part of an overall ICS balanced plan for 2022/23.

3.2 The Licensee will ensure its underlying financial position improves during 2022/2023 on a trajectory to be agreed with the Cheshire and Merseyside ICS and NHS England and Improvement. The source documents for this review will be the 2021/22 financial accounts, the 2022/23 financial plan and the 2022/23 financial performance.

3.3 The Licensee will ensure that robust financial controls, process, and governance are in place to ensure accurate financial reporting and to secure value for money.

3.4 The Licensee will cooperate and actively participate in the Cheshire and Merseyside ICS financial sustainability and efficiency programmes, including by utilising national tools to identify unwarranted variation and productivity opportunities.

3.5 The Licensee will implement sufficient programme management and governance arrangements to enable delivery of the actions in the Financial Plan.

4. Funding conditions and spending approvals

4.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee pursuant to section 40 of the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.

4.2 The Licensee will comply with any reporting requests made by NHS Improvement in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to section 40 of the NHS Act 2006.

4.3 The Licensee will comply with any spending approvals processes that are deemed necessary by NHS Improvement.

5. General

5.1 The Licensee's progress against compliance with these undertakings will be discussed as a regular item on the System Improvement Board established by NHS Improvement.

5.2 The Licensee will:

5.2.1 Develop an Integrated Improvement Plan, by a date and in a form to be agreed by NHS Improvement, that (as a minimum) addresses the quality, performance, and financial concerns as set out above in paragraphs 1 to 4. The Integrated Improvement Plan will be developed in collaboration with key stakeholders from the health and social care system.

5.2.2 Evidence all reasonable steps have been taken to deliver the Integrated Improvement Plan outcomes as set out and agreed by the System Improvement Board, in accordance with the timescales agreed by the System Improvement Board.

5.3 In line with the System Improvement Board Terms of Reference and the requirements of the System Oversight Framework segmentation, the Licensee will cooperate fully with NHS England and NHS Improvement, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address regulatory concerns.

6. Reporting

6.1 The Licensee will provide regular reports to NHS Improvement on its progress in meeting the undertakings set out above and will attend meetings, or, if NHS Improvement

stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. These meetings will take place once a month unless NHS Improvement otherwise stipulates, at a time and place to be specified by NHS Improvement and with attendees specified by NHS Improvement.

6.2 The Licensee will provide NHS Improvement with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.

6.3 The Licensee will comply with any additional reporting or information requests made by NHS Improvement.

The undertakings set out above are without prejudice to the requirement on the Licensee to ensure that it is compliant with all the conditions of its licence, including any additional licence condition imposed under section 111 of the Act and those conditions relating to:

- compliance with the health care standards binding on the Licensee; and
- compliance with all requirements concerning quality of care.

Any failure to comply with the above undertakings will render the Licensee liable to further formal action by NHS Improvement. This could include the imposition of discretionary requirements under section 105 of the Act in respect of the breach in respect of which the undertakings were given and/or revocation of the licence pursuant to section 89 of the Act.

Where NHS Improvement is satisfied that the Licensee has given inaccurate, misleading or incomplete information in relation to the undertakings: (i) NHS Improvement may treat the Licensee as having failed to comply with the undertakings; and (ii) if NHS Improvement decides so to treat the Licensee, NHS Improvement must by notice revoke any compliance certificate given to the Licensee in respect of compliance with the relevant undertakings.

LICENSEE

Signed (Chair or Chief Executive of Licensee)

Dated: 30.06.22

NHS IMPROVEMENT

Signed (North West Regional

Director) Dated: 19 July 2022