NHS
Improvement

UNDERTAKINGS

NHS TRUST:

East and North Hertfordshire NHS Trust
Lister Hospital
Coreys Mill Lane
Stevenage
SG1 4AB

DECISION:

On the basis of the grounds set out below and pursuant to the powers exercisable by NHS Improvement under or by virtue of the National Health Service Act 2006 and the TDA Directions, NHS Improvement has decided to accept undertakings from the trust.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6(c) of the TDA Directions;

"NHS Improvement" means the National Health Service Trust Development Authority;

"TDA Directions" means the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016.

GROUNDS:

1. **The trust**

   1.1. The trust is an NHS trust whose facilities and establishments are situated in England.

BREACHES:

2. **Issues and need for action**

   2.1. NHS Improvement has reasonable grounds to suspect that the trust has provided and is providing health services for the purposes of the

health service in England while failing to comply with the following conditions of its licence: FT4(4)(a)-(c), FT4(5)(a)-(g), FT4(6)(b)-(f) and FT4(7).

2.2. In particular:

Quality of care:

2.2.1. The CQC rated the trust as "Requires Improvement" in its report published on 17 July 2018, which was unchanged from the previous inspection in October 2015;

2.2.2. Two of the trust's services were rated by the CQC as "Inadequate" and the CQC issued a warning notice on 8 June 2018 in relation to those services;

2.2.3. The report published in July 2018 identifies surgery at Lister Hospital and urgent and emergency services at Queen Elizabeth II Hospital are rated as inadequate).

2.2.4. There have been a significant number of serious incidents and Never Events in the surgical service. This included a serious incident in relation to unsent discharge summaries from September 2017 to July 2018 affecting c. 14,600 patient records. The trust has identified that there could be still be unsent discharge summaries due to ongoing IT system issues;

2.2.5. Vacancy and turnover rates are above trust target, impacting agency spend.

Operational performance:

2.2.6. This has been severely affected by the poor implementation of an Electronic Patient Records system to the extent that the trust stopped reporting RTT and Diagnostics from October 2017 to November 2018;

2.2.7. The trust has not reported compliance with the national RTT target since May 2017. Following its return to reporting in November 2018 the trust is reporting a considerable backlog of incomplete patient pathways.

2.2.8. There were 34 x 52 week-wait breaches reported on October 2018 data;

2.2.9. In relation to the Cancer 62 day standard, the trust reported performance at 67.8% for September 2018 and the trust does not expect to meet the performance trajectory planned for January 2019;

Financial performance:

2.2.10. In June 2018 the trust underwent a 'Use of Resources' inspection and was rated 'Requires Improvement';

2.2.11. In 2018/19, the trust highlighted a risk to achieving its control

total deficit and has indicated a forecast gap of £6.1m before Provider Sustainability Funding (PSF).

2.3. These issues demonstrate a failure of governance arrangements and financial management standards, including but not limited to a failure by the trust to establish and effectively implement systems or processes:

2.3.1. To ensure compliance with the trust's duty to operate efficiently, economically and effectively;
2.3.2. For timely and effective scrutiny and oversight by the Board of the trust's operations;
2.3.3. To ensure compliance with healthcare standards binding on the trust;
2.3.4. Of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS;
2.3.5. To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
2.3.6. To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;

2.4. Need for action:

2.4.1. NHS Improvement believes that the action which the trust has undertaken to take pursuant to these undertakings, is action required to secure that the failures to comply with the relevant requirements of the conditions of the trust do not continue or recur.

2.5. 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:

NHS Improvement has agreed to accept, and the trust has agreed to give, the following undertakings:

1. Quality Improvement Plan

1.1. The trust will take all reasonable steps to address the concerns identified in, but not limited to the CQC reports, including carrying out the actions and warning notices set out in the CQC report in accordance with timescales as determined by the CQC such that, upon re-inspection by the CQC (such as any date CQC may determine), the trust will no longer be found to be 'Inadequate' in any CQC domain.

1.2. The trust will develop a comprehensive Quality Improvement Plan (QIP) which addresses the CQC's concerns in its latest report. This plan will be reviewed and revised on an ongoing basis to reflect any subsequent concerns raised either by the CQC, NHS Improvement or other external stakeholders.

1.3. The QIP will be submitted to NHS Improvement and to the CQC at a date to be agreed with the CQC. The trust will ensure that it has a robust governance process in place to manage delivery of the QIP and to provide assurance of delivery of plan on a monthly basis to the trust Board, NHS Improvement, commissioners and other stakeholders.

1.4. The trust will develop a comprehensive quality dashboard to provide assurance on the impact of the implementation of the QIP on quality performance metrics and to highlight areas which need remedial or renewed action. This dashboard will be developed no later than February 2019 and will thereafter be shared with NHS Improvement on a monthly basis.

1.5. The trust will ensure it takes appropriate and timely action to address the issues affecting its ability to provide consistent and timely discharge summaries for all patients. Where delays have occurred, the trust will provide assurance to NHS Improvement that robust processes are in place to assess whether harm has occurred; ensure appropriate action is taken to protect patients; and ensure trust compliance with duty of candour responsibilities.

1.6. The trust is to fully test out the effectiveness of its quality governance arrangements to ensure they are robust and effective. This will include allowing NHS Improvement to undertake Board and subcommittee observations in Q4 of 2018/19 at a date and time to be agreed with NHS Improvement.

1.7. The trust will be required to continue to engage with NHS Improvement on workforce improvement strategies, including workforce and agency oversight meetings and associated collaboratives. The trust will cooperate with NHS Improvement's workforce / agency review and observations of the Workforce Committee as part of this review in Q4 2018/19.

2. Operational performance (Cancer)

2.1. The trust will take all reasonable steps to recover and sustainably maintain cancer performance in the eight national Cancer targets.

2.2. The trust will continue its work with the Elective Intensive Support Team and develop a recovery plan and recovery trajectory that incorporates the feedback from

2.2.1. EIST work under Phase 1 and Phase 2 – output from diagnostics Demand & Capacity modelling, output from IST's pathway analyser tool, feedback and recommendations from IST's review of the trust's MDT management processes and output from review of registration and referrals process at Mount Vernon Cancer Centre (MVCC).

2.2.2. Feedback and output from sessions with NHSI's Operational Productivity team's reviews into effectiveness of systems and processes within the Trust's Cancer Services.

2.3. The trust's cancer recovery plan will be aligned with and consider the impact of implementing the Trust's RTT recovery plan as set out in Section 3 below. The trust will provide NHS Improvement with a copy of the recovery plan, assured and signed off by the trust Board, with clearly identifiable milestones, success metrics and KPIs by end of January 2019.

2.4. The trust will ensure that it has robust and regular programme management of the cancer recovery plans in place. This should include but not be limited to:

2.4.1. Weekly review of the 44-62 day patient cohort for the forthcoming fortnight to ensure all reasonable steps are taken to avoid the patient waiting longer than 62 days.

2.4.2. Weekly review of all patients booked to breach 62 days at the trust access meeting, with an action log maintained and monitored of actions given to divisional management to bring these patients forward to avoid incurring further breaches.

2.4.3. Senior management review on a weekly basis of patients waiting longer than 104 days to review changes and escalate and challenge these as appropriate for further action.

2.4.4. Senior management review of the patients with a 'Confirmed no cancer' diagnosis still appearing on the PTL due to administrative process delays in informing the patients and taking steps to ensure that such patients are dealt with immediately and effectively.

2.5. The trust will ensure that operational management of cancer services is not impacted by compatibility issues between Infoflex (trust's cancer management software) and Lorenzo (trust's electronic patient records system) and where such incompatibility issues are identified this will be resolved efficiently and effectively. All such incompatibility issues and its proposed resolution will be aligned to the wider EPR Stabilisation programme being implemented at the trust.

2.6. The trust will identify any further areas of support required from the IST and/or the Cancer Alliance to support its recovery of cancer performance, including implementation of best practice pathways across tumour sites, and engage with the NHS Improvement regional team to procure such support.

2.7. The trust will review its current arrangement with Hillingdon Hospitals NHS Foundation Trust to ensure a continued and reliable service is operated out

of Mount Vernon Cancer Centre (MVCC) and also develop a medium to long term strategy for the future operations of MVCC.

3. <u>Operational performance (Elective Care)</u>

3.1. The trust will take all reasonable steps to recover and sustainably maintain performance against the 18 week Referral to Treatment standard and to have no 52 week breaches by the end of March 2019.

3.2. The Trust will commence work with the Elective care Intensive Support Team (EIST) to carry out demand & capacity modelling in all specialties by end of December 2018.

3.3. Following completion of the demand & capacity modelling work, the trust will develop a robust RTT recovery plan with detailed milestones, success metrics and trajectories to ensure the Trust clears its RTT backlog position and maintains sustained compliance with the national RTT target.

3.4. The recovery plan will include and incorporate the impact of
- 3.4.1. Cancer services demand & capacity modelling
- 3.4.2. Theatre productivity and outpatient productivity opportunities identified by NHSI's Model Hospital team as well as from the outputs of work carried out by Four Eyes Consulting in 2017
- 3.4.3. Consultant and staff job plans in the short term and vacancy and staff resource management plans in the medium term
- 3.4.4. Process changes and efficiencies from implementation of changes to the Lorenzo system as part of the EPR Stabilisation programme
- 3.4.5. Process improvements and changes made as part of the Trust's Quality Improvement program.

3.5. The trust will develop an urgent recovery plan to ensure that it has Nil 52week breaches by March 2019. The plan will include trajectories and success milestones as well as identify any long wait patients who could fall into the 52 week wait patient cohort before the end of the financial year 2018/2019 and steps that will be taken to prevent these breaches. This plan will be developed and signed off by the trust Board no later than end of January 2019.

3.6. The trust will ensure that it has robust and regular programme management of the RTT and 52 week wait recovery plans in place. This will include but not be limited to:
- 3.6.1. Weekly review of the forthcoming fortnight's admissions with the high risk specialties to ensure sufficient long waiters are booked versus the number of expected tip-ins.
- 3.6.2. Weekly review of all patients booked to breach 52 weeks at the trust access meeting, with an action log maintained and monitored of actions given to divisional management to bring these patients forward to avoid incurring further breaches.
- 3.6.3. Senior management review of the 52 week breach PTL on a weekly basis to review changes and escalate and challenge these as appropriate for further action.

3.6.4. Senior management review of the undated patients on a weekly basis with a process in place to manage and monitor actions given to divisional management against these patients.

3.6.5. Senior management review and sign off of all patients waiting in excess of 50 weeks to ensure pathways are being managed appropriately and robustly.

3.6.6. Regular divisional and senior management discussions between specialties to explore any opportunities of optimising surplus capacity within or assisting with resource requirements of divisional plans.

3.7. The trust will provide regular reporting to the trust executive team of the progress being made against the trust's RTT and 52 week wait recovery plan including KPIs and success metrics to support delivery or otherwise of the recovery plan, risks to the recovery plan and mitigating actions being considered, and escalation of issues faced during implementation of the recovery plan as appropriate.

3.8. The trust will develop a medium to long term strategy on addressing the capacity constraints to deliver on the national RTT target considering present and predicted future levels of demand and taking into account the productivity and efficiencies opportunities available to the trust. In developing solutions to address any capacity constraints the trust will also engage with its partners within the Hertfordshire and West Essex STP to identify possible solutions.

4. Financial Performance

4.1. For the 2018/19 financial year the trust will ensure that robust financial recovery plans are in place to:

4.1.1. mitigate as far as possible any gap to the trust's financial plan;

4.1.2. minimise the trust's reported and underlying/recurrent I&E deficit;

4.1.3. minimise the trust's I&E deficit run-rate;

4.1.4. maximise the delivery of recurrent CIPs; and

4.1.5. minimise the trust's revenue cash support requirements

4.2. For the 2019/20, 2020/21 and 2021/22 financial years the trust will develop its annual financial plans in line with national planning guidelines and timeframes. In so doing the trust will ensure:

4.2.1. its annual financial plans demonstrate year-on-year financial improvement (on both a reported and underlying/recurrent basis);

4.2.2. its annual financial plans fully reflect opportunities for operational and financial efficiency identified in the Model Hospital;

4.2.3. it works with the trust's lead commissioner to minimise any alignment differences on activity and efficiency plans;

4.2.4. its annual financial plans are robust, quality assured and agreed by the trust's Board; and

4.2.5. it takes all reasonable steps to ensure it is able to deliver its annual financial plans, including regular assessments of whether it has sufficient financial capability and capacity to deliver.

4.3. In addition, the trust will develop a high-level long-term deficit reduction financial improvement plan and financial strategy ("the long-term plan") covering the financial years from 2019/20 to 2028/29. This will be submitted to NHS Improvement by autumn 2019 as specified in the recently issued planning guidance in relation to the long term plan. In so doing the trust will ensure the long-term plan:

4.3.1. materially reduces or eradicates the trust's deficit;

4.3.2. is financially consistent with the annual financial plan submitted to NHS Improvement for 2019/20;

4.3.3. reflects the opportunities for operational and financial efficiency identified in the Model Hospital and includes plans for returning loss making services to at least a breakeven operating position or for an agreed alternative delivery solution;

4.3.4. is aligned with commissioner activity and efficiency plans;

4.3.5. includes a summary of key assumptions made; and

4.3.6. is quality assured and agreed by the trust's Board.

4.4. The trust's progress in delivering the long-term plan will be regularly reported to its Board and to NHS Improvement.

4.5. The long-term plan will be periodically updated, as and when required.

5. Distressed Finance and Spending Approvals

5.1. Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the trust under Schedule 5 to the National Health Service Act, the trust will comply with any terms and conditions which attached to the financing.

5.2. Where the trust receives payments from the Provider Sustainability Fund the trust will comply with any terms and conditions which attach to the payments.

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

6. Programme management

6.1. The trust will take all reasonable steps to deliver and implement the recovery plans and improvement actions in paragraphs 1 to 4 above and will ensure that there is sufficient Board level and divisional level capacity and capability at all times to ensure appropriate programme management and oversight of these plans as required. Where required the trust will develop and implement or where appropriate, strengthen, trust wide governance and programme management processes to manage and deliver sustained operational performance covered by these enforcement undertakings.

6.2. Such programme management and governance arrangements must enable the board to:

6.2.1. obtain clear oversight over the process in delivering the operational performance being covered by these undertakings;
6.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and
6.2.3. hold individuals to account for the delivery of the undertakings.

6.3. Such programme management and governance arrangements will include but not be limited to:

6.3.1. A review and refresh of Internal Professional Standards (IPS) and Standard Operating Procedures (SOPs) to be brought in line with best practice guidance. The trust will engage with colleagues of NHS Improvement's regional team in the event that external support is required for this piece of work from experts within the Elective IST and / or NHS Improvement / NHS England. The timeline for this review will be agreed with NHS Improvement.
6.3.2. Refresh and recirculation of trust's escalation processes and procedures from PTL meetings, Access meetings and other divisional meetings to all frontline staff as applicable.
6.3.3. Refresh and redelivery of training modules to incorporate any changes to systems and processes made as a result of 6.3.1 and 6.3.2 above. Any such changes made will be aligned with the elective care and training workstreams of the EPR Stabilisation implementation plan and delivered in a cohesive, clear and coordinated manner to minimise disruption to operational management on the front line and/or impact on data quality.

6.4. In the event that successful delivery of the recovery plans do not result in a corresponding sustained improvement in performance, financial position or quality of patient care, the Trust will consult with NHS Improvement and other stakeholders on alternative course of actions.

7. <u>Access</u>

7.1. The trust will provide to NHS Improvement direct access to its advisors, programme leads and the Trust's board members as needed in relation to the matters covered by these undertakings.

8. <u>Meetings and reports</u>

8.1. The trust will:

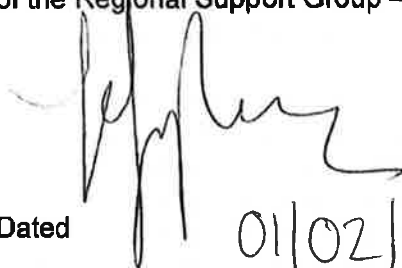
8.1.1. attend meetings or, if NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS Improvement; and
8.1.2. provide such reports in relation to the matters covered by these undertakings as NHS Improvement may require.

Any failure to comply with the above undertakings may result in the NHS Improvement taking further formal action. This could include giving directions to the trust under section 8 of the National Health Service Act 2006.

THE TRUST
Signed (Chair or Chief Executive of the Trust)

Dated 3-1-19

NHS IMPROVEMENT
Signed by the Delivery and Improvement Director (Central and South) and member of the Regional Support Group – Midlands and East)



Dated 01/02/2019.