ENFORCEMENT UNDERTAKINGS

LICENSEE:

University Hospitals Morecambe Bay NHS Foundation Trust ("the Licensee")
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

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

NHS Improvement accepted enforcement undertakings from the Licensee under section 106 of the Act in May 2018 in relation to financial performance in 2016/17 and 2017/18. Since this point the Licensee has reported annual deficits of £69.3m (2018/19) and £61.7m in 2019/20 (excluding Provider Sustainability Fund). In addition, as a consequence of these deficits, the Licensee has previously been reliant on revenue support from the Department of Health and Social Care.

The financial position for 2020/21 was a surplus of £0.5m, however, the finances have been distorted due to an additional £65m of financial support provided by the government during the COVID-19 pandemic. The Licensee still has a significant underlying deficit that will require addressing once the system returns to normal funding arrangement. NHS Improvement is therefore now taking further regulatory action in the form of accepting revised financial undertakings to reflect the current position. The financial undertakings in this letter replace the previous undertakings, some of which are no longer appropriate due to the passage of time and changes in the Licensee's circumstances.

Throughout 2019/2020 to date, the Licensee has experienced several clinical quality and operational challenges, particularly in relation to the emergency care pathway and cancer pathways. Whilst during the pandemic this has been the position of many trusts, this has been further compromised by the significant work the Licensee needed to undertake following the recent Good Governance Institute Report, the financial position and also the significant workload arising from historic investigations and concerns in relation to learning from and transacting recommendations from a number of external reviews.

The Good Governance Institute (GGI) reviewed the organisational governance during Q3 and Q4 2020/ 21 and issued a report with recommendations in January 2021. The report found work was needed to rapidly review Serious Incidents requiring investigations, Patient Advice, complaints and claims, to ensure investigation findings are thematic, triangulated and that the lessons are more effectively shared across the organisation.

Niche were commissioned by NHS England in November 2019 to investigate Urology Services. The investigation found the following:

- Insufficient line of sight from the Urology department to the Board with key risks that are not always identified or monitored effectively, along with a lack of clarity around performance accountability:
- Some dysfunctional staff dynamics which presented risks to a safe and effective clinical working environment, inadequate departmental management, and trust level monitoring of Urology mortality reviews
- limited thematic reporting of complaints, litigation and incidents, or follow-up of reviews which had taken place

Both the Urology Investigation Niche report dated November 2021, and the GGI Report demonstrated the Licensee's quality governance processes were not fit for purpose.

The Licensee is required to provide executive attendance to the System Improvement Board which has been established to oversee the delivery of all actions from external reviews and ensure the actions are complete and embedded. This includes all outstanding actions from CQC inspections.

The Licensee has been in receipt of additional Medical and Nursing Executive Leadership support and an NHS Improvement Director.

Following the CQC Inspection on the 20th of April-14th of May 2021, and subsequent section 31a letter in relation to the Stroke pathway, and publication of the CQC report on 21st August 2021, NHS Improvement will take regulatory action in the form of accepting the undertakings detailed below.

To summarise, as a result of the governance and finance issues set out above, which have led to the Licensee being moved into segment 4 following regulatory review against the System Oversight Framework for 21/22, NHS Improvement is now taking further regulatory action in the form of accepting these undertakings. They replace and supersede the undertakings agreed in May 2018 undertakings, which cease to have effect from the date of these undertakings. This action ensures that the undertakings which NHS Improvement and NHS England has accepted and

remain outstanding are set out in a single document and, where relevant, have been varied and updated.

GROUNDS

1. Licence

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

BREACHES

2. Financial Sustainability and governance

2.1 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(5)(a), FT4(5)(d), an CoS3.

2.2 In particular, the Licensee:

2.2.1 has reported annual deficits of £69.3m (2018/19) and £61.7m in 2019/20
2.2.2 set a draft deficit plan in 20/21 pre COVID of £89m
2.2.3 has a significant underlying deficit of concern. The extent of the deficit will be determined through the 2022/23 planning process as the distribution of system allocations based on the updated national financial regime are confirmed during the Lancashire and South Cumbria ICB planning and contractual processes

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

2.3.1 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.

2.3.2 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)

3. Quality governance

3.1 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 (c), FT4(5)(e) -(f), FT4(6)(a) to (d) and (f), and FT4(7).

3.2 In particular, the Licensee:

3.2.1 Has been subject to a number of external reviews and investigations initiated to investigate concerns raised by third parties which have demonstrated failures of compliance with governance processes. The Good Governance Institute (GGI) reviewed the organisational governance during Q3 and Q4 2020/ 21 and issued a report with recommendations in January 2021. Both the Urology Investigation Niche report dated November 2021 and the GGI report demonstrated the Licensee's serious Incident management processes were not fit for purpose. The Urology Investigation Niche report recommended 'the approach to incident investigation lacks rigour and independence'. The Urology Investigation Niche report identified wider governance failures, including in relation to identification and monitoring of risks.

3.2.2 Was inspected by the CQC between April and May 2021, the inspection reviewed Urgent and Emergency care services, Surgery, and Maternity (core) services of the Licensee. A further CQC inspection of Medical Care at Royal Lancaster Infirmary was carried out in August 2021. The overall rating is 'Requires Improvement' with Well Led rated as 'Inadequate'. The CQC imposed urgent conditions on the registration of the Licensee under s.31 of the Health and Social Care Act 2008 in relation to the Licensee's Stroke Services. The CQC's findings included the following:

3.2.2.1 not all staff supporting children had completed appropriate training in and paediatric advanced life support training and safeguarding.

3.2.2.2 patients identified for the stroke pathway did not always receive care and treatment in line with national guidance or the Licensee's policies.

3.2.2.3 there was not always sufficient staff with the right qualifications, skills, training, and experience to provide care and treatment for children in urgent and emergency departments and sufficient staff to care for women in maternity services.

3.2.2.4 staff did not always adhere to the Licensee's and national infection prevention and control guidance in relation to social distancing and PPE in urgent and emergency services.

3.2.2.5 controlled drugs were not always stored, administered, and recorded safely.

3.2.2.6 the escalation plan for caring for patients in corridors was not always adhered to.

3.2.2.7 women receiving maternity care assessed as at risk of sepsis, did not always receive care and treatment in line with national guidance.

3.2.2.8 it was not clear if national early warning scores were always assessed and used to identify signs of deterioration as they were not always documented in patient records.

3.2.2.9 although grading harm guidance was available, the CQC were not assured that all incidents were graded appropriately to reflect the level of harm.

3.2.2.10 current policies were not always available for staff to access during care and treatment of patients.

3.2.2.11 the Licensee did not always submit information for audits, including national audits.

3.2.2.12 the Licensee's governance processes were not always robust or always effective. Risks were not always identified correctly with appropriate mitigation put in place.

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

3.3.1 effective board and committee structures.

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

3.3.3 clear reporting lines and accountabilities throughout the organisation.

3.3.4 systems and/or processes:

3.3.4.1 to ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively.

3.3.4.2 for timely and effective scrutiny and oversight by the Board.

3.3.4.3 to ensure compliance with healthcare standards specified by the CQC.

3.3.4.4 to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making.

3.3.4.5 to identify and manage material risks to compliance with licence conditions.

3.3.4.6 to ensure the matters relating to quality of care specified in FT4(6)(a)-(d) and (f).

3.3.5 systems to ensure it has in place personnel as required by FT4(7).

4. Need for Action

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

5. 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

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

1. Financial planning

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

1.2 The Licensee will develop and agree with the Lancashire and South Cumbria ICS a financial improvement strategy and the Licensee will agree to deliver these trajectories and any agreed annual variations.

1.3 The Licensee will ensure its underlying financial position improves during 2022/2023 on a trajectory to be agreed with the Lancashire and South Cumbria ICS and NHS England and NHS Improvement. The source documents for this review will be the 2021/22 financial position and the 2022/23 financial plan.

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

1.5 The Licensee will cooperate and actively participate in the Lancashire and South Cumbria ICS financial sustainability and efficiency programmes, including by utilising national tools to identify unwarranted variation and productivity opportunities.

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

2. Funding conditions and spending approvals

2.1 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.

2.2 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.

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

3. Quality of care

3.1. The Licensee will take all reasonable steps to rectify the concerns which are set out in the CQC report dated 20/08/21, in such timescales to be agreed with NHS Improvement (except where otherwise specified), such that the Licensee will:

3.1.1 Comply with the additional conditions placed on the Licensee's licence by CQC under section 31 of the Health and Social care Act 2008, in relation to the stroke services at Royal Lancaster Infirmary and Furness General Hospital.

3.1.2 Within the timeframe required by the CQC, finalise, and submit to the CQC and to the System Improvement Board a Quality Improvement Plan detailing actions which it will take to address concerns raised by CQC in its inspection report.

3.1.3 Specifically, and in line with the actions required in the CQC recommendations, ensure the Quality Improvement Plan includes actions that will ensure robust governance processes in relation to timely identification and management of risk including processes for shared learning.

3.1.4 Develop a vision and strategy for maternity services in line with NHS England's Maternity Transformation Program, that will address the quality

concerns raised by the CQC and ensure effective governance processes are in place to improve the safety and quality of the services and mitigate the risks to women and families using those services. The Licensee must ensure that the vision and strategy aligns with the Licensee's overarching strategy and those of the wider health economy.

3.1.5 Deliver the recommended actions from the Urology Investigation Niche report in line with timelines agreed by the System Improvement Board. The Licensee will improve the approach to incident investigation to ensure rigour and independence.

3.1.6 Deliver the recommendations in the Royal College of Surgeons review within a timeframe agreed by the System Improvement Board.

3.1.7 Deliver the recommended actions from "The Good Governance Institute Report" in line with timelines agreed by the System Improvement Board. The Licensee must ensure thematic reporting of complaints, litigation and incidents is in line with the recommendations of the report and undertake a review and recast of the serious incident process.

3.1.8 Provide Board assurance through the System Improvement Board that the delivery of the Quality Improvement Plan is meeting the agreed trajectory for delivery. Amendments to timelines or deliverables will be agreed by the System Improvement Board.

3.1.9 Ensure that all documentation relating to the regulatory requirements of the provider licence and CQC for "Fit and Proper Persons" are fit for purpose.

4. General

4.1 The Licensee will:

4.1.1 Evidence all reasonable steps have been taken to meet the Recovery Support Programme Exit Criteria as set out and agreed by the System Improvement Board, in accordance with the timescales agreed by the System Improvement Board.

4.1.2 Carry out a review of progress against the Recovery Support Programme Exit Criteria and report to the System Improvement Board, in accordance with the timescales agreed by the System Improvement Board.

4.2 In line with the System Improvement Board Terms of Reference and the requirements of the SOF rating, 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.

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 of Licensee)

Dated: 25 May 2022

NHS IMPROVEMENT

Signed (North West Regional Director)

Dated: 30 June 2022