NHS England and NHS Improvement Board meetings held in common

Paper Title: Kirkup Recommendation 6.8 – Report on regional response

Agenda item: 8 (Public session)

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Paper type: For discussion

Summary/recommendation:
This paper provides a report on Recommendation 6.8 of the 2018 Independent Review by Dr. Bill Kirkup into Liverpool Community Health NHS Trust (LCH). The recommendation stated that all LCH services that transferred to other providers should be reviewed twelve months post transfer to ensure they are safe and effective.

The paper provides an overview of the process undertaken to assess safety and effectiveness of each of the nine organisations receiving LCH services, with the approach being broadly proportionate to the scale of transferring services.

The overall conclusion is that both safety and effectiveness of services have improved. However, risks remain and Mersey Care NHS FT, which took on the majority of transferring staff, has faced the greatest challenges.

Future overview and scrutiny of these organisations will be undertaken by the associated CCGs and NHS England and Improvement's regional quality team through the usual Regional Quality Surveillance Group process.

The Boards are asked to note the contents of this report and agree that no further reporting to the Boards is required on this specific recommendation.

Background

1. The Independent Review into the widespread failings by LCH during the period December 2010 – December 2014 by Dr. Bill Kirkup was published in February 2018.

2. The review made ten recommendations, to be implemented by either NHS Improvement, NHS England, CQC, DHSC, trusts providing former LCH services, or a combination of these organisations. This paper addresses recommendation 6.8

3. Recommendation 6.8 stated that 'Reconfigured LCH services should be reviewed after a year to ensure that the services are now safe and effective', with the action allocated to NHS Improvement and NHS England.

4. Nine organisations received services from LCH with most services transferring to Mersey Care NHS FT.

Approach

5. Improvements to safety and effectiveness have been measured in several different ways, with the approach to NHS Improvement's assessment being broadly proportionate to the scale of services transferring to each organisation.

6. For those organisations receiving the most significant numbers of staff, the approach included a Clinical Services Review (CSR), in which an NHS Improvement team inspected the transferring services to gain insight into safety and effectiveness.

7. This intelligence has been used alongside other evidence, including CQC reports where available, to form an overall view for each organisation on the extent to which safety and effectiveness have improved and any remaining risks.

8. Appendix 1 provides a detailed overview of the methods used to review each of the nine organisations after 12 months.

Key findings

9. Appendix 2 contains a summary of the key findings for each organisation receiving services.

10. It is not possible to form a single conclusion on safety and effectiveness due to the differing nature of transferring services and their organisations. The general trend has been towards an improving picture of safety and effectiveness, but with risks remaining in some areas (as is the case to an extent in any NHS provider).

11. Mersey Care NHS FT received the most significant volume of services and is the provider where we have the greatest residual concern. This is not unexpected given the significant cultural change required in these services and the amount of time it takes for this to embed. However, we are confident that the trust as a whole does have the right culture and ethos to promote the further improvement that is needed. Ongoing monitoring will, of course, be required.

Further Supportive Work and next steps

12. There has been additional sub regional work completed relevant to the Kirkup Review findings that we would like to bring to the board's attention:

    - Quality Risk Profile (QRP) Tool – Task and Finish Group established to ensure findings from Kirkup are reflected in the tool. It was noted that struggling organisations shared common features, such as changes in executive leadership, recent acquisitions or mergers and challenging cost

improvement programmes of more than 4.5%. The new tool has weighted these features and their associated risk scores.

- An annual desk top review is carried out for all organisations regardless of Single Oversight Framework (SOF) segmentation. This enables those organisations that may otherwise be ‘under the radar’ to be adequately monitored.
- Kirkup Stress Testing Exercise completed for the two Cheshire and Merseyside Community Trusts in 2018. A Desk Top Review was undertaken for both organisations as well as a review of quality dashboards.

13. The regional team proposes that there is no further paper to the board in relation to this recommendation and that ongoing monitoring of quality in the receiving trusts is undertaken within business as usual processes. The relevant CCGs , Specialised Commissioners and the regional team will continue to carry out quality surveillance activities in the form of quality review meetings, quality surveillance/oversight visits, annual desk top reviews and engagement in the system wide quality surveillances meetings.