UNDERTAKINGS
LICENSEE
Mid and South Essex NHS Foundation Trust (the Licensee)
Prittlewell Chase
Westcliff On Sea, Essex, SS0 0RY

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.

GROUNDS

1. Licence

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

BREACHES

NHS Improvement has reasonable grounds to suspect that the Licensee has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence: [FT4(4)(b) and (c); FT4(5)(a), (c), (f) and (g), FT4(6)(e) and (f) and FT4(7).]

In particular:

1. Governance

1.1 Underlying, recurrent themes of poor governance, failure to deliver targeted improvement in board-approved remedial action plans and a lack of standardisation of practices and policies across the sites.

1.2 Sub-optimal data quality, management information and reporting processes which do not support informed and effective decision making.

2. Inadequate Maternity Services

2.1 Following a CQC inspection of the maternity services at the Basildon and Thurrock University Hospital in February 2019 the CQC rated the service as requires improvement overall.

2.2 The CQC carried out an unannounced focused inspection on 12 June 2020 to follow-up on safety concerns raised by an anonymous whistle-blower in May

2020 and safety concerns from a cluster of six serious incidents where babies were born in poor condition and were subsequently transferred out for cooling therapy during March and April 2020. The inspection did not include all of CQC's key lines of enquiry (KLOEs). Following this inspection, the maternity service was rated inadequate overall with the safe, effective and well-led domains rated as inadequate.

2.3 The CQC issued a Section 29a warning notice which has since been superseded by Section 64 and Section 31 conditions.

2.4 Data quality has been a recurring issue and following inspection the CQC requested supporting data from the Trust. The CQC were not able to analyse trends on the unvalidated data provided. The need to strengthen reporting and data quality is a recognised risk that the Trust is mitigating.

3. Harm Review Process

3.1 Historic inconsistences in the implementation of the harm review process across the three sites impeded by increasing volumes of patients experiencing delayed treatment.

3.2 Lack of assurance that a robust harm review process is in place across the three sites. Insufficient evidence that outputs (levels of harm) are recorded, that there is adherence to duty of candour and that learning is actioned, shared and embedded in practice.

4. Delayed diagnosis and treatment of cancer patients

4.1 The Trust has a high number of patients waiting over 104 days for treatment. There is greater potential for harm and poorer patient outcomes when treatment is delayed.

4.2 Harm has been reported due to delayed diagnosis and treatment and there is a concern relating to a lack of transparency in relation to both waiting times and the number of patients waiting.

4.3 There is a concern that the harm review process for delayed patients is not sufficiently robust.

4.4 Specialised Commissioning has expressed significant concerns in relation to cancer services for urology, skin and chemotherapy and an ongoing failure to provide sufficient assurance in relation to: the outcome of Cancer harm reviews and the SI process, waiting times, progression of the chemotherapy action plan, and, the management of risk. and greater potential for harm/poor outcomes due to delays.

5. Elective Backlog Growth

5.1 The Trust has a significant number of the longest waiting patients regionally and nationally and this has been exacerbated by COVID-19. The link to potential for harm due to delayed treatment and the additional Harm Review

process pressure this backlog creates has already been stated and links to the grounds for the Harm Review undertaking above.

Appropriateness of Undertaking

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

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

1. **Governance**

1.1 The trust will procure external support to develop the internal governance structures and processes of the combined trust to secure 'Ward to Board' line of sight supported by accurate, repeatable and timely reporting and management information.

1.2 The scope of this review and the provider will be agreed with NHSEI and Commissioners but will include a strengthening of the Quality Governance Framework (focus on Maternity Services specifically).

1.3 The focused governance structure and process review will complete at the end of January 2021.

1.4 The trust Board will respond to the recommendations of the review and agree appropriate, delivery milestones against which progress will be monitored via both the Board and the System Oversight and Assurance Group. The expectation is that the trust will seek to progress all recommendations in Q4 and finalise/embed in practice during Q1 2021.

1.5 At the same time the trust will procure a second and broader external review of Board governance focusing on the domains within the well-led framework by the end of Q1 2021/22.

1.6 The trust Board will implement the recommendations of the external review (part 2 well-led review) and deliver against appropriate, subsequent, Board approved milestones.

2. **Maternity Services**

2.1 Produce and deliver an updated Maternity Improvement Plan (MIP) with appropriate KPIs (which responds to the Section 29a warning notice and

Section 31 conditions) as part of an integrated Quality Improvement Plan that brings together the various Quality improvements targeted. The updated MIP will be produced by 30 November 2020 and be approved by key stakeholders and the Trust Board prior to submission to the CQC.

2.2 The MIP will be subsequently updated to reflect the recommendations and outputs of the following forthcoming areas of work:

2.2.1 National Maternity Safety Advisor Maternity Services Review. The timescale for this is dependent on the national team's availability. Once completed NHSEI and Commissioners will work with the Trust to agree a reasonable timeframe to take the recommended action(s).

2.2.2 Maternity leadership capacity and capability review – timing to be agreed with NHSEI regional Clinical Quality colleagues with a view to completing as far as possible by end Q4. Review scope and milestones to be shared with SOAG for approval.

2.2.3 Workforce and staffing review as part of Birthrate Plus – to be completed by end Q4 2020/21.

2.2.4 Demonstrate compliance with the Maternity Incentive Scheme – '10 Maternity Safety Actions' – by end Q4 2020/21.

2.2.5 Work with the Nursing Midwifery Council and General Medical Council to co-produce and implement a, "Culture and OD improvement plan" which addresses the cultural and professional behaviours highlighted in the August 2020 CQC report. A responsive plan will be in place, and implementation in train, by end December 2020.

2.3 The Trust will share with NHSEI, within 5 working days of receipt or production, any reports and subsequent action plans arising from the HSIB investigations and other arm's length bodies inspections or investigations.

3. Harm Review

3.1 The trust will ensure that 100% of harm reviews for cancer >62-day breaches are complete by February 2021 and agree with NHSEI a plan and associated timescale to complete harm reviews for all RTT >52ww breaches.

3.1.1 Prioritisation to be agreed with Commissioners.

3.1.2 The trust Board and Commissioners will be assured of the robustness of the process; outputs (level of harm is recorded), duty of candour is adhered to, clear evidence that the outputs of the review are learned from, actioned, and learning is embedded in practice.

3.2 A SOAG-approved, risk stratified, plan for >52ww harm reviews to be agreed with NHSEI and Commissioners (and be 'live') by end Q3 2020/21 which the trust will then deliver in line with plan milestones.

4. Delayed Diagnosis and Treatment of Cancer Patients

4.1 The trust will deliver the Cancer Improvement Plan agreed between the trust, system, Cancer Alliance, and Specialised Commissioning within agreed timescales (delivery of plan milestones).

4.2 The trust will evidence that it has addressed, or has robust plans in place to address, the recommendations of the Royal College of Surgeons review of urological cancers (scheduled for November 2020).

5. Elective Backlog Growth

5.1 The trust will take all reasonable steps to reduce the >52ww backlog and the overall elective backlog. To this end, a maximum March 2021 overall backlog position has been agreed that will be supported by underpinning specialty level improvement trajectories.

5.2 Delivery of this trajectory will be overseen by the System Oversight and Assurance Group (SOAG), who will have the authority to amend the requirement on an evidence basis, where it is clear that underpinning assumptions have moved (both positively and negatively). The Trust will be committed to reducing below this threshold as far as possible.

5.2.1 A maximum of 6900 >52ww by end March 2021.

5.3 The trust will submit a board approved improvement trajectory during Q4 2020/21, that sets out how the totality of the >52ww backlog will be eradicated during 2021/22. This trajectory will be predicated on defined modelling variables, to be formally agreed by SOAG during January 2021, and confirmation of the required levels of resourcing in 2021/22 planning guidance. The Trust will demonstrate month on month reductions in the >52ww backlog during Q1.

6. General

6.1 The Trust work with system partners to ensure sufficient programme management and governance arrangements to enable delivery of these undertakings.

6.2 Such programme management and governance arrangements must enable the Board and system to:

6.2.1 obtain clear oversight over the process in delivering these undertakings;

6.2.2 obtain an understanding of the risks to the successful achievement of the plans to meeting all other commitment in these undertakings and ensure appropriate mitigation; and

6.2.3 hold individuals to account for the delivery of the undertakings.

6.3 The Trust will continue to provide NHSEI direct access to its meetings, advisors, programme leads and the Trust Board members as needed in relation to the matters covered by these undertakings.

6.4 The Trust will continue to attend meetings or, if NHSEI stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHSEI; and provide reports in relation to the matters covered by these undertakings as NHSEI may require.

6.5 Where matters are identified which materially affect the Trust's ability to meet the requirements within these undertakings, whether or not identified by the Trust, the Trust will:

6.5.1 Notify the system and NHSEI as soon as practicable; and

6.5.2 Work with the system to update and resubmit relevant plans for agreement by NHSEI within a timeframe to be agreed with NHSEI.

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.

THE LICENSEE
Signed

Nigel Beverley, Chair
Mid and South Essex NHS Foundation Trust

Clare Panniker, Chief Executive
Mid and South Essex NHS Foundation Trust

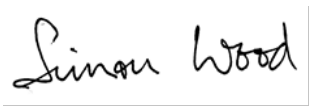
Dated 18 December 2020

The System
Signed

(STP Accountable Officer)

Dated 11th January 2021

Simon Wood
NHSEI



(Chair or member of the Regional Support Group – East)
30 November 2020

Appendix 2 - MSE Undertakings Summary Table					
	Concern/Grounds	**Breach of licence condition**	**Undertaking to resolve**	**Evidence of compliance**	**Timeframe/Milestone**
1.	**Governance** Underlying recurrent themes of poor governance, failure to deliver targeted improvement in board-approved remedial action plans and a lack of standardisation of practices and policies across the sites. Sub optimal data quality, management information and reporting processes which do not support informed and effective decision making.	FT4(4)(b) FT4(4)(c) FT4(5)(a) FT4(5)(f) FT4(5)(g) FT4(6)(e) FT4(6)(f) FT4(7)	a) The Trust will procure external support to develop the internal structures and processes of the combined Trust to secure Board to Ward line of sight supported by accurate, repeatable and timely reporting and management information. Focus required upon strengthening the Quality Governance framework (Maternity Services specifically). At the same time the Trust will procure: b) A broader external review of Board governance focusing on	Trust Board to implement the recommendations of the initial external review and agree and deliver against appropriate, subsequent milestones with SOAG oversight. Trust Board to procure a broader external review. Trust Board to implement the recommendations of the external review (part 2) and agree and deliver against appropriate, subsequent milestones with SOAG	Governance Review initiated in Q3. Report by end Jan 2021. Progression of recommendations (as far as possible) during Q4 2020 and completed/ embedded in Q1 2021. End Q1 Progression of all recommendations by end Q2.

			the well-led framework (capacity, capability and risk management). c) Scope of both reviews to be agreed with NHSEI and Commissioners who will also participate in the provider selection process. The Broader review will also be used to provide assurance that the Trust has a functioning governance structure which provides accurate management information to support effective decision making and that recommendations from the initial review have been actioned and embedded.	oversight.	
2.	**Inadequate Maternity Services**, in the three domains CQC inspected - safe, effective and well led. Section 29a warning notice, Section 64 and Section 31 condition issued.	FT4(5)(a) FT4(5)(c) FT4(5)(f) FT4(6)(f)	Delivery of MIP to expected timescales and level of expected improvement outcomes identified by the various external reviews. (To be updated to include response to the most recent inspection findings S29a/S31.)	Produce and deliver an updated Maternity Improvement Plan (MIP) with appropriate KPIs (which responds to the Section 29a warning notice and Section 31 conditions as part of the trust's integrated Quality Improvement Plan).	December 2020

			The Trust will share with NHSEI in a timely manner any reports and subsequent action plans arising from the HSIB investigations and other arm's length bodies inspection or investigations.	MIP to be approved by the Trust Board and key stakeholders prior to submission to CQC. The MIP will be subsequently updated to reflect the recommendations and outputs of the following forthcoming areas of work: - National Maternity Safety Advisor Maternity Services Review - Leadership capacity and capability review – scope/timing to be agreed with NHSEI colleagues and approved by SOAG - Workforce and staffing review as part of the Birth Rate Plus - Demonstrate compliance with the Maternity Incentive Scheme – '10 Maternity Safety Actions'. - Work with the Nursing Midwifery Council and General Medical Council to co-produce and implement	During Q4 Dependent on national team timetable End Q3 20/21 End Q4 20/21 End Q4 20/21 NHSEI suggest plan in place by end Dec and implementation in train.

				a, “Culture and OD improvement plan” which addresses the cultural and professional behaviours highlighted in the August 2020 CQC report.	
3.	**Historic inconsistences in the implementation of the harm review process** across the three sites impeded by increasing volumes of patients experiencing delayed treatment.	FT4(4)(b) FT4(4)(c) FT4(5)(a) FT4(5)(f) FT4(5)(g)	The Trust will ensure that 100% of harm reviews for cancer >62-day breaches are complete by February 2021 and agree with NHSEI a plan and associated timescale to complete harm reviews for all RTT >52 week breaches.	d) 100% of cancer harm reviews are completed and the Trust Board and commissioners are assured of the robustness of the process and the outputs learned from and actioned. Prioritisation will be agreed with commissioners. Evidence that outputs are recorded (level of harm), adherence with duty of candour and learning is embedded in practice across the Trust. e) SOAG-approved, risk-stratified plan for >52ww harm reviews to be agreed with NHSEI and Commissioners (and be ‘live’).	February 2021 End Q3
4.	**Delay in diagnosis and treatment of cancer patients** and greater potential for	FT4(5)(a) FT4(5)(c)	To deliver the Cancer Improvement Plan agreed between the Trust, System,	Delivery of the Cancer Improvement Plan within the timescales agreed.	Meet or exceed Plan milestones

	harm/poor outcomes due to delay		Cancer Alliance and Specialised Commissioning.	Evidence that it has addressed, or has robust plans in place to address, the recommendations of the Royal College of Surgeons review of urological cancers (scheduled for November 2020).	
5.	**Growth in elective backlog** Trust has a significant number of the longest waiting patients regionally/nationally. Links to potential for harm from delayed treatment and Harm Review undertaking above.	FT4(5)(a) FT4(5)(c)	The trust will take all reasonable steps to reduce the >52ww backlog and the overall elective backlog. To this end, a maximum March 2021 overall backlog position has been agreed that will be supported by underpinning specialty level improvement trajectories. Delivery of this trajectory will be overseen by the System Oversight and Assurance Group (SOAG), who will have the authority to amend the requirement on an evidence basis, where it is clear that underpinning assumptions have moved (both positively and negatively). The Trust will be committed to reducing below this threshold as far as possible.	A maximum of 6900 >52ww by end March 2021. Trust will submit a Board approved improvement trajectory supported by underpinning specialty level improvement plans which eradicates the >52ww backlog during 2021/22. The trajectory will be predicated on defined modelling variables to be formally agreed by SOAG and confirmation of the required levels of resourcing in 2021/22 planning guidance. The Trust will demonstrate month on month reductions in the >52ww backlog during Q1. Changes to this trajectory as a result of COVID, winter or other unavoidable service disruption will need to be evidenced and mutually agreed at the System Oversight and Assurance Group.	End March 2021 End January 2021 Q1 2021/22

Appendix 3 – System Improvement Commitments

AM CP Undertakings
System Commitments.

Broomfield Hospital

Court Road
Chelmsford

CM1 7ET

Anthony McKeever
Accountable Officer
Mid and South Essex CCGs

3rd November 2020

Dear Mac,

MSEFT undertakings and system improvement commitments

I'm writing to you as Accountable Officer for the CCGs in mid and south Essex and also in your role as Executive Lead for the Mid and South Essex Health and Care Partnership.

As you are aware, we have been working collectively with NHS England on the legal undertakings which are going be put in place with the Trust in the following areas:

1. Governance
2. Maternity Services
3. Harm Review Processes
4. Cancer Treatment
5. Elective Care Backlog

As part of these undertakings we have been asked to set out our expectations of our system to assist the Trust in delivering these undertakings successfully. Following discussion with you and your teams we have the established the following areas for improvement across our system.

I set out these requests below.

1. Governance

The system will support the Trust with the Governance Review and will take steps to align commissioning and system governance to align with the findings and recommendations which arise.

The system will work collectively to establish a data and information 'virtual directorate' to improve data quality and common understanding of information across the system.

The system will actively participate in the oversight arrangements for the delivery of the undertakings and take practical steps to assist the Trust in delivering these undertakings where this is within the competence and capability of system partners.

2. Harm review processes

The trust will continue to participate in the harm review processes of the Trust and will support the agreement of prioritisation of the harm review process for 52 week waits.

3 and 4. Cancer / Elective

The system will develop and deliver a demand management programme to ensure appropriate use of elective, cancer and emergency hospital services. For instance we have discussed the introduction of referral management systems, expansion of tier 2 capacity and capability and work to reduce ambulance arrivals at hospital.

The system will develop and deliver capacity expansion within out of hospital services to improve patient flow and reduce hospital occupancy so as to create capacity, support patient flow with the aim of minimising emergency care pressures and releasing physical capacity to support the delivery of the phase 3 plan for cancer and elective care services.

We look forward to working with you on these areas over the course of the coming months.

Yours sincerely,

Clare Panniker
Chief Executive