ENFORCEMENT UNDERTAKINGS

LICENSEE:
Medway NHS Foundation Trust ("the Licensee")
Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

BACKGROUND

The Licensee was authorised as a Foundation Trust on 1st April 2008. Over several years, it has experienced significant quality and financial issues. Specifically:

- It has reported operating deficits in all of the 5 financial years since the year ending 31st March 2010.
- In February 2013, it was identified as an outlier based on the Hospital Standardised Mortality Ratio ("HSMR") (as published annually by Dr Foster) and was one of the Trusts included in the Keogh Review. In light of the findings of the Keogh Review, the Licensee paused integration plans with Dartford and Gravesham NHS Trust in order to enable it to focus on rectifying the key issues identified.
- Over the course of 2013 and 2014, the Licensee was inspected by CQC on several occasions and was found to be "inadequate" overall, and specifically with regard to A&E and Surgery.
- In February 2014, in response to regulatory action by Monitor, the Licensee appointed a new interim Chair and Chief Executive (see below).
- In September 2014, a new substantive Chair was appointed and over the past 9 months, a new Executive Team, led by a substantive CEO has been recruited.
- We are aware that the Licensee has developed a Plan covering the period 1st November 2014 to 30th April 2016, by which it is seeking to address the significant quality issues identified in the Keogh and CQC reviews as well as to start the process of financial improvement.

PREVIOUS AND CURRENT REGULATORY ACTION

Monitor accepted undertakings under section 106 of the Health and Social Care Act 2012 ("the Act") from the Licensee on 23 April 2013. The undertakings related to target breaches and financial planning. On 14 August 2013, Monitor accepted further undertakings from the Licensee under section 106 of the Act in relation to the Keogh review and quality governance. It has been agreed between the Licensee and Monitor that both sets of existing undertakings are no longer appropriate and, to the extent that they have not already been complied with, that they shall cease to have effect on the date that these undertakings take effect. Monitor also imposed discretionary requirements on the Licensee under section 105 of the Act on 22 November 2013 and 4 February

2014. The requirements are deemed to be no longer appropriate and withdrawal notices will be issued and published in relation to those requirements. On 22 November 2013, Monitor imposed an additional licence condition on the Licensee under section 111 of the Act. The Licensee failed to comply with the additional licence condition and on 4 February 2014 Monitor issued a notice under section 111 of the Act requiring the Licensee to appoint specified individuals as interim chair and chief executive with effect from 11 February 2014, on such terms as approved by Monitor. The Licensee made the required appointments.

DECISION

On the basis of the grounds set out below, and having regard to its Enforcement Guidance, Monitor has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its powers under section 106 of the Act.

GROUNDS

1. Licence

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

2. Breaches

Financial breaches

2.1. Monitor 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: CoS3(1), FT4(5)(a) and FT4(5)(d).

2.2. In particular:

2.2.1. The Licensee reported a pre I&T outturn deficit of £33.9 m in 2014/15 (£30.5m post I&T) and has a Continuity of Service (CoS) risk rating of 1. The Licensee is forecasting a deficit of £22.5m in 2015/16.

2.2.2. The Licensee requires distressed funding from the Department of Health for 2015/16.

2.2.3. This demonstrates a failure of financial governance arrangements and financial management, in particular a failure to:

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

(b) effectively implement systems or processes for effective financial management and control; and

(c) adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regard as being suitable for a provider of Commissioner Requested Services provided by the Licensee, and providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

2.3 Need for action

Monitor 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.

Governance

2.4 Monitor 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), (b), (c), (e) and (f); FT4(6)(c), (d) and (f); and FT4(7).

2.5 In particular:

2.5.1 The CQC carried out an announced comprehensive inspection of the Licensee's Medway Maritime Hospital between 23 and 25 April 2014 and an unannounced inspection on 1 May 2014. In its final report published on 8 July 2014, the CQC found the Licensee to be 'inadequate' overall , inadequate in the Safe and Responsive domains in A&E and Surgery, and inadequate in the Well-led domain in A&E. The CQC report identified a number of issues, including the following:

(a) data quality throughout the hospital was poor, resulting in the Licensee's board taking assurance from data that was inconsistent and, at times, unreliable;

(b) governance processes were not robust or standardised, and consequently resulted in difficulty clarifying whether the themes and trends from aggregated data were reliable;

(c) junior medical staffing and nursing staffing was insufficient;

(d) A&E made insufficient progress since the last CQC inspection in December 2013; and

(e) patient flow through the hospital was not efficient.

2.5.2 The CQC carried out further unannounced inspections of the Emergency Department ("ED") on 27 and 28 July 2014 and again on 26 August 2014 and found that the ED had failed to review and optimally utilise its escalation policy to avoid the need to 'stack' or 'cohort' patients arriving by ambulance. Whist patients were being stacked they were not undergoing regular nursing observations, and were not being seen in a timely manner by medical staff. The CQC took urgent action to impose additional conditions on the Licensee's registration with the CQC.

2.5.3 A further unannounced inspection of both the ED and the main theatre department was carried out by the CQC on 9 December 2014. The CQC found that the ED continued to experience significant issues with transferring patients to wards once a decision had been made to admit. The CQC found that further improvements were required, including ensuring that the Licensee's policies and procedures were consistently adhered to, including those relating to the management of 'cohorted' or 'stacked' patients. The CQC found that improvements had been made in theatre but they were still concerned that the department was not being well-led in some aspects. Issues were identified with the Sapphire Ward, including a lack of piped oxygen and suction potentially placing patients at risk of harm.

2.5.4 An independent data quality review commissioned by the board of the Licensee that reported on 8 September 2014 (the 'data quality review') identified data quality failings in the reporting of A&E access targets, cancer access targets and 18 week Referral to Treatment ("RTT") performance; these findings were so significant that RTT reporting was suspended for a 8 month period to allow for a planned Patient Administration System migration.

2.5.5 The Licensee further commissioned a follow-up review in November 2014 in relation to its reporting of cancer waiting times. This review called into question the validity of data gathered previously for reporting of cancer waiting times, significantly altering previous data.

2.5.6 The Licensee's commissioners wrote to the Licensee on 30 January 2015 indicating that the Licensee had not taken the agreed action to address the significant patient safety concerns evidenced by the considerable amount of Serious Incidents and Never Events.

2.5.7 A review of clinical, financial and operational systems was also carried out by University Hospitals Birmingham NHS Foundation Trust between July and October 2014 (the "organisational review") identified a number of cross-cutting themes within the Licensee, including:

(a) corporate and clinical governance processes and procedures are weak;
(b) a lack of clarity around responsibilities at all level, including the Board; and
(c) a lack of clear and consistent strategic direction.

2.5.8 The Licensee has failed to meet the A&E four hour standard for the last nine quarters and has only achieved the target in two quarters since Quarter 3 of 2011/2012.

2.5.9 The Licensee has had higher than expected mortality rates on the Summary Hospital-level Mortality Indicator (as published quarterly by the NHS Information

Centre) ('SHMI'), the HSMR and the Licensee's own crude mortality targets for a prolonged period.

2.5.10 This demonstrates a failure of governance arrangements including, in particular, a failure to establish and effectively implement systems 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)(c), (d) and (f) ; and
(g) to ensure it has in place personnel as required by FT4(7) .

2.6 Need for action

Monitor 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.

3. Appropriateness of Undertakings

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

UNDERTAKINGS

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

1. General Undertakings

1.1 The Licensee will co-operate fully with Monitor, health sector stakeholders and any external agencies or individuals appointed by Monitor or the Licensee's commissioners to work with or support the Licensee.

1.2 The Licensee will attend monthly meetings (or if Monitor stipulates conference calls) with Monitor and other relevant stakeholders at a time and place to be specified by Monitor, with attendees specified by Monitor, and provide a monthly report on the progress made in meeting these undertakings.

1.3 The Licensee will update Monitor on a timely basis on progress against plans and work streams referred to in these undertakings, all material variances to those plans and work streams, and any significant events that come to its attention.

1.4 The Licensee will comply with all additional relevant reporting requests made by Monitor.

2. Financial planning and Continuity of Service

2.1 The Licensee will take all actions necessary to establish and effectively implement systems and processes of financial planning and control to ensure the Licensee's ability to continue as a going concern, including the following actions, unless agreed otherwise with Monitor:

2.1.1 Implement, maintain and update the 15/16 financial plan submitted to Monitor on 15 May 2015 ("the 15/16 financial plan") in accordance with the timescales specified in that plan, unless otherwise agreed with Monitor. The Licensee will regularly update Monitor of progress against the 15/15 financial plan and where it identifies that it is not able to deliver the 15/16 Financial Plan it will inform Monitor as soon as possible and within 30 working days at the most and provide the extent of the variance, together with details of actions to return to compliance with the 15/16 financial plan.

2.1.2 Develop a three year financial plan in line with any planning guidance Monitor may issue ('3 year financial plan"), which sets out a realistic and robust estimate of the Licensee's underlying financial position, and which is supported by detailed and credible workforce plans and the demand and capacity models referred to in paragraph 7.1.1 below.

2.1.3 Maintain and update a 2 year phased capital programme to deliver the seven phase ED redevelopment, which received £13.4m of approved funding from the Department of Health on 19 December 2014 ('ED capital programme') and ensure that the supporting operational models are effectively implemented.

2.1.4 Provide to Monitor on a monthly basis, or at such frequency as Monitor specifies, an accurate 13 week rolling cash flow forecast split into capital and revenue spend.

2.2 The Licensee will take all reasonable steps necessary to ensure that it can continue operating in 2015/16 without needing further distressed provider funding from the Department of Health beyond the amount agreed with the Independent Trust Financing Facility in 2015.

3. Data Quality

3.1 The Licensee will take all actions necessary to ensure that the recommendations and associated actions outlined in the data quality review are implemented in accordance with the timescales specified in the data quality review, unless otherwise agreed with Monitor.

3.2 The Licensee will take all actions necessary to ensure an improvement in data quality within the new Patient Administration System, including training relevant staff and ensuring data quality issues are identified, escalated and rectified through appropriate committees. There will be a specific focus on the accuracy of RTT data.

3.3 The Licensee will provide to Monitor, should Monitor so request, external assurance from a source and according to a scope to be agreed with Monitor, that it has implemented the recommendations and associated actions of the data quality review.

4. Quality of Care

4.1 The Licensee will take all actions necessary to rectify the concerns which are outlined in the CQC reports dated 8 July 2014, 29 August 2014 and 4 February 2015 and any concerns raised in the report produced following the planned CQC inspection of 24 August 2015 (the "August report") (together, the "CQC reports"), such that:

4.1.1 within 28 days of the publication of the August report, the Licensee has reviewed and, where necessary, revised existing plans to ensure that they are sufficient to address all of the issues raised in the August report; any such revised plans will be provided to Monitor;

4.1.2 by 30 April 2016, or such date to be agreed with Monitor, the Licensee will have:

(a) complied with, and continued to comply with, any additional conditions on the Licensee's registration with the CQC;

(b) addressed all 'must do' actions and be able to evidence this to Monitor through its Board assurance processes; and

(c) satisfied itself through its Board assurance processes that the actions taken are sufficient in impact such that if the Licensee were to be inspected by the CQC on that date it would not judge the Licensee to be 'inadequate' in any of the domains or specialty areas; and

4.1.3 the Licensee will have implemented the revised plans referred to in paragraph 4.1.1 above in accordance with the timescales outlined in those plans.

4.2 The Licensee will periodically assess its plans to address concerns raised in the CQC reports to ensure that they remain deliverable and sufficient for the Licensee to comply with paragraph 4.1 above, and will make any necessary amendments. The Licensee will provide Monitor with the assurance relied on by the Board in making this assessment, upon request.

5. Corporate and Clinical Governance

5.1 The Licensee will take all actions necessary (including but not limited to taking the actions in paragraphs 5.2 to 5.6 below) to ensure that it has appropriate corporate and clinical

governance structures and processes in place, which would be reasonably regarded as appropriate for the supplier of a health care service in the UK.

5.2 The Licensee will ensure the following governance structures are in place within six months of the date of these undertakings, or such date to be agreed with Monitor:

5.2.1 effective board and committee structures, underpinned by clear terms of reference, in line with, or with rationale for deviation from, the recommendations arising from the organisational review, in a format that provides an overview of a monthly cycle of governance, incorporates Governor engagement and highlights escalation paths;

5.2.2 a clear framework of accountability and responsibility by role at board and divisional level, to include reporting and accountability lines from ward to division to board, and performance management processes throughout the organisation. The framework will incorporate both clinical and operational leadership, and must provide clarity on the separation and completeness of accountability across the executive and the appropriate escalation and resolution of matters relating to quality of care; and

5.2.3 a set of trust-wide key performance indicators (KPIs) for returning to licence compliance, which will straddle both corporate and clinical performance and provide a mechanism for measuring the success of the Licensee's performance against these undertakings.

5.3 The Licensee will develop and continue to review and adapt the following, both of which will include clear milestones for delivery and links to the Licensee's KPIs:

5.3.1 a clinical strategy, which is supported by the workforce strategy referred to in paragraph 5.3.2 below, and which addresses the issues identified in any diagnostic reviews, CQC inspections, capital developments and any other source of clinical information relevant to the Licensee; and

5.3.2 a workforce strategy, which is consistent with the clinical strategy referred to in paragraph 5.3.1 above and the financial work streams referred to in paragraph 2 above, and which addresses the current issues with staff vacancies, staff retention and agency staff use and any issues identified through diagnostic reviews, CQC inspections and any other source of workforce information relevant to the Licensee.

5.4 The Licensee will develop, implement and regularly review the adequacy of, a board and clinical leadership development programme, which will develop the capabilities and effectiveness of board members and clinical leaders.

5.5 By 30 April 2016, the Licensee must demonstrate that the requirements set out in paragraphs 5.2 - 5.4 above have been substantially delivered. The Licensee will ensure that the process of delivery has incorporated, as appropriate, the findings, recommendations and associated issues identified by the organisational review.

5.6 The Licensee will provide Monitor with the assurance relied on by the Board in relation to its progress in delivering this undertakings, upon request.

6. Serious incidents

6.1 The Licensee will take all actions necessary to ensure it has in place appropriate policies and procedures for the reporting and managing of Serious Incidents and Never Events ("SIs"), including taking the following actions, unless agreed otherwise with Monitor:

6.1.1 undertake a review of the Licensee's SI processes, including the resources allocated to manage those processes, and prepare a revised process to include appropriate identification, timely recording, root cause analysis, reporting and acting on the findings for all SIs, as requested by commissioners by 31 August 2015 or such date to be agreed with Monitor; and

6.1.2 ensure a robust governance process is in place for on-going management of SIs.

7. Referral to Treatment

7.1. The Licensee will take all actions necessary to achieve sustainable compliance with the 18 week RTT target ("the RTT target") by dates to be agreed with Monitor, including taking the following actions, unless agreed otherwise with Monitor:

7.1.1 preparing detailed demand and capacity models and, where relevant, trajectories for sustainable compliance with the RTT target at clinical speciality level, to a standard and level of detail acceptable by the Department of Health Intensive Support Team and the Licensee's commissioners, by a date to be agreed with Monitor;

7.1.2 preparing detailed plans for addressing and prioritising the backlog of patients waiting to receive treatment so that any immediate patient safety concerns are addressed, to be submitted to Monitor on a date to be agreed with Monitor;

7.1.3 carrying out detailed planning of the steps the Licensee will take to meet the trajectories referred to in paragraph 7.1.1 above, by a date to be agreed with Monitor;

7.1.4 implementing the plans referred to in paragraph 7.1.2 and 7.1.3 in accordance with relevant timescales in those plans; and

7.1.5 periodically assessing the plans referred to in paragraphs 7.1.2 and 7.1.3 above to ensure they remain deliverable and sufficient to meet the relevant trajectories on a sustainable basis.

8. Emergency care

8.1 The Licensee will take all reasonable steps to achieve compliance with the A&E target on a sustainable basis, including but not limited to the following actions:

8.1.1 delivering the emergency pathway work stream to enable it to achieve sustainable compliance with the A&E target; and

8.1.2 keeping the emergency pathways work stream delivery under review and where matters are identified which materially affect the Licensee's ability to achieve sustainable compliance with the A&E target, whether identified by the Licensee or another party, the Licensee will notify Monitor as soon as practicable and put plans in place to ensure it returns to compliance within a timeframe to be agreed with Monitor.

9. Cancer target

9.1 The Licensee will take all reasonable steps to achieve compliance with the cancer access targets on a sustainable basis, including but not limited to the following actions:

9.1.1 delivering the plan for improving cancer access to enable it to achieve sustainable compliance with the cancer access targets; and

9.1.2 keeping delivery of the plan for improving cancer access under review and where matters are identified which materially affect the Licensee's ability to achieve sustainable compliance with the cancer access targets, whether identified by the Licensee or another party, the Licensee will notify Monitor as soon as practicable and put plans in place to ensure it returns to compliance within a timeframe to be agreed with Monitor.

10. Mortality

10.1 The Licensee will, by a date to be agreed with Monitor, undertake and submit to Monitor a review of mortality which will assess the reasons behind the Licensee's position as having mortality rates that are higher than expected control limits against certain measures of mortality and whether this could be indicative of underlying quality of care issues and related governance issues at the Licensee. This review of mortality will include as a minimum an assessment of:

10.1.1 the Licensee's historic performance against the SHMI, the HSMR and the Licensee's own crude mortality targets;

10.1.2 the Licensee's mortality governance and procedural controls, including the adequacy of coding of deaths; and

10.1.3 whether the Licensee's position as having higher than expected mortality against certain measures of mortality could be indicative of underlying quality of care issues and related governance issues at the Licensee and an assessment of any such issues.

10.2 The Licensee will, by a date to be agreed with Monitor, submit to Monitor its plan to address the findings of the review of mortality referred to in paragraph 10.1 above, and to achieve consistent and sustainable performance against the SHMI, HSMR and crude

mortality measures within expected control limits by a date to be agreed with Monitor (the "Mortality Plan"). The Mortality Plan will as a minimum:

10.2.1 incorporate and include actions in respect of any issues, findings, recommendations and associated actions arising from the review of mortality described above; and

10.2.2 include key milestones to achieve consistent and sustainable performance against the SHMI, HSMR and crude mortality measures within nationally-accepted control limits.

10.3 The Licensee will implement all of the actions in the Mortality Plan in accordance with timescales specified in the Mortality Plan.

10.4 The Licensee will periodically assess the Mortality Plan to ensure that it remains deliverable and sufficient to address its position as having higher than expected mortality against certain measures.

11. Watchful wait and planned list categorisation

11.1 The Licensee will take all actions necessary to ensure it has appropriate policies and processes in place relating to watchful wait and planned list categorisation, including taking the following action, unless agreed otherwise with Monitor:

11.1.1 carry out a review of the Licensee's policies and processes relating to watchful wait and planned list categorisation to assess whether they are appropriate and take account of all relevant national guidelines, and make all necessary amendments to the relevant policies and processes to address any issues identified;

11.1.2 report to Monitor on the findings of the review referred to in paragraph 11.1.1 above and any amendments made to the relevant policies and processes as a result, by a date to be agreed with Monitor; and

11.1.3 prepare a plan for ensuring that the existing watchful wait cohort and the planned list cohort are managed in accordance with the policies and processes revised under paragraph 11.1.1 above, such plan to be submitted to Monitor by a date to be agreed with Monitor.

12. Buddy Agreement

12.1 The Licensee will comply with the terms of the Buddying Agreement entered into by the Licensee, Monitor and Guy's and St Thomas' NHS Foundation Trust on 9 March 2015 (the "Buddy Agreement"). Additionally the Licensee will ensure that appropriate systems and processes are in place to properly consider the recommendations arising from the work under the Buddy Agreement and, where appropriate, to implement those recommendations.

13. Improvement Director

13.1 The Licensee will cooperate with the Improvement Director appointed by Monitor to oversee and support the Licensee's delivery of these undertakings and the additional licence condition imposed on 22 November 2013, including taking all reasonable steps to promptly provide the Improvement Director with the information required to carry out their role.

14. Distressed funding

14.1 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.

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

14.3 The Licensee will comply with any spending approvals processes that are deemed necessary by Monitor.

15. Programme management and governance

15.1 The Licensee will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

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

15.2.1 obtain clear oversight over the progress in delivering the requirements;

15.2.2 obtain an understanding of any risks to the successful achievement of the requirements and ensure appropriate mitigation of any such risks; and

15.2.3 hold individuals to account for delivery of the requirements.

THE UNDERTAKINGS SET OUT HERE ARE WITHOUT PREJUDICE TO THE REQUIREMENT ON THE LICENSEE TO ENSURE THAT IT IS COMPLIANT WITH ALL THE CONDITIONS OF ITS LICENCE INCLUDING THE ADDITIONAL LICENCE CONDITION IMPOSED ON 22 NOVEMBER 2013 AND THOSE 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 MONITOR. THIS COULD INCLUDE THE REVOCATION OF THE LICENCE UNDER SECTION 89 OF THE ACT.

WHERE MONITOR IS SATISFIED THAT THE LICENSEE HAS GIVEN INACCURATE, MISLEADING OR INCOMPLETE INFORMATION IN RELATION TO THE UNDERTAKING: (i) MONITOR MAY TREAT THE

LICENSEE AS HAVING FAILED TO COMPLY WITH THE UNDERTAKING; AND (ii) IF MONITOR DECIDES SO TO TREAT THE LICENSEE, MONITOR MUST BY NOTICE REVOKE ANY COMPLIANCE CERTIFICATE GIVEN TO THE LICENSEE IN RESPECT OF COMPLIANCE WITH THE RELEVANT UNDERTAKING.

LICENSEE

Dated 13.8.2015

MONITOR

Dated 05.08.15

Signed (Chair of relevant decision-making committee)