NHS Improvement

To:	The Board
For meeting on:	22 March 2018
Agenda item:	8
Report by:	Ian Dalton, Chief Executive Officer
Report on:	Response to recommendations made in the Independent review into Liverpool Community Health NHS Trust

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Summary

1. This paper sets out NHS Improvement's response to the recommendations in the Kirkup report into issues at Liverpool Community Health NHS Trust (LCH). Dr Kirkup's report is a thorough and balanced examination of the factors surrounding what happened at Liverpool Community Health and his findings make difficult reading.

2. Dr Kirkup's report describes a series of failings in the care provided by LCH to its patients. The review found evidence of a broken culture, inadequate clinical governance and a failure of leadership at the Trust. Information and concerns were not shared effectively between those responsible for oversight and it took too long for the issues at the Trust to be recognised by these organisations. Dr Kirkup's findings remain highly relevant for my organisation, and the way we work with other national bodies. I take his findings and recommendations very seriously and I propose that the Board accepts all of these recommendations.

3. This paper focuses mainly on actions that I propose to take in response to the recommendations directed at NHS Improvement. For those recommendations where NHS Improvement does not have the lead, I am committed to working closely with other stakeholders to support the actions they will take in response to Dr Kirkup's findings. Separately, NHS Improvement has commissioned an independent investigator to look into the circumstances under which roles were found or facilitated for individuals identified in Dr Kirkup's report as bearing some responsibility for the issues at the Trust. This review is not discussed in this report but is well underway.

4. NHS Improvement's actions must have lasting impact and give us confidence that we can avoid a similar situation ever occurring again. NHS Improvement already provides elements of the support or oversight discussed and proposed below; however I believe that we must substantially strengthen and broaden our work in a number of areas. Taken together, the actions proposed in this paper represent a substantial programme of work and will have resource implications

for NHS Improvement. I would expect to update the Board in May, and thereafter, on progress in planning and implementation.

5. The Board will be asked to consider the response to the recommendations as set out in this paper and to agree to the full implementation of the measures described.

Background to the review

6. LCH was created in 2010, providing services including adult care, child and adolescent care, community dentistry, prison healthcare and public health. Dr Kirkup's independent review was commissioned by my predecessor at NHS Improvement, to look into issues at LCH from November 2010 to December 2014. The review also looked at the oversight of the Trust by the NHS Trust Development Authority (NHS TDA), NHS England and commissioners.

7. Dr Kirkup's review found that cost improvement programmes imposed by the trust in a bid to gain foundation trust status put the safety of patients at risk. The review found evidence of inadequate staffing levels, low morale, poor HR practice and, more generally, a culture of bullying. Staff were actively told not to report incidents and whistleblowing was discouraged; those who did were ostracised by their manager/leader and later let down by HR. As a result, staff were afraid to speak up.

8. External oversight of the Trust failed to identify problems with the services for at least four years. NHS TDA, one of the organisations responsible for oversight, identified concerns but subsequently reversed its assessment of risk for unexplained reasons. The review found evidence of silo working and poor sharing of concerns and information within NHS TDA, and that important information may not have been passed between oversight organisations, including between two of the organisations – Monitor and NHS TDA – that later formed NHS Improvement. Furthermore, external organisations, including NHS TDA, provided insufficient support to an inexperienced trust Board.

9. The review concluded that earlier intervention would have reduced the avoidable harm that occurred to patients and staff across the Trust.

Response to recommendations

Trust appointments

Recommendation 1: In approving Trust Board appointments, NHS Improvement should take note of the level of experience of appointees and level of risk in the Trust, and should ensure a system of support and mentorship for Board members where indicated. **Action: NHS Improvement.**

10. Dr Kirkup's report is a reminder of the importance, and the difficulty, of ensuring that individuals appointed to leadership positions have experience that reflects

the challenges they will face. His report also demonstrates how vital it is that senior leaders receive support and mentorship that reflects their particular experience and circumstances. I believe that NHS Improvement should have a central role in ensuring that individuals with sufficient experience and capability are appointed to senior roles in the NHS.

11. NHS Improvement has a statutory role in appointing Chairs and non-executive directors to NHS trust boards. NHS Improvement's Provider Leadership Committee and Sub-Committee make these appointments, and members of these committees will continue to expressly take into account the experience of prospective appointees, and the level of risk in a trust, when considering whether to approve such appointments.

12. For NHS foundation trusts, NHS Improvement does not have a statutory role in approving any Board appointments, executive or non-executive. NHS Improvement also has no statutory role in the executive appointment process in NHS trusts. However, senior NHS Improvement staff sit on NHS trust selection panels as external assessors and our organisation provides support and advice to both types of provider on an informal basis.

13. I believe that the role NHS Improvement plays in board appointments (executive and non-executive) is not sufficiently clear and that there would be benefits in reviewing and codifying our oversight and support arrangements. Any changes should pay due regard to the fact that autonomy in appointing executives is an important NHS foundation trust freedom.

Action: I have asked my team to review NHS Improvement's role in board appointments in light of Dr Kirkup's findings, and to report back with recommendations by **May 2018**.

14. More fundamentally, I believe that NHS Improvement must play a greater role in the professionalisation of talent management within the NHS provider sector. I want our organisation to play a more active role in defining what good talent management looks like, in supporting providers to nurture talented leaders, and in providing mentorship to senior individuals where this would support their development.

15. I want to work with system partners, including Health Education England (HEE) and NHS Leadership Academy, to achieve this and we have an immediate opportunity to do this as part of the consultation exercise for HEE's health and care workforce strategy, which will be developed over the next few months.

16. As well as supporting individual providers and local systems to nurture and manage their talent, we must also recognise that as regulator of the sector which employs the vast majority of health professional in England, NHS Improvement has a role to play in supporting rehabilitation of individuals who have had performance issues, but who nonetheless have a valuable role to play in the NHS. I want to ensure that we are able to distinguish more readily between situations where it may no longer be appropriate for an individual to work within

the NHS, and those cases where, with appropriate support and in the right role, an individual can learn, develop, and contribute in a valuable way.

Action: NHS Improvement will work with other national bodies, including HEE and NHS Leadership Academy, to develop an ambitious talent management and professional development offer for the provider sector.

This needs to include support for the recruitment, development and career progression of trust leaders; a more structured offer around mentorship for less experienced leaders; and will take account of the role that NHS Improvement should play in managing failure, distinguishing between situations where an individual should no longer work within the NHS, and those where someone can be supported to learn and make a valuable contribution.

I intend to bring a detailed proposal to the Board in **May** and the Organisational Development work that we are undertaking with the support of McKinsey will consider how this offer should be organised and delivered. I would like to have made substantial progress in building a scale operation by the **end of 2018/19**. As part of this, I would like to clarify ours, and other organisations', respective roles in this area.

Assessing the risk facing trusts

Recommendation 2: In assessing the level of risk facing a trust, regulators and oversight organisations should take into account the cumulative impact of relevant factors, including a newly established organisation, inexperienced Board, cost improvement targets and service acquisitions. **Action: Care Quality Commission (CQC), NHS Improvement, NHS England.**

17. Dr Kirkup's report found that national and regional NHS organisations failed to fully recognise the level of risk facing trusts from 2010 to 2014. Since this time, much progress has been made by national organisations in improving the scope and quality of oversight; however, I agree with Dr Kirkup that there is more to do.

18. Since 2014, NHS Improvement, the CQC and NHS England have established a number of approaches to oversee providers and identify risk in the provider sector. The CQC comprehensively revised its regulatory approach in 2014, and national organisations have developed a more coherent view of risk in the provider sector, informed by the following related approaches:

    a. NHS Improvement's Single Oversight Framework;
    b. the CQC and NHS Improvement's well-led framework;
    c. the CQC's well-led inspections and Insight monitoring tool;
    d. NHS England and NHS Improvement's Integrated Support and Assurance Process to support the successful delivery of novel and complex contracts; and
    e. measures to help staff raise concerns, including a national whistleblowing policy (published by NHS Improvement and NHS England) in April 2016, a new National Guardian's Office, and a Freedom to Speak Up Guardian in every trust.

19. As a result of these new approaches, I believe that national bodies collectively would be far more likely to identify problems such as those at LCH should they arise elsewhere. Nonetheless, I want to ensure that we are continuously improving these processes.

Action: NHS Improvement will work with other national organisations to conduct exercises that 'stress test' our current oversight approach against a range of example scenarios. We will use the findings of these exercises, which will be complete by **autumn 2018**, to improve our approach to assessing risk.

20. Dr Kirkup specifically noted the detrimental impact of excessive cost improvement targets at LCH. Provider boards have primary responsibility for oversight of cost improvement plans, and should ensure that their teams develop meaningful and realistic plans, which are subject to robust measurement and reporting. Medical Directors and Chief Nurses are required to undertake a Quality Impact Assessment of these plans to ensure that they are appropriate from a clinical perspective.

21. At present, the degree of Board oversight of these plans varies between organisations and, furthermore, planned levels of cost improvement are not calculated on a consistent basis by providers. Boards must retain primacy regarding cost improvement plans, but I believe that NHS Improvement should do more to improve the quality of cost improvement plans and to seek assurance from providers that plans are credible and appropriate.

Action: Based on our judgement of organisational risk, and the credibility of proposed savings, NHS Improvement will seek additional assurance where appropriate that robust and clinically-led processes have been followed in the development of cost improvement plans.

22. More immediately, Dr Kirkup's report highlights that there is a risk of an imbalance between leadership experience and risk in the community sector, and my team is taking urgent action on this front.

Action: My regional teams are conducting a rapid review of the level of experience and risk in community trusts. Based on the findings of this review, NHS Improvement will take action required to support specific providers, and will also consider whether any changes are needed to our business-as-usual support for the community sector.

Joint working between oversight organisations

Recommendation 3: Regulators and oversight organisations should review how they work together jointly at regional and national level, and implement mechanisms to improve the use of information and soft intelligence more effectively. **Action: CQC, NHS Improvement, NHS England.**

23. I am pleased to report that there has been substantial progress in aligning the work of various national bodies since 2014, and a number of important systems

and processes have been embedded in our operating models. Collectively, national bodies have taken a number of actions worth noting:

a. NHS Improvement and NHS England are developing our joint approach to oversight of Integrated Care Systems and Sustainability and Transformation Partnerships, and the providers and clinical commissioning groups within them. This approach is designed to ensure that NHS England and NHS Improvement set consistent expectations and provide streamlined oversight and support for local systems, to avoid duplication or mixed messages and to ensure our time and resources are used as effectively as possible;
b. NHS Improvement and the CQC have also worked closely together to develop and implement Use of Resources assessments to improve our understanding of how effectively trusts provide high quality, efficient and sustainable care for patients, and what further support may be required;
c. We and CQC have also developed a new approach to Well-Led assessments, which is designed to look at clinical and financial governance in the round;
d. Quality Surveillance Groups have evolved, at a regional and local level, to bring together oversight organisations to triangulate and share quality and performance information for trusts and to put in place support or intervention required to drive improvement, along with the Joint Strategic Oversight Group at national level.

24. However, there is a lot left to do, and improving the way NHS Improvement works with other national organisations – in particular with NHS England – has been one of my priorities since joining the organisation.

25. It is my ambition, which I share with the Chief Executive of NHS England, to provide more cohesive leadership for the NHS; to speak to systems with one voice and to streamline, where possible, the oversight and support we provide. A formal programme of work is underway to more systematically distinguish between where it makes sense to integrate our work, where it makes sense to collaborate more closely and where it makes sense to remain distinct. Proposals have been submitted to the Boards of both NHS Improvement and NHS England.

Action: Subject to Board approval, this work will continue at pace over the **spring and summer of 2018** and I will update the Board on progress in **May**.

26. More generally, I am committed to sharing information and soft intelligence more effectively with other national bodies, although I recognise the importance of safeguarding the CQC's role as an independent inspectorate. We have already taken important steps to improve the way we share intelligence at national and regional level, including the recently-established Joint Strategic Oversight Group, which is jointly chaired by NHS Improvement's Medical Director and the CQC's Chief Inspector of Hospitals. This group acts as a forum for discussion of emerging issues in providers.

27. I have also approved a programme of work to transform NHS Improvement's IT infrastructure, which will facilitate the more effective sharing of information within NHS Improvement, and with NHS England.

Action: NHS Improvement's programme to transforming its business systems will launch in **April 2018** and the first changes will be delivered by **late July**.

Recommendation 4: Regulators and oversight organisations should ensure that, during both local and national reorganisations and reconfigurations, performance and other service information is properly recorded and communicated to successor organisations. **Action: CQC, NHS Improvement, NHS England.**

28. I recognise that local reconfigurations to improve care for patients bring with them a continuity risk of the type Dr Kirkup has identified. Our work with NHS England to develop a more integrated approach to regional oversight of local health systems – and the providers and commissioners within those systems – provides an opportunity to systematise more clearly the approach to ensuring relevant information is passed on to successor organisations in local reorganisations.

Action: Our work with NHS England to develop a more integrated approach to regional oversight will address the need to ensure relevant information is passed on to successor organisations locally.

29. In the event of any national reorganisation affecting NHS Improvement, it would be incumbent on us to ensure that relevant information was passed on to organisations taking on any of our functions.

Action: NHS Improvement will review its standard operating procedures for its regulatory support committees to ensure information is collected and codified in a way that supports timely and effective transfer in the event of any changes to national functions.

Reviewing the handling of LCH incidents

Recommendation 6: Organisations taking on former LCH services should review the handling of previous serious incidents to ensure they have been properly investigated and lessons learned. **Action: Trusts providing former LCH services.**

30. The current providers of former LCH services should lead on responding to this recommendation; however I have discussed these issues with Dr Kirkup and agree with him that these reviews must be handled with an appropriate degree of independence and openness, in order to assure patients, families and staff that these matters are being dealt with seriously and thoroughly.

31. NHS Improvement has engaged with providers of former LCH services to support them in responding to this recommendation. We will do the same for all remaining LCH services, including those that are part of an ongoing transaction.

A number of clinical issues identified in Dr Kirkup's report (e.g. pressure ulcers and falls) are the focus of existing NHS Improvement support offers.

Action: NHS Improvement is providing advice to the provider that has to date taken on the most former LCH staff, to commission and conduct an independently-led review into previous serious incidents. We will continue to work with them as this proposed review develops. Based on the findings of this review, NHS Improvement will support the trust, through our various improvement offers, to ensure that improvement activity is focused on areas of greatest concern.

We will advise other trusts that have taken on former LCH services to take similar action and will support trusts with these reviews.

Recommendation 7: Organisations taking on former LCH staff as part of service transfers should review the handling of disciplinary and whistleblowing cases urgently to ensure that they have been properly and appropriately resolved. These organisations should ensure that staff are not placed back into working relationships previously the subject of bullying and harassment. **Action: Trusts providing former LCH services**.

32. As above, NHS Improvement has engaged with trusts providing former LCH services and will support them in responding to this recommendation. Given the poor quality of record-keeping identified in Dr Kirkup's report, it is vital that robust safeguards are in place to ensure that no individuals are placed into inappropriate working relationships. There should also be an ongoing mechanism by which staff can raise any concerns or request support to address this issue.

Action: The provider that has to date taken on the most former LCH staff has confirmed its intentions that an independent practitioner will undertake a review of whistleblowing records. For disciplinary investigations, this provider intends to commission an independent HR practitioner to review these. For both issues, we will ask other trusts that have taken on former LCH services to take similar action and will support trusts with these reviews.

NHS Improvement will work with all relevant providers to ensure that staff have appropriate channels to raise grievances and disciplinary cases that may not be identified as part of this exercise, and to ensure these cases are reviewed; will support the trusts to ensure that no individuals are placed into inappropriate working relationships; and will ensure that staff can raise concerns on an ongoing basis.

Reviewing the safety and effectiveness of former LCH services

Recommendation 8: Reconfigured LCH services should be reviewed after a year to ensure that the services are now safe and effective. **Action: NHS Improvement, NHS England.**

Action: I have agreed with Dr Kirkup that a review of the relevant services will take place by 31 March 2019, using the joint quality oversight infrastructure

established since the period covered by his report. I have also committed to publishing the results of this work so that the public can be assured of the safety and efficacy of these services.

Recommendations where NHS Improvement will support other organisations

Recommendation 5: The Department of Health should review the working of the CQC fit and proper persons test, to ensure that concerns over the capability and conduct of NHS executive and non-Executive Directors are definitively resolved and the outcome reflected in future appointments. **Action: Department of Health.**

33. A robust process for determining whether senior leaders meet appropriate standards of capability and conduct is an important element of the broad approach to NHS talent management outlined in our response to Recommendation 1. I understand that the Department of Health and Social Care will commission an independent review of the fit and proper persons test. NHS Improvement will participate fully in this review.

Recommendation 9: Health services in HMP Liverpool should be subject to urgent review to ensure that future arrangements are fit for purpose and will be effectively monitored. **Action: NHS England.**

Recommendation 10: NHS England should review the arrangements for commissioning prison health services nationally to ensure that these are safe and effective. **Action: NHS England.**

34. NHS England is responsible for commissioning of prison health services and will describe separately how it is acting on these recommendations. NHS Improvement will provide full support to NHS England in implementing its response.

Next steps

35. As sector regulator for NHS providers, NHS Improvement should take the lead in driving change in the areas discussed above. Together, these proposed actions constitute a significant expansion of NHS Improvement's role in supporting NHS leaders and an evolution of the way that NHS Improvement works with other organisations to oversee the provider sector.

36. The Board is asked to consider and agree:

    a. The proposed actions for NHS Improvement in response to the Kirkup report; and
    b. Our proposed direction of travel for joint working with partner organisations in response to the Kirkup report.

37. I will provide an update on implementation to the Board in May.