Quality, safety and management assurance review
Liverpool Community Health NHS Trust

Final Report

Liverpool Community Health NHS Trust

Quality, safety and management assurance review at Liverpool Community Health NHS Trust

Capsticks Solicitors LLP
Governance Consultancy Service

22 March 2016

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This document has been prepared by the Capsticks Governance Consultancy Service on behalf of Liverpool Community Health NHS Trust.

This report is confined to those issues that came to our attention during the course of this review and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist or existed, nor of all the improvements that may be required.

The Capsticks Governance Consultancy Service has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information we have been provided and documentation reviewed. However, no complete guarantee or warranty can be given with regard to the advice and information contained herein.

This report is prepared for the Board of Liverpool Community Health NHS Trust.

No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

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22 March 2016
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Section 1: Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2. Section 2: Executive Summary</td>
<td>7</td>
</tr>
<tr>
<td>3. Section 3: Background to Liverpool Community Health NHS Trust</td>
<td>15</td>
</tr>
<tr>
<td>4. Section 4: Terms of Reference</td>
<td>16</td>
</tr>
<tr>
<td>5. Section 5: Methodology</td>
<td>18</td>
</tr>
<tr>
<td>6. Section 6: Key Review Themes: Part One</td>
<td>23</td>
</tr>
<tr>
<td>7. The Trust Board</td>
<td>23</td>
</tr>
<tr>
<td>8. The Drive to Achieve NHS Foundation Trust Status</td>
<td>38</td>
</tr>
<tr>
<td>9. Cost Improvement Programmes and Quality Impact Assessments</td>
<td>46</td>
</tr>
<tr>
<td>10. A Failure to Investigate Concerns</td>
<td>61</td>
</tr>
<tr>
<td>11. Cost Improvement Programmes and Quality Impact Assessments</td>
<td>70</td>
</tr>
<tr>
<td>12. Intermediate Care Bed Based Service</td>
<td>84</td>
</tr>
<tr>
<td>13. Culture of Bullying and Harassment</td>
<td>96</td>
</tr>
<tr>
<td>14. NHS Staff Survey Results</td>
<td>106</td>
</tr>
<tr>
<td>15. Investigation of Grievances</td>
<td>124</td>
</tr>
<tr>
<td>16. Corporate Governance Arrangements in the Trust</td>
<td>128</td>
</tr>
<tr>
<td>17. Clinical Governance Systems in the Trust</td>
<td>133</td>
</tr>
<tr>
<td>18. Section 7: Key Review Themes: Part Two</td>
<td>143</td>
</tr>
<tr>
<td>19. Addressing an Inherited Agenda</td>
<td>143</td>
</tr>
<tr>
<td>20. The Corporate Governance Arrangements in the Trust Today</td>
<td>156</td>
</tr>
<tr>
<td>21. The Framework and Structure for Clinical Governance Today</td>
<td>166</td>
</tr>
<tr>
<td>22. Creating a Cohesive Trust Culture</td>
<td>176</td>
</tr>
<tr>
<td>23. The Trust Whistleblowing Policy</td>
<td>184</td>
</tr>
<tr>
<td>24. Duty of Candour</td>
<td>185</td>
</tr>
<tr>
<td>25. Section 8: Conclusion</td>
<td>189</td>
</tr>
<tr>
<td>26. Section 9: Recommendation</td>
<td>193</td>
</tr>
<tr>
<td>Appendices</td>
<td>199</td>
</tr>
</tbody>
</table>

## Appendices

- Appendix 1: Schedule of Documents Reviewed
- Appendix 2: Timeline of Key Events
- Appendix 3: Board Composition 2010/11 Onwards
- Appendix 4: District Nursing Incident Data 2012 – 2014
- Appendix 5: Prison Health Incident Data 2012 – 2014
- Appendix 6: Letter to Sue Page, Interim Chief Executive from Monitor dated 4 July 2014 re: Monitor Quality Governance Pilot
- Appendix 7: Ward to Board Questions: Trust Quality Self-Assessment
- Appendix 8: Duty of Candour Additional Actions
1 Introduction

1.1 Our report into Liverpool Community Health NHS Trust sets out a series of events that began in 2011 with a sustained drive towards achieving NHS foundation trust status by the Board. What followed until the early part of 2014 was an accompanying focus to reduce costs, which resulted in enormous pressures on many front line services and the emergence of a culture of bullying and harassment of staff at various levels within the organisation and the delivery to some patients of poor and in some cases sub-standard care.

1.2 The Board failed to recognise the nature and severity of the problems and they did not ensure Cost Improvement Programmes were accompanied by a robust underpinning programme of Quality Impact Assessments. Undue reliance was placed by the Board on external reviews. Instead of proactively seeking assurance from the Executive Directors, in our view, Non-Executive Directors took reassurance too easily and failed to provide sufficient scrutiny and challenge across a number of key areas. They collectively represented a series of missed opportunities to intervene. Had any of these opportunities been taken, the subsequent sequence of failures could have been broken.

1.3 Equally the Board failed to analyse properly the negative comments by its own staff coming out of the annual NHS Staff Surveys and to properly understand service failings and deaths in custody at Her Majesty’s Prison Liverpool and the factors that contributed in part to those deaths.

1.4 Non-Executive Directors were not made aware of some critical issues by the Executive Directors leading to an erosion of good governance. Our report also details a series of concerns in individual clinical areas and the subsequent actions of an inexperienced Executive Team.
1.5 Risks were escalated upwards in the Trust but were either downplayed by Executive Directors and certainly in one key area, the Intermediate Care Bed Based Service, they were downgraded by the Executive Director of Operations & Executive Nurse, with no subsequent challenge by first the Integrated Governance Quality Committee and then the Board.

1.6 In saying the above, we are acutely mindful that it is easier with the benefit of hindsight and all the information in front of us to make these linkages but our view is that a great deal of this was known and available at the time. What it required was for the Board to provide greater scrutiny, challenge and oversight.

1.7 For many of these concerns, it is hard to come to any other conclusion than that they were managed in the way they were in order to ensure the Trust application for NHS foundation trust status remained on track.

1.8 In the last eighteen months, a new leadership team has been appointed and made progress in taking the Trust on a systematic improvement journey. A key feature of the work of the new leadership team has been to ensure the Trust delivers safe and effective care.

1.9 The work of the new leadership team in actively seeking to support staff and to create a culture of openness and transparency is also to be welcomed.

1.10 However, for all the progress that has certainly been made by the new leadership team, they are at a formative stage and there are some key areas where more needs to be done, whilst in others there needs to be a tighter grip and in some areas, we would encourage the Trust to quicken the pace of change.

1.11 The value of setting out a catalogue of previous shortcomings in this way will inevitably be questioned by some and challenged by others. Our response to this is clear; that the Trust needs to learn from what went wrong in the past to avoid it happening again in the future.
1.12 Sadly today, the name of Liverpool Community Health NHS Trust has been added to a growing list of organisations across the NHS whose reputation and image has been tarnished. Our report sets out why it happened and how it could have been avoided and perhaps most importantly draws out lessons for the Trust today.

1.13 Many of the staff who took part in this review told us frankly and respectfully about some of their experiences. They deserve a huge credit for not giving up when it would have been so easy to do so.

1.14 The Trust owes it to them to learn the lessons from the issues we have set out in our report and to take forward its findings in a timely and effective manner.

Moosa Patel
Head of Governance Consultancy Service
Capsticks Solicitors LLP
22 March 2016
2 Executive Summary

2.1 Our review was established by Liverpool Community Health NHS Trust in April 2015 and with the support of the NHS Trust Development Authority. We have sought to set out the facts as clearly as possible and to comment on them.

2.2 We have carried out a thorough and independent review and whilst our initial terms of reference were to focus on the period from January 2013 onwards, we quickly found that many of the issues we were concentrating on commenced from the period Liverpool Community Health NHS Trust was formally established in November 2010 and that is therefore where our review starts from.

2.3 The review team included expert advisers in management, human resources and governance. We reviewed many hundreds of documents and interviewed over forty people, mostly current and former members of staff.

2.4 Our findings catalogue a series of failures at multiple levels. The nature of these problems is very serious and it is important for the lessons of those events to be learnt to ensure that they do not happen again.

2.5 The origin of the issues we have set out began with the appointment in our view of a largely inexperienced executive team at this level and their subsequent approach and way of working, alongside a Non-Executive Director cohort that on the whole did not provide sufficient scrutiny, challenge and oversight across a number of key areas.

2.6 Added to this was a sustained drive almost from day one to achieve NHS foundation trust status and as part of the process towards achieving that strategic goal, an aggressive top down push to achieve Cost Improvement Programmes which were hugely challenging and in many cases, ultimately unrealistic without significantly compromising the safe delivery of care.
2.7 So whilst the Trust appeared financially sound the failure to recruit to established clinical posts contributed to the Trust surplus position. In some services, carrying unfilled posts to deliver a Cost Improvement Programme resulted in both poor staff experience and inconsistent quality of services across the Trust. Despite this, Cost Improvement Programmes were nevertheless driven forward persistently.

2.8 The impact of Cost Improvement Programmes on staff morale, on staff numbers and the quality of services was not considered by the Board in the way that it should have been. Indeed, as far as we can ascertain Quality Impact Assessments of Cost Improvement Programmes largely did not happen in the way they should have, despite assurances provided to the Board and its Committees. For its part the Board should have more proactively been seeking evidence as opposed to accepting re-assurance on this point. In the few areas where Quality Impact Assessments were undertaken, they were not consistent with national guidance and fell well short of the standard expected.

2.9 Our review shows that on paper from 2011 onwards the Trust had in place some reasonable, appropriate and well developed systems and processes to ensure a strong clinical governance framework and to a point they worked. Clinical governance meetings took place at departmental level. They discussed the range of issues we would have expected them to. Staff did report incidents on the Trust incident reporting system (Datix) and risks were escalated upwards in the Trust, particularly within the health services provided at Her Majesty’s Prison Liverpool and within the Intermediate Care Bed Based Service. What did not work though was that when risks were escalated upwards, they were either ignored or watered down by those in more senior positions to make them look less significant than they were, without any clear rationale for doing so. For those staff that completed those incident forms and escalated risks, it must have felt that no one at the Trust was listening to their legitimate concerns.
2.10 The Integrated Governance and Quality Committee and the Healthcare Governance Sub-Committee we found wanting in their ability to provide sufficient scrutiny and oversight, whilst the Human Resources & Organisational Development Committee and the Finance & Commercial Committee, in our view, were either too operational or too readily accepting of the assurance provided or both, and failed to largely provide effective oversight and scrutiny of the issues they were responsible for.

2.11 Inappropriate and unsafe care was not addressed, even where that was clearly set out in internal or external reports, and the response to adverse incidents was grossly deficient, with a failure to investigate properly and learn lessons. Indeed the culture in the Trust was not conducive to raising concerns. It was hierarchical and seen by some as oppressive. Speaking out about concerns was not easy. Such was the impact of this culture that some staff were driven to the brink.

2.12 Ultimately, if all else failed, some of those staff could have raised these issues to their professional regulatory body, though they did not do so. In the circumstances perhaps they should have done so, though we recognise it is easy to say that with the benefit of hindsight.

2.13 It is probably too simplistic to look for one reason behind all of this but the desire to achieve NHS foundation trust status by an executive team inexperienced at this level, alongside a Non-Executive Director cohort that did not provide effective oversight in a number of key areas, accompanied by an aggressive Cost Improvement Programme (with its resultant impact on staff numbers and morale) and which ultimately drove a culture of bullying and harassment; cumulatively all played their part.
2.14 Added to this, staff concerns were not properly investigated and neither were specific incidents, in order to manage negative news so as to not jeopardise the NHS foundation trust application. Where investigations were undertaken, they were deficient and failed to identify manifest problems. There appeared no coherent system for feedback to staff from incidents and therefore little evidence of individual, team or organisational learning. Although we heard different accounts, it is clear that some of these were kept away from the Non-Executive Directors of the Board by the Executive Directors.

2.15 Throughout, the Board missed opportunities and did not carry out its responsibilities. This included a failure to look closely at the outcomes of the NHS Staff Survey, in 2011 and especially in 2012, which showed clearly the concerns of many staff; a failure to ensure that a robust quality impact assessment process accompanied Cost Improvement Programmes; and a failure to consider reports from either Her Majesty’s Inspectorate of Prisons for England and Wales or the Prisons and Probation Ombudsman for England and Wales into services at Her Majesty’s Prison Liverpool. Indeed the Board in our view was too passive on a number of key areas and rather than proactively exercising effective governance was responding to what it was told by the Executive Directors, taking re-assurance too easily and not actively seeking out assurance.

2.16 Our conclusion is that these events represent failures at multiple levels. There were strategic failures around a desire to achieve NHS foundation trust status as opposed to seeking to deliver a well governed, well run organisation which should lead in turn to NHS foundation trust status. There were failures of process and oversight, especially around the Quality Impact Assessment of Cost Improvement Programmes. There were failures of governance whether that was around downgrading of risks, ignoring incident reports on Datix, the failure of the Board to apply the required level of scrutiny to the NHS Staff Survey Results in 2011 and 2012, or around the failure to properly understand concerns and deaths in custody at Her Majesty’s Prison Liverpool.
2.17 There were repeated failures by the Executive Directors to be open and transparent with the wider Board, which is ultimately responsible for the care and welfare of its staff. This included not sharing with the Board details of a serious assault carried out on a health care professional and not sharing with the Board the results of a survey of staff views and opinions undertaken by the Staff Side which amongst other things highlighted that 96% of respondents believed bullying was a moderate or worse problem at the Trust. This failure to present a complete picture to the Board is both inexcusable and wholly unprofessional. Indeed it represented in our mind a clear attempt to erode good governance.

2.18 The culture of the Trust at the time was hierarchical and seen as oppressive by many we spoke to. Inappropriate behaviour by some Executive Directors and senior and middle managers went unchecked. Speaking out about concerns was not easy.

2.19 There also appears to have been a failure of external regulatory bodies and commissioners to provide at times appropriate scrutiny and challenge. For instance, with regards to the poor NHS Staff Survey results; for assessing the rigour of the Quality Impact Assessment processes in relation to Cost Improvement Programmes; or in relation to offender health services at HMP Liverpool or the Intermediate Care Bed Based Service.

2.20 Following inspection visits carried out in late November and early December 2013 by the Care Quality Commission, they published their report into the Trust in January 2014 which stated the presence in the Trust of “a culture they found unsupportive and oppressive.” The Trust was issued with two Warning Notices and the report precipitated the departure of the then Chief Executive, Director of Operations & Executive Nurse and Director of Human Resources & Organisational Development and the subsequent arrival of a new leadership team in spring 2014.
2.21 We set out the progress that has been made particularly since the arrival of a new leadership team with a clear focus around ensuring the Trust delivers safe and effective care. Critical to this has been the recruitment of more than 150 district nurses, health visitors and other frontline staff as part of a systematic and well thought through improvement programme. It is essential that change is sustained and built upon. The appointment of a new substantive Trust Chairman in May 2015 and new Non-Executive Directors in August and October 2015 is to be welcomed and will provide additional experience, fresh perspectives and insights.

2.22 We have been assured by the desire of the new leadership team to make a clean start and to learn from the past and feel that an important corner has been turned.

2.23 We were equally pleased to see the desire of the Trust today to be open and transparent, to learn the lessons from what happened in the past and to take the required action to put patient quality and safety at the heart of everything they do. We were also impressed by the realism of the new leadership team and their energy to drive forward change for the better and to deliver a clear and well thought through Improvement Plan.

2.24 However, for all the positive change that has happened, it remains work in progress and the pace of improvement in our view needs to be quickened and there remain some key areas that need to be addressed. The scale of the task the Trust faces therefore cannot be underestimated and it is important to understand the lessons of the past to ensure there is no return in the future.

2.25 Some staff rightly feel let down and many have been enormously damaged and their capacity to trust those in more senior management roles and the Board needs to be repaired. The Trust must continue to reach out to them and work to rebuild their confidence for the future.

2.26 We also continue to detect some worrying signs around Trust culture and it is an indication that the Trust must continue to do all it can to ensure that staff across all parts of the Trust, clinical and non-clinical, are valued and respected. They also need to be fully engaged and supported during a period of transition for the Trust.
2.27 We also welcome the development of a new locality structure which at its core enables decision making to be made closer to the patient and fundamentally values clinical leadership. At the time of this review, the Trust was restructuring the management functions to align with the new locality management structure.

2.28 The Trust needs to ensure that there is a clear and consistent understanding at locality and sub-locality level of the systems and structures for clinical and corporate governance, and in particular around how concerns, risks and incidents are routed into the leadership teams at locality level and then escalated upwards. During all too many of our interviews we observed a lack of a coherent and consistent understanding of escalation of risks and concerns within the Trust today.

2.29 Equally, there needs to be a clear feedback and learning loop from concerns, risks and incidents as that will help to create a climate of confidence in the systems and processes that are in place to ensure good clinical governance.

2.30 Risk management processes need a closer look and the clinical governance resource needs to be enhanced to address the scale of the agenda.

2.31 We have made a series of recommendations designed to draw a line on what happened in the past, as well as set out how the current governance arrangements in the Trust can be strengthened in order to ensure that high quality services are delivered by a workforce that is valued, respected and engaged.

2.32 Our review has sought to set out the facts as clearly as possible. We do believe that some individuals who worked for and in some cases still work for the Trust have a significant responsibility to shoulder. But for there to be any real understanding and in order that lessons can be learned it is vital to not focus on finding blame. When things go wrong it is mistaken and naïve to imagine that one person or a group was solely responsible. Rather the focus must be on the systems and structures in place which brought about what happened and how those systems and structures can be strengthened to prevent similar issues occurring again in the future.
2.33 That is not to deny of course that questions of accountability need to be addressed. But it is not our role to hold people to account. That is for others to do but what we have done is establish what went on as clearly as possible so that others can reach informed judgements.

2.34 We want to thank the Trust for commissioning this review in the first instance and for its support throughout. We would not have been able to complete our review in a timely manner without that support.

2.35 We also emphasise that we were impressed by the dedication of many of the staff we interviewed. Their commitment to the delivery of high quality, safe and effective patient care and indeed their resilience is something that the Trust can be proud of and bodes well for the long term future of the Trust and for the communities served by the Trust.

2.36 Finally, we wish to thank all those that we interviewed for their openness in answering our questions and providing supplementary information, which has been helpful to us during the course of our review. Without those inputs it would have been difficult to conclude this review.
3 Background to Liverpool Community Health NHS Trust

3.1 Liverpool Community Health (referred to hereafter a “the Trust”) became an NHS Trust on 1 November 2010 and on the 1 of April 2011 the Trust acquired community services for the majority of Sefton.

3.2 Liverpool Community Health NHS Trust delivers community health services to people in their own homes and in over seventy locations including health centres and clinics, five Walk-in Centres, Intermediate Care Bed Based Service and GP practices across Liverpool and Sefton.

3.3 The Trust also delivers specialist Dental Health Care, Therapies, Medicines Management and Nutrition and Dietetic Services.

3.4 Until the beginning of 2015, the Trust also provided health care services to Her Majesty’s Prison (HMP) Liverpool.

3.5 Liverpool Community Health NHS Trust serves the communities of Liverpool and Sefton, reaching a population of approximately 750,000 people, many of whom are living in some of the most deprived areas of the country.

3.6 The Trust employs over 3,000 staff of which 80% are practicing health professionals including Nurses, Community Matrons, Health Visitors, GPs, Dentists, Dieticians, Podiatrists, Physiotherapists, Occupational Therapists and Speech and Language Therapists.

3.7 Of the Board members that led the Trust from broadly its inception until the early part of 2014, the only two Executive Directors that remained in post at the time we were commissioned to undertake our review in April 2015 were the Medical Director, the Director of Finance (though he has recently left the employment of the Trust) and in terms of the Non-Executive Directors, this was the case for the Chair (she has now left the Trust as her term of office had expired), two Non-Executive Directors and one Associate Non-Executive Director (they have since left the Trust).
4  Terms of Reference

4.1 The Trust appointed the Governance Consultancy Service at Capsticks Solicitors LLP in April 2015 to undertake an assurance review into the framework, management, systems and processes for quality and clinical governance within the Trust and the services it provides.

4.2 The review was split into two parts:

Part One of the review was a “look back exercise” into the governance issues within the Trust from January 2013 onwards and:

- Explored the relevant arrangements for clinical governance, including compliance and whether any concerns could have been identified earlier;

- Considered incidents from this period and the reviews into them to determine whether any further investigation or action was necessary;

- Considered whether the processes and procedures for individuals leaving the Trust needed strengthening;

- It became quite evident early on that the issues we were looking at in Part One of the review commenced from around the time the Trust was itself established in late 2010 and that the review team needed to take that broader perspective. The review team therefore very much focused this part of the review from that time period onwards and until the departure of a number of the Executive Directors in early 2014, following the publication of the Care Quality Commission report into the Trust in January 2014. This change to the terms of reference was accepted by the Trust and was also communicated to everyone who was interviewed at the start of their interview and furthermore reflected in the questions that were asked of them.
Part Two of the review focused on the governance issues within the Trust today and:

- Explored whether any findings from Part One also apply to the Trust today;

- Reviewed the clinical governance arrangements within the Trust today to ensure that they are robust in the light of the Quality Governance Framework published by Monitor (Quality Governance: How Does a Board Know that its Organisation is Working Effectively to Improve Patient Care?, Monitor, April 2013), as well as any key issues from the Berwick (A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, National Advisory Group of Patients in England, August 2013), Francis (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, HC 947, 6 February 2013) and Keogh Report (Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, Professor Sir Bruce Keogh, 19 July 2013);

- Considered the clinical governance pathway from the frontline to the Board, including whether there are systems in place to ensure that the Trust Board has timely sight of key risks issues;

- Reviewed and assured the Trust Board that processes are in place to support the Duty of Candour and that the Trust Whistleblowing Policy is robust and consistent with national guidance, including the recently published review by Sir Robert Francis QC (Freedom to Speak Up: An Independent Review into Creating an Open and Honest Reporting Culture in the NHS, Sir Robert Francis QC, February 2015).
Methodology

The review commenced in May 2015 and was led by Moosa Patel, who heads up the Governance Consultancy Service at Capsticks Solicitors LLP, supported by Janice Smith, Governance Consultant at Capsticks Solicitors LLP and Tracey Burke, Business Manager at Capsticks Solicitors LLP.

Throughout the review he was able to draw upon the extensive experience of Karen Charman who has been working with and for the NHS since 2001. Karen has recently completed a role as Interim Director of People and Organisational Development at Imperial College Healthcare NHS Trust in London and previous to that was Director of Engagement at NHS Employers. The review team also benefited hugely from the input of Paul Martin, who until recently was Director of Clinical Governance at University Hospitals Coventry and Warwickshire NHS Trust and who has considerable knowledge of clinical governance arrangements and their contribution to safe and high quality health care. Finally the review team benefited from the clinical experience and insights of Dr Tom Goodfellow who retired at the end of November 2014 after 40 years working in the NHS.

The review team were able to call upon Peter Edwards, Senior Partner at Capsticks Solicitors LLP for legal advice during the course of the review. The review also received advice from Gerard Hanratty, Partner in the Public Law advice team at Capsticks Solicitors LLP and Charlotte Harpin, who is Senior Lawyer also in the Public Law advice team at Capsticks Solicitors LLP.

Our methodology included two key elements.

Firstly a review of key background documentation supplied to us by the Trust and secondly interviews with key Trust staff, past and present.
5.6 The documentation initially supplied to us by the Trust included papers from Board and committee meetings, outcomes of previous reviews, policies and procedures, structure charts, job descriptions and director portfolios, and details of clinical governance arrangements in the Trust largely from 2013 onwards.

5.7 During the course of the review, we also requested a range of additional documentation from the Trust dating back to 2011 as well as documentation that was mentioned to us during the course of our interviews. We were also given a range of background documentation by many of the Trust staff we interviewed. In total, we reviewed nearly 900 documents. A full list of all the documentation we reviewed is provided at Appendix 1.

5.8 There may of course be some documentation we have not seen. That is not because the Trust has sought to keep that documentation from us but because it simply reflects the scale of the task, given the period we were looking at and because changes in the senior management team at the Trust meant that the new leadership team have not always found it easy to locate documentation.

5.9 Given the number of key events since that period and in order to understand better the sequencing of them, we have produced a brief timeline at Appendix 2.
5.10 The list of people the review team identified to be interviewed as part of our review was initially based on our reading of key documents provided by the Trust. This initial list of people invited for interview was subsequently expanded following a further review of additional material and also because in a small number of cases, during some of our interviews, additional suggestions of people we should interview were made known to the review team. Consequently, the review team interviewed 43 people in total. In a small number of cases, we interviewed people twice to raise with them further supplementary questions or seek their clarification on specific matters. Most interviews were conducted face to face but, for logistical reasons, three were conducted over the phone. Many interviews included recollections of difficult and stressful situations that occurred some years ago and we are enormously grateful to all those who assisted us in this way and recounted those events. We do not believe our report would have been possible to write without the input of all the people who we interviewed.

5.11 Each interview was based on a range of questions, most of which were consistent across all the interviews we conducted, though some were specific to the individual concerned.

5.12 The face to face interviews were conducted by a combination of Moosa Patel, Janice Smith, Karen Charman, Paul Martin and Dr Tom Goodfellow. A number of the interviews were conducted by one member of the review team due to diary issues.

5.13 All the interviews were recorded, in order to provide an accurate record of each interview. Written transcripts from each interview were provided to the individual concerned, as an opportunity to check for factual accuracy, make any additional points they felt would be helpful to our review and also to check that anything they said to us was clearly articulated, and if not, to provide an opportunity to make any final amendments. Some interviewees also took the trouble at this stage to provide us with further documentary evidence, including emails, reports, internal documents and letters which the review team found most helpful.
The review team are acutely mindful of the fact that a number of former employees of the Trust – Executive Directors, Non-Executive Directors and senior managers, both clinical and non-clinical, declined to take part in the review. We had no power to compel them to take part.

That they did not seek to participate in our review is regrettable. We are certain that their contributions would have helped the review team enormously and enabled us to triangulate what we heard from those we did speak to as part of this review and from the documentation we have considered.

However we appreciate that for some they will not wish to revisit issues they were party or privy to some while back and want to simply move on; while for others, alternative factors may have impacted on that decision. For those who did not accept our request to be interviewed there are other processes that they may be involved in and understandably, therefore, they did not wish to take part in this review. We did not draw any adverse inferences from them declining to be interviewed.

During the course of our review we have had to make best judgements in drawing out conclusions and making recommendations. Often we were reliant on the memories of individuals we spoke to when asking them to recall events that happened some years ago.

Where we have heard differing views, and regrettably were not able to draw any firm conclusions, we have clearly said so.

We have split our review report into two distinct parts. Part One focuses largely on the issues that related to the Trust from its inception until the early part of 2014, when there was the publication of the Care Quality Commission report and the departure of a number of the Executive Directors of the Trust. Part Two focuses on the progress the new leadership team has made in creating a new Trust wide culture and moving the Trust forward.
On the whole within the report, where we have used quotes from interviews we have conducted they have been to illustrate a point and where we have done that, we have largely protected the anonymity of the person who provided that quote.

Finally, when we refer to the Board, we are commenting on the whole Board, though on occasions in the report we specifically refer to the actions of the Executive Directors or the Non-Executive Directors.

Prior to the Report being finalised, a verification process was carried out. This included providing those individuals who were the subject of criticism in the draft Report with an opportunity to view and comment on those criticisms. This is known as the ‘Salmon’ process.

The purpose of providing this opportunity is to ensure procedural fairness to those participating in reviews and, relatedly, ensuring that the outcome of such reviews (i.e. reports or other formal documents) is accurate. It is important to see the Salmon process as the culmination of the review process.

We are very grateful to all those who participated in the review process generally and to those who provided comments and further information as part of the Salmon process. Where comments provided indicated factual inaccuracies or points that required clarification, these have been made. In terms of the other comments provided, the review team carefully considered those and, where they indicated an alternative view to that expressed in the draft report, this has been noted in the final report.
6 Key Review Themes: Part One

6.1 It became quite evident early on that the issues we were looking at in Part One of the review commenced from around the time the Trust was itself established in late 2010 and that the review team needed to take that broader perspective. The review team therefore very much focused this part of the review from that time period onwards and until the departure of a number of the Executive Directors in early 2014, following the publication of the Care Quality Commission report into the Trust in January 2014. This change to the terms of reference was accepted by the Trust and it was also communicated to everyone who was interviewed at the start of their interview and furthermore reflected in the questions that were asked of them.

6.2 The composition of the Board from late 2010 to early 2014 is set out in Appendix 3.

7 The Trust Board

7.1 An effective Board needs a number of ingredients in order to work effectively. This includes an experienced group of Executive Directors alongside a Non-Executive Director cohort which is able to provide effective challenge, scrutiny and support. In this section we set out our view that challenge and scrutiny was largely absent across a number of critical agendas during the period from its inception in late 2010 to the period up to and including the departure of several Executive Directors of the Trust in early 2014. This lack of challenge was evident across a number of key areas; perhaps most critically in relation to ensuring Cost Improvement Programmes were accompanied by a robust Quality Impact Assessment process, and around ensuring that the findings from NHS Staff Survey results led to further analysis, action and change.

7.2 The purpose of NHS boards is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands.
7.3 Good governance guidance (*The Healthy NHS Board 2013: Principles for Good Governance*, NHS Leadership Academy, 2013) states that effective NHS boards demonstrate leadership by undertaking three key roles:

| Formulating strategy for the organisation | Ensuring accountability by holding the organisation to account for the delivery of the strategy, by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable | Shaping a healthy culture for the board and the organisation |

7.4 Underpinning these three roles are three building blocks that allow boards to exercise their role properly. Effective boards according to *The Healthy NHS Board 2013: Principles for Good Governance* (NHS Leadership Academy, 2013):

| Are informed by the external context within which they must operate | Are informed by, and shape the intelligence which provides an understanding of local people’s needs, trends and comparative information on how the organisation is performing together with market and stakeholder analyses | Give priority to engagement with stakeholders and opinion formers within and beyond the organisation; the emphasis here is on building a healthy dialogue with, and being accountable to, patients, the public, staff, governors, commissioners and regulators |
7.5 The three roles of the board and the three building blocks all interconnect and influence one another.

7.6 The Board of the Trust was no different to that of others in the NHS. It comprised Executive Directors and Non-Executive Directors, including the Chairman, with the latter being greater in number in order to maintain a balance on the Board.

7.7 The role of the Non-Executive Directors was to bring a range of varied perspectives and experiences to strategy development and decision-making; ensure effective management arrangements and an effective management team was in place; and whilst operational responsibility was delegated to the Executive Directors, the Non-Executive Directors had the role of holding the Executive Directors to account for performance of the Trust.

7.8 The role of Executive Directors was to share collective responsibility with the Non-Executive Directors as part of a unified Board and to shape and deliver the strategy and operational performance in line with the Trust’s strategic aims.

7.9 The Chair role was to lead the Board of Directors; making sure it effectively governed the Trust, whilst the Chief Executive’s role was to lead the Executive Directors in delivering the strategy and managing operational delivery.

7.10 Further detail around the distinct roles for different members of the Board are set out in the table below, which also shows how they are aligned to the role of the Board. This is taken from *The Healthy NHS Board 2013: Principles for Good Governance* (NHS Leadership Academy, 2013).
<table>
<thead>
<tr>
<th>Chair</th>
<th>Chief Executive</th>
<th>Non-Executive Director</th>
<th>Executive Director</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formulate Strategy</strong></td>
<td>Ensures board develops vision, strategies and clear objectives to deliver organisational purpose</td>
<td>Leads strategy development process</td>
<td>Brings independence, external perspectives, skills, and challenge to strategy development</td>
</tr>
<tr>
<td><strong>Ensure accountability</strong></td>
<td>Makes sure the board understands its own accountability for governing the organisation</td>
<td>Leads the organisation in the delivery of the strategy</td>
<td>Holds the executive to account for the delivery of strategy</td>
</tr>
<tr>
<td></td>
<td>Ensures board committees that support accountability are properly constituted</td>
<td>Establishes effective performance management arrangements and controls</td>
<td>Offers purposeful, constructive scrutiny and challenge</td>
</tr>
<tr>
<td></td>
<td>Holds the Chair accountable for delivery of strategy</td>
<td>Acts as Accountable Officer</td>
<td>Chairs or participates as member of key committees that support accountability</td>
</tr>
<tr>
<td></td>
<td>Leads the board in being accountable to governors and leads the council in holding the board to account</td>
<td></td>
<td>Account individually and collectively to Governors for the effectiveness of the board</td>
</tr>
<tr>
<td><strong>Shape culture</strong></td>
<td>Provides visible leadership in developing a healthy culture for the organisation, and ensures that this is reflected and modelled in their own and in the board’s behaviour and decision making</td>
<td>Provides visible leadership in developing a healthy culture for the organisation and reflects this in their own behaviour</td>
<td>Actively supports and promotes a healthy culture for the organisation and reflects this in their own behaviour</td>
</tr>
<tr>
<td></td>
<td>Board culture: Leads and supports a constructive dynamic within the board, enabling grounded debate with contributions from all directors</td>
<td>Ensures all board members are well briefed on external context</td>
<td>Ensures all board members are well briefed on external context</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>Ensures all board members are well briefed on external context</td>
<td>Mentors less experienced Non-Executive Directors where relevant</td>
<td></td>
</tr>
<tr>
<td><strong>Intelligence</strong></td>
<td>Ensures requirements for accurate, timely and clear information to board/directors (and governors for FTs) are clear to executive</td>
<td>Ensures provision of accurate, timely and clear information to board/directors (and governors for FTs)</td>
<td>Satisfies themselves of the integrity of financial and quality intelligence including getting out and about, observing and talking to patients and staff</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
<td>Plays key role as an ambassador and in building strong partnerships with: Patients and public Members and governors (FT) All staff Key partners Regulators</td>
<td>Plays key leadership role in effective communication and building strong partnerships with: Patients and public Members and governors (FT) All staff Key partners Regulators</td>
<td>Ensures board acts in best interests of patients and the public</td>
</tr>
<tr>
<td></td>
<td>Senior independent director is available to members and governors if there are unresolved concerns (FTs) Shows commitment to supporting the work of the Council of Governors (FTs)</td>
<td></td>
<td>Shows commitment to supporting the work of the Council of Governors (FTs)</td>
</tr>
</tbody>
</table>
7.11 Whilst the Executive Directors were full time, the Non-Executive Directors were expected to fulfil their role within a notional 2.5 days a month. This is a point that a number of the Non-Executive Directors have made to us as part of the Salmon process and in particular that they were limited in what they could achieve within that time frame. We have a degree of sympathy with this perspective but a crucial point within the context of this review is that Executive and Non-Executive Directors have the same legal duties, despite a distinction in their respective levels of time commitment and depth of knowledge about the business concerned.

7.12 Furthermore, Directors of the Trust, whether Executive or Non-Executive were not short of guidance as to what the post entailed. The Department of Health as far back as 2003 published *Governing the NHS: A Guide for NHS Board*. This set out the roles of the Chair, Chief Executive and Directors. This guidance was further updated with the publication of *The Healthy NHS Board: Principles for Good Governance* (NHS National Leadership Council, 2010) and this was then further revised in 2013 with the publication of *The Healthy NHS Board 2013: Principles for Good Governance* (NHS Leadership Academy, 2013) to reflect the Francis Inquiry findings at Mid Staffordshire NHS Foundation Trust.

7.13 *Governing the NHS* provided a useful reminder of the respective duties of executive and non-executive directors and of the collective role of the Board. It is pertinent to pick up a few points from it. Directors were left in no doubt about the importance of the Board leading and taking responsibility for clinical governance, and engaging with the public:

“*Within the NHS following the Bristol Inquiry, the Alder Hey Inquiry and others, serious questions were being asked about the quality of clinical care. It was realised that responsibility for quality extended beyond the clinicians concerned and was in reality a multi-faceted responsibility that could only be shouldered in its entirety by the Board. This quality management responsibility was encapsulated for the NHS in a system of Clinical Governance. The message that runs through the entire guide is that, whatever the type of Board, the interests of patients are best served by a strong system of governance. Through good governance, the Board can enhance the care and wellbeing of patients and those staff who look after them.*”
7.14 Governing the NHS went onto say:

“Conversely, in an organisation which is not properly governed and which is out of control, staff time is wasted in fire-fighting with inadequate plans and resources, with the effect that the care given to patients and their families inevitably suffers. It is the duty of the Board to ensure through Clinical Governance that the quality and safety of patient care is not pushed from the agenda by immediate operational issues. The need for public accountability puts a special obligation on NHS Boards to conduct themselves and their business in an open and transparent way that commands public confidence. For that reason, Board meetings are open to the public and should operate in a way that makes their business understandable to the public...it follows from this commitment to open debate that the use of the confidential part of the Board meeting should be restricted to those areas generally concerning named individuals or commercially sensitive information, where there is an overriding need for confidentiality.”

7.15 Monitor also published The NHS Foundation Trust Code of Governance in 2006. This covers many of the same areas but emphasised in particular the Board's responsibilities:

“Directors are ultimately and collectively responsible for all aspects of the performance of the foundation trust [and therefore] need to be able to provide more focused strategic leadership and more effective scrutiny of the trust’s operations.”
It is also clear that along with this responsibility came collective accountability for NHS Boards which is clearly described in *The NHS Foundation Trust Code of Governance* (Monitor, 2006) and applies to NHS Trusts as much as NHS Foundation Trusts:

“All directors have joint responsibility for every decision of the board of directors regardless of their individual skills and status... [They] have responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. As part of their role as members of a unitary board, non-executive directors have a particular duty to ensure such challenge is made. Non-executive directors should scrutinise the performance of the management in meeting agreed goals and objectives and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management are robust and defensible...where directors have concerns, which cannot be resolved, about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.”

We observed that the Executive Directors of the Trust, while they were previously senior directors in their own right in the NHS or outside of it, for all of them this was their first substantive director role at this level. For some, like the Director of Finance and the Director of Human Resources & Organisational Development this was their first exposure to an NHS environment, having come into the Trust from a commercial background; while for the Chief Executive this was her first such role. The Director of Operations & Executive Nurse had worked at director level in a primary care trust provider arm but not across the combined portfolio of nursing and operations. The background of the Medical Director was in a deputy capacity in acute health care services and not community services.

During the course of our review we observed a number of significant issues or areas where there was a degree of inexperience in the approach taken such as the way Cost Improvement Programmes were managed, how Quality Impact Assessments were approached and how serious clinical incidents were investigated.
7.19 We also felt that the lack of substantive director level experience came through very strongly in the decisions the Executive Directors made in some of these areas. Indeed we feel many of the Executive Directors within the Trust from when it was established struggled to fulfil the breadth of their portfolio and several were regrettably out of their depth.

7.20 This combined with a sizeable agenda for a new organisation, and during a time of major transformational change at a national level, would inevitably have created a challenging environment for the Executive Directors.

7.21 The Executive Directors in our view created for itself additional challenges through the way it was structured. In particular we think that the combined role of Director of Operations & Executive Nurse was a mistake.

7.22 The Chief Executive noted that experienced deputy directors were in place to support the Director of Operations & Executive Nurse and made the following point: “when we appointed Helen [Helen Lockett, Director of Operations & Executive Nurse]...the advice from the Strategic Health Authority...at the time was to bring it together, you want a small team, you don’t want lots of people on your team. Now on reflection that might not have been the right advice to have been given us but at the time we believed it was so that was the approach that we took and Helen actually took the job because it was a joint portfolio...So that was one of the things that drew her to the job. And interestingly enough from a Board perspective when she came in what she brought was that clinical side, so she very early on was talking about.” She went onto say that “I think where there was a sense of that this is a bigger challenge was when the Care Quality Commission came in actually and cause I was saying to Helen, right I want you to lead the improvements following the Care Quality Commission visit in November 2013 and it was really at that point when she said “I think this job is becoming bigger and the capacity, I don’t feel I personally have all of the capacity to lead the Care Quality Commission improvements alongside the challenge around operations.””
7.23 As part of the Salmon process, the Director of Operations & Executive Nurse stated “those who appointed her were confident that she would be the best person for the joint role” She also added that after sometimes working 14 hour days and most weekends she “did have a conversation with the Chief Executive about the role, the fact that it was too much for one person and should be split.”

7.24 However on balance and given everything we have heard, we are of the view that this was an unmanageable post within the Trust from the outset. This was indeed a point made in the report entitled “Liverpool Community Health NHS Trust Independent report on the governance of quality” (Deloitte LLP, 11 September 2012 and re-issued 5 November 2012) which stated that “the Director of Nursing and Operations portfolio is very large (and at risk of increasing, therefore carrying considerable succession and contingency risks).”

7.25 In our view it also created an unhealthy set of conflicts within the role between the “Chief Operating Officer” elements and those which pertained to being a “Director of Nursing.” As one member of staff stated “It’s just a huge conflict of interest - you’re not challenging. The director of operations should be getting challenged by the director of nursing, to make sure quality is still maintained...you can’t have it in the same post, because policy will always be compromised, because it will just be from an operations point of view.”

7.26 This conflict particularly was the case around such areas as safe staffing levels and whether operational considerations took precedence over nursing and professional considerations. This applied particularly when it came to delivery of Cost Improvement Programmes. Indeed we do not believe that these two roles can be combined in this way without a significant loss of professional nursing objectivity. It is our view that the Chief Executive as the Accountable Officer, but also the Board, should have been alert to these matters and taken action to address it.
In making these comments, we appreciate that it was ‘fashionable’ for the ‘Director of Nursing’ and ‘Chief Operating Officer’ roles to be combined under a single post holder in other NHS trusts at that time. In fact it is still a practice that prevails today in some parts of the NHS. However many Trusts have recognised the difficulties of delivering the differing elements of this role and have reverted to stand alone posts.

It was also the case that clinical governance (as part of the Integrated Governance portfolio) sat under the Director of Finance for a substantial part of the early period after the Trust was established in late 2010. Indeed, as far as we can ascertain, he led this portfolio until the very early part of 2012 and reported to the private part of the Board on Serious Untoward Incidents. This only changed from March 2012 when responsibility passed to the Director of Operations & Executive Nurses. The Director of Finance did receive in this period support from others to enable him to undertake these duties.

This is most unusual given that the Director of Finance had no prior clinical experience, though we heard from some interviews that this lack of prior knowledge was advantageous. In fact one senior member of staff we spoke to stated to us “it put him in a very strong position to be able to challenge the approaches that were being taken.” The Director of Finance already had a sizeable responsibility which extended beyond the traditional remit to include director level accountability for corporate governance in the Trust.

The construction of this portfolio was also negatively commented upon in the report entitled “Liverpool Community Health NHS Trust Independent report on the governance of quality” (Deloitte LLP, 11 September 2012 and re-issued 5 November 2012) which stated that “the Finance Director has an inherited portfolio which includes key areas of quality governance which are heavily delegated (lessening opportunities for challenge at Board).”
For his part, Director of Finance stated to us as part of the Salmon process that “I was asked to lead integrated governance pending the permanent appointment to the Director of Nursing post or retirement and replacement of the Medical Director. The Acting Director of Nursing had been told she would not get the role on a permanent basis, and the Medical Director was part time and I was told did not have the capacity to lead integrated governance. The significant time in recruiting to the Director of Nursing post was not anticipated at the time. I tried to utilise the clinical and governance expertise in the Executive and Senior Team in the development and functioning of the integrated governance until I handed responsibility to the new Director of Nursing/Director of Operations and new Medical Director.”

In our view, the Board should have recognised that this arrangement was not consistent with good governance practice or with practice that prevailed in other parts of the NHS. It also meant in our view that some of the concerns around clinical governance arrangements in this period were not gripped in a way that they should have been and we cover that in more detail in Section 17.

During the course of our interviews it also became clear to us that the Executive Team operated less as a team and more in silos. It is inevitable in organisations that to some degree individual directors may get on better with some of their fellow directors than others. However it is clear from our interviews that at the Trust it went beyond that. One senior member of staff we spoke to stated “Once something was put into a silo it was like a wall had been put around it and a bit of a secretive thing so if something happened I might have been aware of and if I asked a question “oh it’s nothing to do with you” that’s what I felt like. If it was a quality issue Helen was looking at that and you didn’t really need to be involved in it.” They went onto say “Well I think the HR Director and the Director of Nursing worked very closely...and it wasn’t really widely shared outside of that group so for quite a lot of the issues I wasn’t sighted on what was happening. It was reinforced by the Chief Executive that it was being managed by specific Executives, and we don’t need to share those issues; so they weren’t.”
7.34 The Chief Executive however as part of the Salmon process responded “My approach was to consistently deal with things across the team; however, there would be specific issues which are the responsibility of key Directors. This is normal practice. At no point would I ever have explicitly indicated that we did not need to ‘share’ issues.”

7.35 We were told that this created tensions in the relationship between the Medical Director and the Director of Operations & Executive Nurse. Indeed in one interview we were told that the Medical Director “had a difficult role in terms of trying to shape and manage the framework [for clinical governance] but with no, well less (sic), direct influence on how it operated.” Whilst in another interview we were told “...there were reasonable relationships but the way the demarcation was reinforced created that barrier of, you know, “this is you, this is you’” (sic). However, as part of the comments we have received via the ‘Salmon process’, it was stated by the Director of Operations & Executive Nurse that this was not the case and that she had a “good working relationship” with the Medical Director.

7.36 The issues we have highlighted above around the lack of experience of the Executive Directors at this level could have been mitigated if the Trust had in place a strong Non-Executive Director cohort capable of providing sufficient scrutiny and challenge, but doing so in a way that was supportive and constructive.
The Non-Executive Directors came from a wealth of different backgrounds and brought to the Board a range of complementary experiences, which enabled the Trust to make progress in some key areas, of which arguably one of the most significant was to successfully establish a stand-alone community provider. In our interviews with Board members there was plenty of reference to challenge and scrutiny being applied by the Board and that this was observed as part of the scrutiny applied to the Trust by first the North West Strategic Health Authority and then the NHS Trust Development Authority and by externally commissioned assessments of the Trust. Indeed one member of the Board that we interviewed stated to the review team: “As you will know, from speaking to us...we are not shrinking violets. I think everybody’s impression, well these are Non-Execs who don’t challenge, and we were always challenging.” Other Non-Executive Directors we interviewed also stated that they provided extensive challenge and constructive criticism at Board and Committee meetings.

Up to a point, this is indeed correct. Observations of the Board and its Committees by external bodies which we mention in Section 8 do acknowledge that they “saw good examples of Non-Executive Directors challenging Executive Directors in a constructive way but believe there is a need for more of this, especially in areas that they are less comfortable with (i.e. outside their own direct experience).” This was a point made in the report entitled “Liverpool Community Health NHS Trust Preliminary Review and Financial Reporting Procedures Report, Final Draft” (PricewaterhouseCoopers LLP, 22 June 2012). Whilst the report entitled “Liverpool Community Health NHS Trust Independent report on the governance of quality” (Deloitte LLP, 11 September 2012 and re-issued 5 November 2012) stated “there was an inconsistent level of challenge from Non-Executive Directors on quality (some contributed significantly more than others).”

However, the review team have concluded that this lack of scrutiny from the Non-Executive Directors on the Board appears to have been particularly the case when it came to scrutinising subjects such as the impact of Cost Improvement Programmes on quality, safety and staff morale, analysing and challenging on the content of NHS Staff Survey results, or in terms of failing to understand the totality of the Trust operations for example in relation to services provided at HMP Liverpool by the Trust or to understand risks within the Intermediate Care Bed Based Service.
Regrettably, we saw very little evidence of that challenge or scrutiny in the minutes of the Integrated Governance and Quality Committee (IGQC), the Human Resources & Organisational Development Committee or in the Finance & Commercial Committee that we looked at from 2011 onwards on the above areas but more generally too.

Also our detailed review of the public minutes of Board meetings from 2011 until April 2014 do not show that Non-Executive Directors on the Board collectively and individually held the Executive Directors to account. Indeed our extensive review of these minutes shows little evidence of scrutiny and challenge. Our review of private Board minutes for this period shows more evidence of challenge and scrutiny and this was largely from the Chair and one of the Non-Executive Directors [Wally Brown]. Whilst our review of Audit Committee minutes from the inception of the Trust until early 2014 shows far more evidence of challenge and scrutiny than in the other Board Committees we looked at and indeed was to the level we would have expected.

We accept that minutes provide a summary of the key areas of discussion and cannot be expected to cover every single comment or contribution but as they are the evidential record of proceedings, we would expect them to set out clearly the key areas where there has been challenge and scrutiny. The Institute of Chartered Secretaries and Administrators in its comprehensive Guidance Document on Minutes published in 2015 states “The purpose of minutes is to provide an accurate, impartial record of the business transacted at a meeting. Properly constructed minutes provide a record of corporate decisions, reflect director dissent where appropriate and offer guidance for future board action. They should be clear, concise, impartial and free from any ambiguity and they also serve as source of contemporaneous evidence in judicial or regulatory proceedings.”

Shortly after the publication of the Care Quality Commission report which we refer to in Section 2.20 and 5.19, the NHS Trust Development Authority commissioned Sir Ian Carruthers (formerly the Chief Executive of the South Strategic Health Authority Cluster which until March 2013 provided oversight of the NHS across the South West, South Central and South East Coast) to undertake a governance review.
This was commissioned “in the light of the significant challenges facing the organisation on its journey to be a sustainable organisation delivering high quality services for patients.” The terms of reference of the Governance review were to:

- Assess the Board governance and senior leadership capability and capacity of the organisation to respond to the findings of the Care Quality Commission;
- Identify action that should be taken by the Trust to strengthen its Board governance, leadership capability and capacity;
- Identify action that should be taken by the NHS Trust Development Authority, including identifying areas of support to ensure strong Board governance and leadership capability in the Trust.

The review report was completed in April 2014 and received from the NHS Trust Development Authority by the Trust in December 2014. By this stage the new leadership team was in place but as the focus of this review had been on the period before the appointment of the new leadership team, we feel our observations are reinforced by the following comment in the report which noted the need for “development of the Board and organisational style to support...constructive challenge.” The accompanying letter to the review report from the then Chief Executive of the NHS Trust Development Authority further added “It will be important that Non-Executive Directors develop their ability to challenge and hold to account the executive team.”

In making the above points, we are acutely mindful they are strongly challenged by the Non-Executive Directors. Those who responded through the Salmon process all said that they did provide constructive challenge and appropriate scrutiny. Indeed one stated to us as part of the Salmon process “I, along with my colleagues, were proactive in giving detailed oversight to the issues within the Trust, subjecting them to proper scrutiny and, where appropriate, challenging on behalf of staff and patients.”
7.47 Regrettably, we have largely concluded otherwise. Even if the minutes do not record all the challenge that was made, it is clear that a number of key issues were not identified and followed up appropriately as they would have been, had sufficient scrutiny taken place. In addition, all Board members would have been privy to Board and Committee meeting minutes at the time in draft form and would have all had an equal opportunity to challenge their accuracy but do not appear to have done so. Based on evidential information that we have reviewed: the combination of an inexperienced set of Executive Directors at this level; a readiness to accept the findings of external reviews without triangulating against other sources of evidence available; alongside a Non-Executive Director cohort which accepted reassurance on a number of key issues as opposed to proactively seeking assurance; all combined to create the climate for future failings to occur, and allowed important warning signs to be missed.

8 The Drive to Achieve NHS Foundation Trust Status

8.1 In this section we have sought to focus on the push within the Trust to achieve NHS foundation trust status and how this impacted on the way the Trust operated and the priorities it pursued.

8.2 We heard from a number of interviews that the Senior Management Team had a clear focus to achieve NHS foundation trust status and that they were encouraged in achieving this objective by first the North West Strategic Health Authority, and then subsequently by the NHS Trust Development Authority. This was not unusual and similar encouragement was given to other suitable NHS Trusts, not just in the North West but nationally.

8.3 We were told by the Chair and Non-Executive Directors that there was considerable external pressure placed on the Trust to achieve NHS foundation trust status, which explains the focus of the Board at the time. We put this comment to the NHS Trust Development Authority as part of the Salmon process who stated that no undue pressure was placed on the Trust by them or by the former North West Strategic Health Authority, as far as they were aware. As we do not know what actually happened, we have reflected both points in our report.
8.4 We have also heard from the Chief Executive that her approach was “we need to focus on being a sustainable organisation, the organisational form comes secondary.” Our review however has drawn a different conclusion.

8.5 Achieving NHS foundation trust status in our view became the dominant strategic theme for the Board. Board Time Out session notes even prior to the establishment of the Trust in November 2010 show that this was indeed a significant area of discussion at these meetings, at the expense of discussion of any other organisational form or model. One senior member of staff stated to the review team “There was certainly a drive to get past the post as quickly as possible.”

8.6 Our review of public Board papers show that from March 2011, an update on the NHS foundation trust programme was more or less the first substantive strategic agenda item at almost every meeting of the Board until February 2014. The Chief Executive as part of the Salmon process stated to us that this report was produced on the advice of the North West Strategic Health Authority. The public Board meeting held on the 17 May 2011, received a paper entitled “Organisational Development and Strategy Report” which determined that “given the importance of the Foundation Trust Programme the Board had agreed to act as the Programme Board, with the Chief Executive Officer as Programme Sponsor and the Executive Team taking on the role of programme executive.” At the same meeting, the Board approved the Project Plan to achieve NHS foundation trust status by April 2013.

8.7 The issue of achieving NHS foundation trust status was also classed at this stage as a top five risk to the Trust with the Risk Register stating “failure to achieve CFT [community foundation trust] status will lead to potential dispersal and/or vertical integration of community services to the detriment of patients and the health economy as a whole.”
The focus of the Board and therefore of the most senior people in the organisation became that of achieving NHS foundation trust status. It is hard to say whether that was at the expense of addressing other issues within the organisation, notably the quality and safe delivery of services or staff welfare, but given the pre-occupation of the Board on this subject it must have had an impact in terms of the significant time, energy and focus it attracted. Our reading of Board papers from the inception of the Trust is that achieving NHS foundation trust status was the sole strategic focus of the Trust. The point can be extended to Board Time Out sessions. As one Board member stated “If I was brutally honest it was coaching, giving guidance to the FT process, that’s what the focus of Board development was.”

We heard from several quarters that the desire to achieve NHS foundation trust status was the primary focus of the Executive Directors and accompanying that drive was an equally strong focus on reducing the cost base within the Trust in order to secure a healthier financial position and greater cash liquidity. The aim was that NHS foundation trusts status would as a result be more achievable and we will cover that in greater detail in Section 9.

On balance, given everything we have heard during the course of our interviews in particular, we are also of the view that the manner in which negative news was managed within the Trust was motivated by a desire to not jeopardise in any way the NHS foundation trust application process.
8.11  The Trust Chair was, for a period of a few months, on compassionate leave and was not present at Board meetings between September 2012 and January 2013 and then was on a phased return to work over the following six months. This was a difficult time for the Trust as this period included a board to board with the North West Strategic Health Authority in November 2012. The Trust Chair stated to us that after returning from compassionate leave she had become concerned about the pace within the Trust towards achieving NHS foundation trust status and that this was too fast, and that she voiced these concerns directly with the Chief Executive and that they were raised at Board Time Out sessions. Concerns around the pace to achieve NHS foundation trust status was also mentioned by one of the Non-Executive Directors we interviewed. However it was not something the Chief Executive recalled being raised and there is no record of this kind of questioning or challenge having occurred from the notes of Board Time Out sessions or minutes of the public or private Board meetings that we have reviewed. Even if it was raised, we cannot detect any change to the pace and momentum from March 2011 onwards, and furthermore that the full Board was supportive of this direction of travel.

8.12  Several Board members stated to us that the Trust was the subject of external assessments by first the North West Strategic Health Authority, then the NHS Trust Development Authority and a range of management consultancies as part of its readiness for NHS foundation trust status and that these reports had been favourable in terms of their feedback on the strength of the Trust governance arrangements and engagement with staff. Nothing we were told had come through those external assessments that raised concerns. Indeed as one Board member told us “they thought there was challenge ’cause they would’ve told us if they didn’t think there was challenge. So do we ignore what they said?”

8.13  We reviewed the following internal reports which were undertaken between June 2012 and November 2013 by a range of consultancy organisations on behalf of the Trust:

8.14 Collectively these reports were undertaken within a relatively short timeframe spanning 18 months. Indeed five were undertaken within a six month period by four different consultancy organisations. Overall, these reports drew a number of positive conclusions, highlighted some areas of risks and made recommendations for improvement. There is also evidence that the issues raised in these external review reports resulted in action plans and progress was made in addressing many of the issues highlighted in a timely manner. It is understandable therefore that the Board will have taken a degree of assurance from those reports but in our view these pieces of work did not negate the need for the Board to look more widely at other sources of information, to triangulate and perhaps most importantly to proactively seek assurance not re-assurance.
8.15 When addressing the same issue, Sir Robert Francis in his seminal report into the failings at Mid Staffordshire Hospitals NHS Foundation Trust (Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, Volume I, Chaired by Robert Francis QC, HC375-I, February 2010) stated: “The Board gained unjustified reassurance about the Trust’s standard of performance from external assessments without taking into account the fact that most of these were based on information generated by the Trust itself. In any event, such reference points should not have discouraged them from fulfilling their duty to be aware of what was happening under their direction.”

8.16 We believe for example that if the Board had considered more closely the NHS Staff Survey results in 2011 and 2012 or looked at the impact on staffing, morale and service delivery of the Cost Improvement Programme, or looked closely at the reports from the Prisons and Probation Ombudsman for England and Wales, or for that matter considered the extent of incident reporting within the Intermediate Care Bed Based Service, they would not have been as assured, as is suggested in the comment in section 8.12.
These reports also drew out some areas that we ourselves have commented on within this review already in Section 7. So for example, the report entitled “Liverpool Community Health NHS Trust Preliminary Review and Financial Reporting Procedures Report, Final Draft” (PricewaterhouseCoopers LLP, 22 June 2012) stated “We found that Non-Executive Directors were weaker in two specific areas which are important going forwards: how they get assurance over the quality of non-financial data reported to them. Some Non-Executive Directors were able to come up with some sources of assurance but none were able to provide a comprehensive response. One individual felt that Non-Executive Directors should just be able to assume the Executive Directors have addressed this; and the processes for assessing the possible impact on quality of Cost Improvement Programme schemes, and for monitoring schemes to identify any unforeseen impacts on quality on an ongoing basis. Again Non-Executive Directors were able to come up with some ideas but unable to give a comprehensive response.” The report also noted “that there is a current gap in the Non-Executive Directors of someone with a clinical background who is able to challenge the Medical Director and Nursing Director on clinical issues. The Chair and Chief Executive are conscious of this and are considering the appointment of an associate Non-Executive Director with a clinical background. The Trust should also consider whether it has a Non-Executive Director with sufficient experience of large scale change programmes.” In relation to appointing a Non-Executive Director with a clinical background, this was later addressed with the appointment of Deborah Morton in April 2013.

The conclusion of some of these reports across a range of issue are also challenged, albeit much later by Monitor when it reported the outcomes of its Quality Governance Pilot which we discuss in more detail in Section 19.3. This specifically drew out:

- Concerns over the extent to which quality was driving the Trust agenda;
- Concerns around Board awareness and oversight of risks to quality;
- Concerns over the Trust culture;
• Concerns around the board committee and its sub-committee focused on oversight of the quality agenda;

• Concerns around a lack of escalation of key issues to the Board.

8.19 Several staff mentioned to us a monthly “Business Leaders Meeting” which were led by the Chief Executive. The first part of the meeting was used by the Chief Executive to relay key national messages and local priorities to senior leaders, clinical and managerial, within the Trust. The remainder of the session was always conducted by another Director or a senior manager or clinician to share details of a specific initiative or programme of work. At these meetings, the thrust towards achieving NHS foundation trust status was most regularly articulated to senior leaders in the Trust and their part in “making it happen.” Some staff we spoke with stated to us that achieving NHS foundation trust status was the only area of focus at these meetings. Though this was an area contended by the Chief Executive who stated to us that Business Leaders meetings covered a range of subjects and she felt she made every effort to get out into the Trust, using a range of forums to understand the views of staff across the Trust. As we do not know what actually happened, we have reflected both points in our report.

8.20 In February 2010 the first Francis Inquiry report into failings at Mid Staffordshire NHS Foundation Trust (Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, Volume I, Chaired by Robert Francis QC, HC375-I, February 2010) made clear that management thinking at Mid-Staffordshire NHS Foundation Trust between January 2005 and February 2008 was dominated by a desire to achieve NHS foundation trust status to the detriment of quality of care.

8.21 Given this high profile report set out clearly the dangers of such a single minded approach to achieving NHS foundation trust status, it is deeply regrettable that the Trust failed to take heed of the lessons from this seminal national report.
8.22 In conclusion, we feel that a sustained drive towards achieving NHS foundation trust status from the inception of the Trust in late 2010 consumed a significant amount of time, energy and focus of the Board and the Executive Team in particular. Perhaps more importantly as a consequence, anything that would have created negative news was managed, motivated by a desire to not jeopardise in any way the NHS foundation trust application process and we return to that particular theme later in the report in Section 10.

9 Cost Improvement Programmes and Quality Impact Assessments

9.1 The Trust set itself a challenging Cost Improvement Programme target during 2011/12, 2012/13 and 2013/14, as part of the drive towards achieving NHS foundation trust status, and the two processes very much went hand in hand. In this section, we consider in detail the emphasis the Trust placed on achieving challenging Cost Improvement Programme targets and how the requirement to undertake Quality Impact Assessments manifested itself.

9.2 As part of the Salmon process, the Director of Finance clarified to us that “The Trust set five year Cost Improvement Programme targets based on National and Monitor efficiency expectations, which had been, and subsequently were in the future, applied to block contracts. Delivery of efficiencies incorporated into annual contracts were required to maintain a surplus position, which was defined as a statutory obligation in regulatory reporting. Targets set for services and divisions were based on independent assessment of benchmark comparatives and interviews with specific services and clinicians in LCH [the Trust].”

9.3 A paper presented to the December 2011 Board entitled “Foundation Trust Programme Report October 2011” states “Cost Improvement Programme plans must be reflected for both the outturn year and for two forecast years. Non-achievement of Cost Improvement Programmes is often scrutinised by Monitor as a downside scenario and the Business Development Team are working to ensure Cost Improvement Programme monitoring is embedded throughout the Trust.”
9.4 In June 2012, the private Board received a more substantial paper from the Director of Finance setting out a strategic approach to developing Cost Improvement Programmes which confirmed that: “All Cost Improvement Programmes will have a Quality Impact Assessment prior to the Cost Improvement Programmes commencing to give the Board assurance that quality of service will not be adversely impacted by the delivery of Cost Improvement Programmes. The Director of Operations & Executive Nurse, or the Medical Director, will sign off the Quality Impact Assessment for each Cost Improvement Programmes. LCH [the Trust] have developed a comprehensive Quality Impact Assessment document, which was submitted to Executive and IGQC. The document challenges and records the potential quality impact of Cost Improvement Programmes, and mitigating actions to ensure quality is improved or maintained. Every Cost Improvement Programme will have a Quality Impact Assessment.”

9.5 The Board thereafter received monthly updates and were assured that Cost Improvement Programmes were on target, but there is limited evidence in the minutes of any discussion about the impact of Cost Improvement Programmes on staff and on their ability to then deliver safe effective health care. Indeed we found little or no questioning from Board members to that effect in either the public or private Board minutes during the rest of 2012, 2013 or the early part of 2014.

9.6 The Trust delivered Cost Improvement Programmes totalling £7,096k or 5% of turnover in 2011/12; £6,450k or 4.4% of turnover in 2012/13 and £6,951k or 5.1% of turnover in 2013/14. These figures are taken from the Annual Reports of the Trust for each of those years.

9.7 Our extensive review of Committee meetings shows a similar lack of scrutiny and challenge. The terms of reference of the Finance & Commercial Committee stated “The committee will monitor and review Cost Improvement Plans.”
9.8 One of the Non-Executive Directors we interviewed as part of the review and who was a member of the Finance & Commercial Committee stated to us that they challenged regularly around the impact on quality of Cost Improvement Programmes at the Finance & Commercial Committee. Regrettably, we found no evidence of that in the minutes of the meetings that we have reviewed and more importantly no changes because of it. Indeed, whilst there was some discussion recorded of Cost Improvement Programmes at meetings in May 2011, in March, May, August and November 2012, as well as in February and December 2013, not one of those focused on the impact on quality of Cost Improvement Programmes.

9.9 The discussions meanwhile at IGQC meetings on Quality Impact Assessments of Cost Improvement Programmes were confusing, at times contradictory and lacked follow through. They also deviate considerably from that set out to the Board in June 2012 (See Section 9.4). For example, the IGQC minutes of the 4 October 2012 state: “ARW [Anne Rosbotham-Williams, Trust Secretary/Head of Governance] noted that it would be important to maintain an on-going review of the impact of delivering Cost Improvement Programmes on the quality of services and that one element of this would be to question front line staff about Cost Improvement Programmes and how it affects the quality of the services being delivered. Action: Staff to be asked about the impact of Cost Improvement Programme delivery on the quality of service they can deliver in the quarterly climate survey.”

9.10 The above comment from the Trust Secretary/Head of Governance represents one of the few cases in either a Board or Committee meeting between 2011 and 2014 where a connection between Cost Improvement Programmes and their impact on quality of services was even made. It was regrettable therefore that the resulting actions which we discuss in the rest of this section felt to us weak and not sufficiently focused to understand more clearly that connection. We also have seen no evidence of a quarterly climate survey being undertaken in the Trust or of its outputs being presented to the Board or one of its Committees and no subsequent follow up of an agreed Board action.
9.11 The 4 December 2012 meeting of the Audit Committee noted “The Board Assurance Framework was approved subject to the following comments/actions: SR [Sue Ryrie, Non-Executive Director] noted that the Quality Impact Assessments have not yet been to the IGQC and this was essential to provide the necessary assurance. ARW [Anne Rosbotham-Williams, Trust Secretary/Head of Governance] confirmed that these were on the agenda for December’s meeting.” There was indeed then further discussion around Quality Impact Assessments at the IGQC on the 18 December 2012 when it was noted “The paper outlined the Quality Impact Assessments process, which is on-going. SR [Sue Ryrie, Non-Executive Director] queried the scoring methodology and stated that in order to compare individual Quality Impact Assessments with others it would need to be consistently applied...HL [Helen Lockett, Director of Operations & Executive Nurse] asked how the Committee would like future reports and how often. It was agreed that: further work should be undertaken on refining the process, including how to demonstrate both positive and negative quality impacts; the Quality Impact Assessment should be RAG [red, amber, green] rated and with clear timescales; the papers to the Workforce Sub-Group should include Quality Impact Assessments; an update on the number completed/number of reassessments and the changed scores and the outcomes of the assessments; staff climate survey to include questions about the impact on quality.”

9.12 The IGQC went on to agree that “Further updates to be brought to the April 2013 meeting...it was confirmed that there should be a Quality Impact Assessment for each Project Initiation Document for the Cost Improvement Plans.”

9.13 There was an update progress report at each meeting in 2013 with the exception of December 2013.
9.14 So for example, at the IGQC meeting on the 15 August 2013 it was noted that on Quality Impact Assessments “CG [Craig Gradden, Medical Director] informed the Committee of the process that is in place to conduct quality assessments. The testing of all risks is taking place and work is on-going to produce a more refined electronic template. Quality Impact Assessments are conducted around the change in projects and reported to the IGQC. Medicines Management have carried out a piece of work autonomously on Quality Impact Assessments and have found ways in which to improve and add quality. Medicines Management have confirmed that CG/HL [Craig Gradden, Medical Director/Helen Lockett, Director of Operations & Executive Nurse] will receive assurance as changes take place. IGQC agreed to circulate new Quality Impact Assessment template to the members of the IGQC. At the meeting the IGQC approved the Quality Impact Assessment template subject to any comments from Committee members.”

9.15 At the IGQC meeting on the 10 October 2013 the Committee was given a progress report on Quality Impact Assessments. The following points were highlighted and discussed: “All Quality Impact Assessments have been reviewed by the Medical Director and the Executive Nurse. The new Quality Impact Assessment template, that is due to be rolled out, clearly highlights the residual risk after mitigating actions to ensure attention is focussed in the right area. Following discussion, the Committee requested to see the detail of those areas causing concern, in the form of a highlight report. SR [Sue Ryrie, Non-Executive Director] suggested incorporating more examples on the same lines as Medicines Management, with narrative. DM [Deborah Morton, Non-Executive Director] suggested including 20 areas where LCH [the Trust] are expecting to have quality issues. HL [Helen Lockett, Director of Operations & Executive Nurse] felt that it would be beneficial to report on Quality Impact Assessments when there has been an impact; HL [Helen Lockett, Director of Operations & Executive Nurse] pointed out that Quality Impact Assessments are about impacting on quality and felt that it may be necessary to adjust figures accordingly, for example, a reduction in savings to ensure less impact on quality. IGQC agreed that Quality Impact Assessment highlight report to be submitted to the IGQC on the 4 December 2013 to show the detail of those areas causing concern.”
In January 2014 Quality Impact Assessments was discussed again and the notes of the IGQC state “HL [Helen Lockett, Director of Operations & Executive Nurse and CG [Craig Gradden, Medical Director] have gone through all the Quality Impact Assessments and signed them off. Some that required further mitigating actions have been returned to complete.” No evidence was sought around this nor was there any scrutiny or challenge provided by any member of the IGQC. This again we feel constituted poor corporate governance and a failure by the IGQC to apply the necessary oversight in this key area, particularly when the position being reported to the IGQC in January 2014 seemed to represent such momentous progress compared to the situation being reported just a few months earlier. IGQC were clearly aware of the importance of Quality Impact Assessments and discussed this throughout 2013, however, it is not clear what evidence they actually saw and it seems that re-assurance from Executive Directors was too readily accepted.

These IGQC minutes are also clearly contradictory with what we have heard directly during our interviews. The reality for those staff working in the organisation was that Cost Improvement Programmes were not undertaken in the way it was set out to the Board as we have described in Section 9.3. External consultants had been appointed to very much drive this process forward within the Trust and a Programme Management Office was established to develop Cost Improvement Programmes, own them and secure their delivery.

This role seems at odds with the way the review team understands a Programme Management Office normally operates, which is to function in a much more supportive and facilitative capacity, to co-ordinate the Cost Improvement Programme plans and report progress to the Trust. We heard from several quarters that Cost Improvement Programmes for individual clinical areas and divisional teams were set centrally by the Programme Management Office, which was accountable to the Director of Finance. There was limited discussion about whether these were achievable or realistic and what their overall impact on service quality and patient safety would be.
9.19 In several areas initial cost improvement proposals amounted to a nearly 50% planned reduction in the overall budget. Indeed one member of staff when describing the role of the Programme Management Office stated “They fronted it because it was a very effective way of keeping, certainly, the executives away from the front end, so we never had any contact with the Director of Finance at this point. There was obviously financial representation at these meetings, but they were very much, and this is my personal opinion, in the pocket of the Programme Management Office. They were doing what the Programme Management Office was telling them to do and that was to challenge each time.”

9.20 The Medical Director described to the review team the process of undertaking Quality Impact Assessments within the Trust and it is clear from this that the process lacked a clear structure from the outset nor was what he told us consistent with that which was reported to the Board or to the IGQC.

9.21 He informed us that “They [Quality Impact Assessments] didn’t happen on a regular basis, we had one or two which came through. To me the Quality Impact Assessments I was doing was actually talking to people....there were all sorts of reasons for them coming in late, and so on, they changed the template, they changed this and they changed that...so, they were done on a lot of services, not right at the beginning, it came later on. So they were done, I signed them off, gave them to Helen [Helen Lockett, Director of Operations & Executive Nurse] to sign-off as well - I don’t think she got through all of them. And then they’d give them back, and then that’s it. That’s it, from then on it stopped. They [The Trust Board] didn’t actually get to see...I think they may have seen one or two as examples. But I don’t think the full pack went to them, no.”
The Director of Finance commented to us “The efficiencies process went through an external assessment, identifying Cost Improvement Programme opportunities. Then the process went through the Programme Management Office. The Programme Management Office was responsible for holding services to account for delivering the Cost Improvement Programmes. Naturally they were engaged with the services rather than something being done to them, more something that they were doing themselves. The Programme Management Office were giving services facts about differences in benchmarks, because that's where the scale of the opportunity that was presented to the Board came from, such as differentials between our organisation’s productivity and other similar organisations and what we could do to enable and support the release of that lost productivity. But I think from a service perspective a lot of it then felt it was done to them and I don’t think that got picked up well enough from a quality perspective so the pressure went into Operations, basically, you've just got to deliver this now.”

Whilst the Chief Executive as part of her comments back to us through the Salmon process stated “As Chief Executive I was frustrated at the length of time it seemed to be taking to integrate the Quality Impact Assessments into our plans. I also raised my concerns at the IGQC and can remember asking for a report on how many Quality Impact Assessments we had undertaken and the actions we had taken as a result of the Quality Impact Assessment in terms of changes to financial assumptions.”

The Interim Director of Nursing who joined the Trust upon the departure of the Director of Operations and Executive Nurse in spring 2014 stated to us “They did a very few [Quality Impact Assessment] and, and then presumably told the Board...Craig [Craig Gradden Medical Director] and I went through every single one and...it took us about five full days bringing everybody in and doing it properly.”
9.25 It was not clear to those working in front line services how these Cost Improvement Programmes were derived and they painted for us a very different picture to that presented to the Board in June 2012 or that described above by the Medical Director and the Director of Finance. There were a number of people who spoke to us about the relentless drive behind this process. Where teams were not able to sign up to the planned level of Cost Improvement Programmes, then pressure was placed on them initially by the Programme Office and then escalated upwards in the Trust. To illustrate this, we have set out two specific case studies of how the Cost Improvement Programme was implemented within the Department of Community Dental Health and then within the Adults Division.
Cost Improvement Programme Case Study 1: Department of Community Dental Health

We have reviewed in some detail the Cost Improvement Programme process in the Department of Community Dental Health and found it to be deficient on several fronts when compared to the guidance we have referred to later in Sections 9.27 to 9.30 from the National Quality Board or when it is considered against that which was discussed at the Board or the IGQC. The process first and foremost was not clinically driven but rather imposed from the Programme Management Office which for 2013/14 proposed savings in the Dental Department amounting to 49% of the overall budget of the service. In financial terms this equated to £2.7m of savings in 2013/14 and would mean the loss of some 50 WTE staff. The level is certainly much higher than those set out in the National Quality Board guidance which talked about efficiency savings amounting to around 2-4% of budget in a single year. In effect this meant the Department was being asked to deliver the same level of service with half the staff and half the budget. The proposal from the Project Management Office was wrapped-up in a Project Initiation Document which also included reference to a Quality Impact Assessment having been undertaken by the Programme Management Office but which was never shared with the Dental Department, despite their request to have sight of it on numerous occasions and neither had it had input from the Clinical Directors for the service.

Indeed it was stated to us in this case that “At the eleventh hour and the Quality Impact Assessment was actually, I believe, manipulated to reflect what the finance wanted to show. They were all very keen to make sure that in fact the quality assessment was just a kind of add-on. It was, to me, a tick-box exercise that was never mentioned at the beginning and it was only realised, I think, towards the end that there would need to be at least some evidence that that had been done...the Project Initiation Document also made no reference to what the impacts of the Cost Improvement Programme would be on the ability of the Dental Department to continue to meet local and national standards or provide safe and effective services. It also provided no details about where those staff cuts would fall or how they would be distributed across the range of services provided by the Dental Department.”
We found that when the Dental Department were unable to sign up to the Cost Improvement Programme, the subsequent process of escalation led to meetings between the Clinical Directors for the service and the Director of Finance, Director of Operations & Executive Nurse, Medical Director and the Programme Management Office. We were informed that these meetings were symbolic of a culture where staff views were not valued and legitimate concerns ignored. Indeed, at one such meeting one of the Clinical Directors for the service stated “we were actually told by Helen Lockett [Director of Operations & Executive Nurse] in Craig’s [Craig Gradden, Medical Director] presence that we were blockers. We were blocking progress.” We also found that when clinical members of the Department tried to discuss the whole process with the Medical Director he stated to them this was a service redesign matter and not something for him to become involved in.

As part of the Salmon process the Director of Finance commented that he accepted “the difficulty the clinical leads had raising their quality concerns” with regards to the Cost Improvement Programme. He also added the following points by way of additional context:

- “The Dental Division was overspending both the internal budgets and the externally commissioned income for the service;

- Commissioners were formally challenging LCH [the Trust] for the high cost of community dental services and proposing to further cut funding to benchmark levels (£ per 1000 population) and had already started to apply financial penalties based on Units of Dental Activity targets set;

- Dental Services had been commissioned some time earlier to provide a full and comprehensive community and emergency dental service in a large number of sites across Liverpool and Sefton;

- Independent benchmarking analysis highlighted that a number of the sites providing access across Liverpool and Sefton were providing significantly more capacity than demand for appointments.”
Cost Improvement Programme Case Study 2: Adults Division

One senior member of staff, central to these discussions stated to the review team:

“Well it came through, it came through Helen [Director of Operations & Executive Nurse] but it was driven by Finance absolutely. So, so for example Adults was given a £2.8m target, Cost Improvement Plan target, to deliver and we were told right, and you’re going to go before the Exec Team in two weeks’ time with your plans for delivering it which is absolutely dire, poor in terms of how that was. And considering don’t forget organisationally, yes we’d always looked at efficiencies and driving, you know, making us lean and whatever but it had never been a sort of really, you know, financially driven as this. So needless to say…the first meeting with the Exec Team two weeks down the line was really bad. It, honestly how not to get the best out of your Management Team. We all had to go in on a one, so I’ll just talk about mine. So I went in by myself in front of the whole of, in front of the Exec Team sitting round and it was like ‘right, what are your plans, share them with us now.’ And needless to say they weren’t fully thought through because they wouldn’t be; I’d been given two weeks to do it. And yes there were gaps in them because we hadn’t done the working through any of the detail. And it was like high level, this is where we can, we can drive…efficiencies. Well I absolutely, it was, I mean I’m not intimidated by much but...‘well that’s not good enough’ they all, it was like there was no almost Good Cop Bad Cop…. It was all Bad Cop!”

When we asked whether the impact on quality and safety of this level of Cost Improvement Plan target was ever raised in this meeting, the resounding response back from the senior person we interviewed was “not once did it come in in that meeting.”
What we have set out above in our view calls in to question the comment made to the review team by the Chief Executive when she stated “we really drove very hard around quality impact assessments and actually I know now that we had developed, we did have a very well developed system for quality impact assessment.” This statement is also at variance with the statement provided by the Chief Executive as part of the Salmon process which is at Section 9.23.

When asked to set out her views on why the process of Cost Improvement Programmes and Quality Impact Assessments had been experienced so differently in that case amongst the people we spoke to as part of our review, the Chief Executive stated that it was in the translation of the approach where there had perhaps been a disconnect: “it wasn’t so much the what we were trying to do it was how we were trying to do it. So there wasn’t a full engagement with those clinical teams by the Programme Management Office to say “This is the trajectory of savings that we want to try and deliver as an organisation what ideas do you have?” which would be my way of doing it. That was recognised by Gary [Gary Andrews, Director of Finance] so he took some steps around the Programme Management Office at the time around the leadership because I think that was part of the difficulty. But we had gone some way down the line where actually there was a challenge around the dental one, there was a challenge around the Quality Impact Assessment, I think that was detailed. I do remember that one, so we had to go back and say “Okay well if that’s not deliverable what are we going to do?” So I think there was an issue about the how we were going to deliver the Cost Improvement Programmes.”

The most comprehensive guidance at the time on Quality Impact Assessments was produced by the National Quality Board (How to: Quality Impact Assess Provider Cost Improvement Plans National Quality Board, June 2012) and came out at around the time these processes in the Trust had just commenced. It stated:
“Every autumn trusts begin to plan their annual Cost Improvement Programme for the following financial year...each trust will identify its projected income...and estimate its projected expenditure, taking account of the requirements contained in each year's Operating Framework...the Operating Framework will identify a minimum percentage saving to be made (typically 2% - 4% of overall income). Every year there is an efficiency/productivity requirement set for the NHS and there is an annual expectation that savings and efficiencies will be made...at this stage there will inevitably be a gap between a trust's projected income and expenditure. The trust then plans how it will close that gap, which may involve a number of measures...Cost Improvement Programmes are not necessarily about cuts or closures but rather the focus is usually on improving efficiency.”

9.29 The National Quality Board guidance critically goes onto state:

“All Cost Improvement Programmes are subject to change and need to be dynamic documents since revisions in policy or circumstances require adjustments to the Cost Improvement Programme during the year. Only a trust board can best determine how to deploy its resources within a Cost Improvement Programme and we must not lose sight of the fact that ultimately, the board of the organisation is responsible for preparing a plan which is deliverable and not detrimental to the quality of patient care. All of this reinforces the need to focus on the impact on quality of the savings schemes identified as part of Cost Improvement Programmes...all Cost Improvement Programmes should be agreed by provider medical and nurse directors.

9.30 The National Quality Board guidance goes onto conclude:
“Although the contribution of the medical and nurse directors is crucial, it is the collective responsibility of the board to ensure that a full appraisal of the quality impact assessment is completed and recorded and that arrangements are put in place to monitor work going forward. Given the dynamic nature of Cost Improvement Programmes this exercise should not be a one off application for the board but should feature as core business on a frequent and regular basis throughout the year. The board and chief executive must endorse the process. They must support the medical and nurse directors to work collaboratively with other key colleagues such as the finance and performance directors, to complete the assurance process. In this regard the process should be formally adopted by the board and underpinned by clear governance arrangements which confirm lines of accountability through to the board, and which fully acknowledges the primary responsibility of boards to satisfy themselves on matters of detail.”

9.31 We have quoted from the National Quality Board guidance extensively for two reasons: firstly it was comprehensive in its coverage and secondly clear in its message, affirming in particular the centrality of the Board within this process.

9.32 The process adopted for Quality Impact Assessments and Cost Improvement Programmes by the Trust was at variance with that guidance. Indeed the Guidance is not mentioned once in any Board or Committee papers we have seen on this subject and it became clear in our interviews with the Chief Executive, Medical Director, Director of Finance and for that matter the Chair and Non-Executive Directors that they were not aware of it. In our view, the Board should have been fully aware of the National Quality Board guidance and ensured it was adhered to within the Trust and ensured that discussions at the Board, IGQC and the Finance & Commercial Committee on Quality Impact Assessments and Cost Improvement Programmes were guided by the simple process of proactively seeking assurance as opposed to re-assurance.

9.33 If it had done so, we are confident that it would have led to a more considered approach to Cost Improvement Programmes that would have avoided or reduced the scale of cuts made in a number of front line services, and their resultant impact on staffing levels, staff morale and ultimately the safe and effective delivery of services would have been avoided or lessened.
9.34 That the lack of a clear, transparent and robust Quality Impact Assessment process at the Trust to support Cost Improvement Programmes was not something that was picked up by commissioners or regulators is a further cause of concern. Both should have been questioning and certainly examining the quality impact process in the Trust more closely than was evidently the case.

9.35 We will return to Cost Improvement Programmes and Quality Impact Assessments in Part Two of our report and set out what progress has made within the service since the arrival of the new leadership team in spring 2014.

9.36 In conclusion, we are clear that the Trust persistently pursued Cost Improvement Programmes and despite what was being reported into the Board and the relevant Board Committees, the reality was that Quality Impact Assessments were limited at best. The Board and its Committees for their part failed to understand the impact of such a significant Cost Improvement Programme on the quality and staffing of front line services and did not provide the required level of proactive oversight, too willing in our view to accept Executive Director assurance of a process which was largely at variance with that set out in national guidance. In that sense, the Board failed in its primary responsibility to satisfy itself on matters of detail regarding Cost Improvement Programmes and the Quality Impact Assessment process.

10 A Failure to Investigate Concerns

10.1 We will now consider in this section a number of specific incidents which took place within the Trust from 2011 onwards. They raise for the review team serious concerns about both the conduct and judgement of the Executive Team.

10.2 In spring 2013 a health care professional was taken “hostage” and was subsequently subjected to a very serious assault by a relative of the patient. The incident was initially reported to the Director of Finance (as the lead Trust director for health and safety) and on the same day, he then relayed this more widely, including to the Chief Executive, Director of Human Resources & Organisational Development, Medical Director and Director of Operations & Executive Nurse. The incident was recorded on Datix on the same day.
10.3 In this case, the Director of Operations & Executive Nurse assumed responsibility for the management and investigation of the incident. The Director of Operations & Executive Nurse simply stated in an email at the time “Just to assure everyone” and went onto say that a member of her team was taking the lead in providing support and “doing a Root Cause Analysis on the incident, which I have asked to be reported to me directly.”

10.4 Our subsequent detailed review of this incident confirms that, despite the comment from the Director of Operations & Executive Nurse that the incident would be the subject of a Root Cause Analysis, no proper investigation or Root Cause Analysis was undertaken, despite this being a clear requirement under the Trust Risk Management Policy. It is also not clear, given that the Director of Finance was the executive director lead for health and safety within the Trust, why he subsequently left the matter entirely to the Director of Operations & Executive Nurse.

10.5 The Director of Finance as part of the Salmon process noted that he accepted that “he should have followed up the incident personally to get assurance that the incident was reported appropriately and that the organisation had taken all the appropriate steps to support the individual and mitigate any risk of re-occurrence; instead of taking re-assurance from the Director of Operations and Executive Nurse and the health and safety reporting system that both downplayed the seriousness of the incident.”

10.6 The patient’s relative who carried out the assault was subsequently charged and received a lengthy custodial sentence alongside additional actions by the Court.

10.7 In order to fully understand the significance of this incident, we wanted to set out the issues that only came to light upon arrival of the new leadership team in spring 2014. We feel that in order to provide a complete picture, it is more appropriate to cover these points here rather than in Part Two of the report.
10.8 At the end of April 2014, as a result of the failings of the Trust to investigate this matter properly or learn from it, the health care professional who had been the subject of the assault contacted the Health and Safety Executive directly to look into this matter. The Interim Chief Executive first became aware of this matter in June 2014 when she unexpectedly met a representative of the Health and Safety Executive who at that point was visiting the Trust headquarters to gather further background information on this assault.

10.9 The Interim Chief Executive and the Interim Director of Nursing in July 2014 met the health care professional that had been assaulted and after undertaking a detailed review of the actions taken by the Trust since the assault occurred in spring 2013, the private Trust Board received a very detailed paper on the matter at its meeting on the 23 September 2014.

10.10 The paper to the Board set out a detailed chronology of events and concluded that the incident had highlighted a number of “systematic failures” by the Trust.

10.11 The private Board meeting of the 23 September 2014 was attended by the Medical Director and the Director of Finance and who were, as we have stated in Section 10.2, both fully aware that the incident had occurred in spring 2013. The minutes of the private Board meeting on the 23 September 2014 record “the Board expressed disappointment that they were not made aware of the incident.” The minutes go on to state “CG [Craig Gradden, Medical Director] confirmed that it had been reported in the “Weekly Meeting of Harm”, but had not been reported to the Board, as it had been risk rated too low.”
10.12 In summer 2014, with the support of the NHS Trust Development Authority, the new leadership team commissioned an independent desktop review of the management and Board response to a number of serious incidents at the Trust, which had come to light since the arrival of the new leadership team and to determine whether any further investigation was required. The desktop review was undertaken by Liz Craig, a former Director of Nursing and Midwifery in the NHS and with over ten years’ experience in improving organisational safety and quality and June Goodson-Moore, a former Director of Human Resources and Corporate Governance in the NHS and with a decade of experience in these areas and conducting investigations. Their report which was concluded in November 2014 found a number of deficiencies in the way the Trust had responded to this and other issues in the past. Specifically, with regards to the assault on the health professional that took place in spring 2013, the report noted the following:

“From an examination of the Trust’s incident chronology in relation to this event, it is apparent that there were multiple errors in how this incident was handled before June 2014 including:

   Lack of appropriate response by the Medical Director and Director of Operations & Executive Nurse at the time of reporting and during the investigation period;

   Wrongly rated by the Governance Department as a category twelve;

   No proper investigation or Root Cause Analysis undertaken before 2014;

   Inadequate note taking by staff involved on numerous occasions. Notes done retrospectively when challenged but without reference to this not being contemporaneous;

   No evidence of it being raised at any governance forum or Trust Board;

   Insensitivity in charging the member of staff to access the records in relation to the investigation;

   Apparent lack of support by managers;
Reluctance to learn lessons."

The reviewers considered that there was a dereliction of duty by the organisation in respect of this health care professional prior to the arrival of the Trust’s new executive team. They added that the health care professional had been “let down at every stage of the investigation and failed to receive sufficient support. It was evident that within governance and risk management and at executive level, the Trust did not recognise the seriousness of the incident and ensure it was dealt with appropriately. Lessons were not learned and the implications for staff safety were not considered until some 16 months later.”

10.13 We have not heard anything during the course of our review or read any new paperwork that enables us to draw a significantly different conclusion from that reached by Liz Craig and June Goodson-Moore, except in two specific areas.

10.14 Firstly, it is undeniably the case, as Liz Craig and June Goodson Moore pointed out in their report that the Medical Director and Director of Operations & Executive Nurse, given their overall responsibilities around clinical governance, were at fault for their failure to respond.

10.15 But we would go further. Under the Health and Safety at Work Act 1974 all directors have corporate responsibility to provide a safe working environment and ensure adequate arrangements and resources are provided to implement the requirements of the Act. In addition, we would say each of the Executive Directors had individual responsibilities and obligations which they failed to fulfil.

10.16 The Chief Executive as the Accountable Officer under the Health and Safety at Work Act 1974 has overall responsibility to provide a safe environment throughout the Trust. The Director of Finance had delegated responsibility for health and safety and this would extend to informing the Board on all relevant health and safety management issues, including alerting the Board to the requirements of this policy and any actual or potential breaches of Health and Safety Legislation. The Director of Human Resources & Organisational Development has a key role around promoting staff welfare within the Trust.
When we discussed this incident with the Chief Executive, she informed us: “I sent...a personal note saying we were sorry about what had happened and...asked to come and see me, to thank me for sending the note.” Upon further discussion, it became apparent that the Chief Executive, until we explained that the actual incident had involved an assault on the health care professional, was not aware of the full nature of the incident. It was not until over two years had elapsed since the assault had occurred and a year since the Chief Executive had left the Trust that she became aware of the true extent of what had happened to a member of staff whilst she was the Accountable Officer for the Trust. The Chief Executive stated to us as part of the Salmon process comments we received from her that “As the Chief Executive I would expect Executive Directors to follow the systems and processes for incident reporting.” She went on to say “As Chief Executive, I can only act on what I know and would have clearly expected this information to have been reported to me by an Executive Director. The initial low rating of this incident by the Medical Director clearly resulted in this incident not following the normal, well-developed route of serious incident reporting to the Board. This is the root cause of the issue.”

Secondly, we wanted to focus a little more on how a matter of such significance failed to reach the wider Board.

The confirmation from the Medical Director in the minutes of the Board meeting held on the 23 September 2014 that this issue was discussed in the “Weekly Meeting of Harm” is at variance with the point made in the Liz Craig and June Goodson-Moore report that there is “no evidence of it being raised at any governance forum or Trust Board.”
10.20  The rationale for why the Medical Director had then not escalated the matter to the Board despite it being discussed at the “Weekly Meeting of Harm” “as it had been risk rated too low” simply does not in our view stand up to closer scrutiny. The “Weekly Meeting of Harm” regularly presented to the private session of the Board and its reports were not exclusively confined to issues, incidents or risks commanding a high risk score. For example, the report from the “Weekly Meeting of Harm” in spring 2013, which is when the assault on the member of staff occurred, included on it “email accounts of those who have left the organisation” and “Exec team have approved the appointment of Clinical Safety Officer and Chief Clinical Informatics Officer.” Whilst at the very same private Board meeting on the 23 September 2014 which received the “Lone Worker Incident” report, the “Weekly Meeting of Harm” report included an update on a “theft of a PC”, “Accommodation pressures for asylum seekers” and “Car parking at Burlington: tensions with local community/neighbours.”

10.21  In fact, in our view each of the Executive Directors in spring 2013 should have recognised this incident for what it was. It is easy to hide behind risk ratings, as the statement from the Chief Executive in Section 10.17 and the Medical Director in Section 10.20 suggest. On occasions it is intuitive that, while something may not be graded as reportable and whilst the full facts may not have been known at the time, your work and for that matter life experience and instinct should alert you to the fact that a serious assault on a member of staff whilst carrying out their role is just such an incident. We also do not as a review team accept the comments made to us that the serious nature of the incident was not known at the time. Our reading of the Datix entry on this incident clearly indicates the nature and seriousness of the incident.

10.22  The Board should have immediately been made aware of the incident and the Trust should have put in place the necessary support for the member of staff, undertaken a full and detailed investigation and implemented any recommendations that subsequently flowed from it as quickly as possible.

10.23  What led to none of the above happening is something only each member of the Executive Team can ultimately answer and calls into question the experience and judgement of each and every one of them on this issue.
10.24 All NHS staff have a clear duty to be open and transparent in all their dealings. Those staff subject to professional codes of conduct had a professional responsibility which predated the legal Duty of Candour that has been placed on NHS staff following the events at Mid Staffordshire Hospital. These are also clearly laid out principles within the Nolan Standards (*The Seven Principles of Public Life*, Committee on Standards in Public Life, 31 May 1995) and in the *Code of Conduct for NHS Managers* (Department of Health, October 2002).

10.25 This was a grave issue that should have been dealt with far more robustly to ensure staff safety, and in particular around ensuring action to support lone workers.

10.26 It is our view that the handling of this incident by the senior management team was significantly flawed and represented a serious breach of NHS Code of Conduct and the Nolan Principles.

10.27 Another example we wish to draw out centres around the Director of Operations & Executive Nurse who was presented with a report entitled *District Nursing Complaints and Incidents* by the then Senior Manager of Adult Community Nursing on the 2 November 2011.

10.28 This report was undertaken against a backdrop of increasing numbers of complaints received from patients and relatives, and within the context of a high number of clinical incidents reported by nurses. A key theme within this report was that the service was understaffed, resulting in difficulties in staff completing mandatory training, in particular around preventing pressure sores. The report in our view clearly drew out significant issues regarding patient quality and safety.

10.29 The Director of Operations & Executive Nurse followed up receipt of the report with an email to then Senior Manager of Adult Community Nursing on the 4 November 2011 thanking her for the report and noting her desire to “*focus on solutions and improvements*” but then also stating during the implementation of the Adult Nursing Specification (which was the programme which had been agreed with commissioners and the CCG) “*the findings could be very damaging to the organisation...can you please not share the report any further.*”
10.30 We have found no subsequent evidence to suggest that any further actions were taken in relation to this report by the Director of Operations & Executive Nurse even though the report clearly highlighted a range of concerns around patient quality and safety. Though as part of the ‘Salmon process’, the Director of Operations & Executive Nurse stated that she did share the report with the Chief Executive but beyond that provided no further information on actions taken. In Appendix 4 we have set out details of the number of incidents over the two year period of 1 April 2012 to 31 March 2014 in District Nursing Services. This shows a total of 4,340 reported incidents. This equates to over five reported incidents each and every day over a two year period. Over the same period of time there were 11,575 reported incidents across the Trust, meaning that approximately 37.50% of incidents were reported by the District Nursing Services.

10.31 We also wanted to draw out here our concerns around the Trust Risk Register. It came through in several of our conversations with Trust staff who stated that where risk ratings were identified by front line staff they were then watered down in order to make the position look better than it actually was in presentational terms, without any real evidence for doing so.

10.32 Indeed the review undertaken by Liz Craig and June Goodson-Moore which we refer to in Section 10.11 noted “there is some inconsistency in how risks are described, rated and treated with supporting evidence – for example, four risks were consistently rated red at all stages from open through to review and closure without evidence to support the actions. It is unusual to close off a risk rated red without either a related risk being identified due to closure or a reason for closure.” We also make further comment about this later in the report in Section 17 around clinical governance, where we reference the downgrading of risks within the Intermediate Care Bed Based Service.
10.33 In conclusion, whether it was the single minded focus to achieve NHS foundation trust status which was behind these decisions and which then drove the Executive Team to ensure negative news was suppressed so as to not jeopardise the NHS foundation trust process, or the lack of experience amongst the Executive Directors that was the reason behind it, ultimately we can only speculate. What we can be more certain about is that the impact on the Trust was to create a climate where staff and patient welfare and safety were not always seen as paramount and where the identification of risks was not encouraged.

10.34 Interestingly, in the external review report entitled “Board Governance Assurance Framework Independent Report, Liverpool Community Health NHS Trust, Review of the Board Governance Framework, Final Report”, (Cap Gemini Consortium, 3 July 2012) it noted following interviews with the Executive Directors that “there is a recognised tendency...to reflect a ‘positive gloss’ in the interpretation of data.” Whilst the interviews with the Non-Executive Directors noted “there was a view however that the executive team tended towards reporting the “good news” to the board and there was work to be done to shift to franker discussions around complexities and ambiguities that will inevitably arise.”

11 Prison Health Services

11.1 The Trust operated the Health Suite at HMP Liverpool from its inception in November 2010 until the service transferred to Lancashire Health Care NHS Trust from 1 January 2015. By way of explanation, this section of our report only covers the period from November 2010 until spring 2014, when the new leadership team was appointed. Issues and actions regarding HMP Liverpool from spring 2014 onwards are captured in Part Two of our report.

11.2 The services provided to HMP Liverpool by 100 or so health care professionals included:
- A 28 bedded unit providing inpatient care;
- Primary care services – physical and mental health;
- Integrated drug treatment services;
- Dental services;
- Allied health services including Chiropody, Optometry and Physiotherapy.

11.3 The services were managed by the Head of Offender Healthcare at the Trust, a qualified nurse professional by background (though this was not a clinical role), who split her time between HMP Liverpool and the Trust headquarters. She reported to the Divisional Manager for Primary Care and Public Health who in turn reported to the Director of Operations & Executive Nurse, who was the Lead Director for the services provided by the Trust to HMP Liverpool from when she was appointed in 2011 and until the responsibility was passed to the Medical Director in 2012/13 due to the size of the portfolio of the Director of Operations & Executive Nurse.

11.4 We were not able to interview, save for one member of staff, anyone within the Trust who worked within the multi-disciplinary team that provided health care services at HMP Liverpool. A number of former prison health care services staff in key decision making roles left the employment of the Trust and did not come forward to be interviewed, despite the Trust contacting them on more than one occasion. This includes the former Head of Offender Healthcare at the Trust.

11.5 We have therefore relied largely in this section on Board and IGQC meeting papers to understand what was discussed in relation to the services provided at HMP Liverpool, alongside some of the interviews we conducted which covered prison health services and an extensive review of reports produced in this period by both the Prisons and Probation Ombudsman for England and Wales and Her Majesty’s Inspectorate of Prisons for England and Wales (HM Inspectorate of Prisons), as well as those of the Care Quality Commission.
11.6 As part of the Salmon process we received an extensive response from the Head of Offender Healthcare and the Primary Care Manager who was responsible for the clinical aspects of the Offender Healthcare Services at HMP Liverpool, which we have taken account of.

11.7 We have approached this section in this way to understand the actions the Trust and in particular the Board took to address concerns regarding health services at HMP Liverpool from November 2010 to spring 2014, and if it could have done more.

11.8 During the course of our interviews we were informed that the Head of Offender Healthcare met separately with both the Divisional Manager for Primary Care and Public Health and the Director of Operations & Executive Nurse regularly but the Head of Offender Healthcare told us as part of the Salmon process that she only met the Director of Operations & Executive Nurse about three times and that meetings with the Divisional Manager for Primary Care and Public Health were often cancelled.

11.9 We also heard that within HMP Liverpool clinical governance meetings did not function effectively. One person we interviewed stated: “The governance meetings which were due to take place six weekly they were quite frequently cancelled at the last minute as well, more than half of them in one year I remember counting, over 50% were cancelled at the last minute.” The Head of Offender Healthcare also said as part of the Salmon process that meetings were frequently cancelled, often key staff did not attend, and support for these meetings was poor. She also added that risk were escalated upwards into the Trust but were subsequently downgraded.

11.10 They went on to say that when meetings did take place: “There were lots of things that just stayed on the agenda and these working parties were meant to form, to complete these various tasks but the same tasks and the same agenda items stayed on for months after months and after months and nothing was ever resolved.” They added “for example there was a condom policy within the policy and that must have stayed on the agenda for about 18 months.” This was also confirmed by the Head of Offender Healthcare as part of the Salmon process who said that it took over a year for the Trust to ratify the policy.
Some Board members we spoke to also told us they visited the Health Suite at HMP Liverpool between 2011/12 and 2013/14 but that they did not come away from those visits with any concerns about the service.

There were sixteen deaths in custody between 2011/12 and 2013/14 at HMP Liverpool (Liverpool Community Health NHS Trust Deaths in Custody Study (2011 – Present) Understanding the effectiveness of the current policy – Dr Tony Ryan and Dr Elaine Church, November 2014). All deaths in custody must be recorded on the Strategic Executive Information System or STEIS. This is a national requirement and codified in Trust policies, and yet within the Trust not all deaths in custody were recorded in this way. Each death in custody also results in a formal independent report produced by the Prisons and Probation Ombudsman for England and Wales. These are very comprehensive and cover in detail the care provided by the Trust as well as commenting on the prison service itself.

These reports were formally sent to the Head of Offender Healthcare at the Trust and were shared by her with her line manager, the Divisional Manager for Primary Care and Public Health, who in turn reported to the Director of Operations & Executive Nurse. In a report to the public Board on the 22 October 2013 entitled “Management of Reportable Issues including Serious Untoward Incidents”, which was a report that featured at almost all public Board meetings it notes “All deaths of patients/prisoners are investigated fully by Prisons Ombudsman and a full clinical review is held. There will also be an inquest held by the coroner. This is routine and normal procedure for prison healthcare departments.”

It would appear however that the reports from the Prisons and Probation Ombudsman for England and Wales were never discussed by the Senior Management Team, the IGQC or the Board. It is also important to note that these are not confidential reports and are freely available on the website of the Prisons and Probation Ombudsman for England and Wales.

Yet, there are in these reports concerns persistently raised over a period of time about the quality of the health services provided by the Trust. We reviewed a total of thirteen such reports covering deaths in custody at HMP Liverpool between the 9 May 2011 and 14 April 2014.
11.16 Many of the issues highlighted in these reports centre on a failure to conduct health screening and the lack of care plans to manage the care of patients and poor record keeping. Accurate and contemporaneous record keeping is a required standard of the General Medical Council and Nursing and Midwifery Council. In fact these are both consistent failings during the period between the 9 May 2011 and 14 April 2014.

11.17 There are two deaths in custody where we feel criticism of the Trust was particularly strong by the Prisons and Probation Ombudsman for England and Wales.

11.18 The first relates to a death in custody that occurred on the 30 March 2012. The report from the Prisons and Probation Ombudsman for England and Wales notes:

“The man had a number of existing medical conditions, including hydrocephalus; a condition which causes the body to produce excess cerebral and spinal fluid. To relieve this build-up of fluid, a ventricular shunt had been fitted into the base of his skull to drain fluid away from his skull and disperse it into his body. Healthcare staff were unaware of this when he first arrived in prison. On 21 May 2011, he told a nurse that he had had the shunt fitted 21 years earlier. No care plan to manage his condition was implemented.

No care plan was put in place to manage the man’s condition and I consider that healthcare staff should have been more proactive in arranging hospital admissions for observation when he was unwell with symptoms apparently related to his shunt. While it is not possible to say whether this affected the outcome for him, in these respects I do not consider that his care at Liverpool was of a sufficient standard.

As in a previous investigation at Liverpool, I consider that there is a need for the relevant healthcare commissioners to satisfy themselves of the quality of delivery of health services at the prison.”
11.19 The Report also noted:

“There were significant shortcomings in the care that the man received at Liverpool. We also make recommendations about the quality of the record keeping by healthcare staff, availability of medical equipment, assessing those with complex care needs and facilitating hospital appointments.

We have investigated a number of natural cause deaths at Liverpool. The investigation into the death of a man in 2011, found shortcomings in respect of record keeping and we identified deficiencies in clinical management in a more recent investigation. We recommended that the relevant PCT should commission a detailed review of clinical care at Liverpool prison to ensure that provision of healthcare was in line with the GMC Good Medical Practice guidance. There are similar concerns in this case and we have therefore repeated this recommendation to the newly established NHS Local Area Team.”

11.20 There is no evidence we have seen that the above actions recommended by the Prisons and Probation Ombudsman for England and Wales were followed through by the Trust.

11.21 Whilst another Report in to a death in custody in April 2012 notes:

“There is no evidence that prison staff offered support to the man following the diagnosis, or that he was involved in the care planning process while in the healthcare centre....It is very likely that the man suffered from lung cancer when he arrived at HMP Liverpool. In my opinion it is therefore a significant omission of the medical staff at HMP Liverpool to have not pursued the causes of these symptoms. The clinical reviewer concludes that it was likely the man was suffering from lung cancer when he arrived at HMP Liverpool, but it was not diagnosed for four months. He believes that the medical care the man received fell below the expected standard for general practice. He also considers that record keeping was poor and the management of investigation test results needs to be revised. As a result, on several occasions doctors did not appear to respond appropriately to medical symptoms.”
11.22 It is our view that given the level of criticism placed against the Trust particularly in the above two reports from the Prisons and Probation Ombudsman for England and Wales, they should have merited some Board discussion. There is no evidence however of such a discussion.

11.23 There were also in this period two characteristically high profile reports by HM Inspectorate of Prisons into HMP Liverpool. The first was published in May 2012 following an inspection of HMP Liverpool from the 8-16 December 2011, and the second was published in March 2014 following an inspection from the 14-25 October 2013.

11.24 The report following the visit from the 8-16 December 2011 drew out clearly those areas where HM Inspectorate of Prisons had the greatest number of concerns. These particularly centred on medicines management and many of these concerns had already been identified in the previous visit to HMP Liverpool in 2009 by HM Inspectorate of Prisons. Below is an extract from the report of the visit by HM Inspectorate of Prisons on the 8-16 December 2011:

“Medication was administered by nursing staff during three daily treatment times. All medicines were supplied through gated hatches that provided an adequate interface. Patients on or in possession medication were usually given a patient information leaflet with their medications but those on supervised medications did not always receive one. Medicines supplied in possession were not always appropriately labelled. Medicine stock was poorly maintained, with a number of tablets and tablet foils loose in the cabinets. Extra tablet foils had been inserted into some containers and discontinued or uncollected medicines were found in the stock cupboards. No date-expired medicines were found but some stock containers did not include batch numbers or expiry dates on the label. A few general stock medicines were held, including Dihydrocodeine tablets, Chlordiazepoxide capsules and Diazepam syrup. There was no audit of the use of these medicines and no reconciliation of the amount of general stock supplied against prescriptions issued.”
In the report from the visit on the 14-25 October 2013 the following was noted:

“Health care services were generally good but prisoners expressed some negative perceptions and some delays were evident. Pharmacy services were a particular concern, with little professional leadership and some aspects of medications management needing urgent attention. In our survey, responses to questions relating to health services were less favourable than the comparator, but overall services were good. Problems recruiting nurses and doctors were adversely affecting the prison’s ability to provide a comprehensive service.

Care plans were subject to clinical audit. The health centre environment was excellent, but the quality of some wing-based medical rooms was poor. Primary care services were sufficient to meet needs, although treatment for lifelong conditions was underdeveloped. The rate of secondary assessment had dropped to 30%. Waiting times were good, but failure-to-attend rates were unacceptable. The use of in-patient beds for overnight ‘lodging’ had become routine.

Pharmacy services lacked professional leadership. Several aspects of medicines management needed urgent attention to meet required standards. The dental service was very good. There was no waiting list for urgent treatment. Mental health services were extensive and well regarded by prisoners. However staff shortages were affecting integrated working between health providers and the rest of the prison.”

It is our view that given the concerns raised in both reports from HM Inspectorate of Prisons and given their overall high profile, they should have merited some Board discussion. Regrettably, we could not find any evidence however of such a discussion.
Indeed our review of Board and IGQC papers is that they never received a single standalone report into this service during the period from when it was established through to the end of 2013/14. Whilst it is difficult nor is it necessary to receive a report at either the Board or at a Board Committee level on each of the services provided by the Trust, given that this was a high risk service delivered to a very vulnerable client group, we would have expected to see more visibility of the service than we did.

This is perhaps even more surprising given that in this time period, there were two key reports from HM Inspectorate of Prisons and thirteen reports from the Prisons and Probation Ombudsman for England and Wales into deaths in custody at HMP Liverpool. None of these made their way onto the Board or IGQC meeting agenda.

What evidence of discussion there is at Board or Committee level is limited. For example, there was a brief discussion at the private Board meeting on the 20 September 2011 regarding two separate incidents at HMP Liverpool (The first incident related to a death threat made against a member of Trust staff working at the prison and the steps taken by the member of staff following advice to ensure their on-going safety; the second incident related to an assault on a member of Trust staff and the effect on a colleague who witnessed the incident).

We also note that the IGQC in its report to the Board of its meeting held on the 18 February 2012 noted “Four Deaths in Custody have been recently reported at HMP Liverpool. Three were due to natural causes, one suicide. Process for reporting internally not as robust as it should be and needs reviewing...all future deaths in custody are to be reported to the IGQC who will then assure the Board.”

We also note that in the “Weekly Meeting of Harm” report March 2013 which was reported to the 23 April 2013 private Board by the Medical Director, this noted the following issues regarding Offender Health Services:

- Pressure on Prison staffing levels;
- Impacts on Prison Health Care Team;
- Levels of stress and absence increased;
- Information being triangulated to feedback to IGQC and the Prison Service.
11.32 There is also a detailed record in the private Board minutes of the 21 May 2013 meeting regarding a specific death in custody.

11.33 There is subsequently no evidence of any follow up of action from the above meetings of the Board.

11.34 When there were deaths in custody, they were reported to the Board via the “Management of Reportable Issues including Serious Untoward Incidents” report which was presented to the Board by the Director of Operations & Executive Nurse. This featured at most Board meetings, but there was no subsequent explanation in any of these papers around deaths in custody or evidence of discussion in the minutes. Critically there is no reference to actions taken and lessons learnt.

11.35 Indeed as we have stated in Section 11.27 the Board never received a single report on the services it provided at HMP Liverpool. However what we can see are a number of references in Serious Untoward Incident reports to the Board about deaths in custody and other comments or reports regarding concerns at HMP Liverpool as we have highlighted in Sections 11.28 to 11.31. Collectively they should have raised the anxieties of the Board to require a more detailed report to be provided on the service as a whole or a “deep dive” session at the IGQC to which the Head of Offender Healthcare at the Trust and the Divisional Manager for Primary Care and Public Health or Director of Operations & Executive Nurse should have at the least been invited to attend or undertake a ‘fact finding’ visit to HMP Liverpool. This in our view would have been consistent with good governance principles and is indeed custom and practice in other parts of the NHS where the Board or its Committee is seeking to understand in detail a particular issue or area of concern.

11.36 The Care Quality Commission published a report into the Health Suite at HMP Liverpool in November 2013. The report followed an unannounced inspection of the prison healthcare service in October 2013. The key findings are shown below and confirm that action was needed in four of the seven standards:
Quality, safety and management assurance review
Liverpool Community Health NHS Trust

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<td>Respecting and involving people who use services</td>
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<td>Care and welfare of people who use services</td>
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<td>Co-operating with other providers</td>
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<td>Safeguarding people who use services from abuse</td>
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<td>Supporting workers</td>
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11.37 The Care Quality Commission Report noted the following:

“We saw that it was the practice that when prisoners were first received into HMP Liverpool they saw a nurse and an initial health screen was completed, if additional health needs were found, for example, if a person had a history of mental ill health or a history of substance misuse then referrals to relevant healthcare professional across the prison would be made. It was the practice that all prisoners received a secondary health screen within 72 hours of coming into the prison. This was a detailed comprehensive assessment which involved a further review of prisoner’s health care needs. We reviewed patients’ health care records and could not find an example of a completed secondary health screen. The Trust sent us a copy of their record keeping audit for May 2013, in which they too had identified that a significant number of prisoners were not receiving a secondary health screen; they attributed this to prisoners declining the service.

Strategies need to be developed to vastly improve the uptake of this service. Chronic shortage of nursing and GP staff within outpatients, which meant that staff were unable to complete secondary health screen assessments. This meant that patients’ health needs were not being fully assessed and there was a risk that some patients were put at risk because their health needs had not been fully identified and responded to.”
The Care Quality Commission report went on to say:

“We looked at assessment and care planning documentation for outpatients at HMP Liverpool. We found that treatment and intervention were recorded on patients’ records for one off appointments made to the outpatients’ clinic. However we found that there were no care plans in place for patients with chronic long term health conditions, for example, diabetes and asthma. This meant there was no audit trail that demonstrated what treatment and corresponding action had been provided to a patient who attended outpatients.

They told us they would take action to implement care plans for patients with long term health conditions and cited a chronic shortage of nursing and GP staff across healthcare for the lack of care plans. Nursing and healthcare staff were not fully supported to deliver care and treatment to people who used the service. We spoke with staff about clinical supervision arrangements.

We found that clinical supervision was not in place for nursing and healthcare support staff. Qualified nursing staff did not receive regular clinical supervision.

Some staff expressed dissatisfaction with the senior management team at the healthcare unit and they told us that staff morale was low.

Our colleagues in HM Inspectorate of Prisons inspected the arrangements in place around the management of medicines within the prison and found a number of areas of concern including medicine stocks were poorly maintained and loose medication was found in medicine cabinets.

Named patient medicines being used as stock for other patients, and waste medicines were not appropriately segregated from stock. Fridge temperatures were not monitored and loose insulin pens with attached needles were found stored in one fridge. This meant there was a risk of cross contamination.”
Despite these concerns raised by the Care Quality Commission, there is no record of the Report being discussed at either IGQC or at the Board. The only action we can evidence is that the Divisional Manager for Primary Care and Public Health commissioned two internal reviews in 2013 and 2014 to help support delivery of an action plan to address the areas highlighted by the Care Quality Commission. Concerns around medicines management identified in the Report were also the subject of a detailed report produced by the Lead Manager for Medicines Management for the attention of the Prison Medicine Management Group at the end of January 2014.

The Care Quality Commission undertook a follow up visit in March 2014. This set out a much improved position at HMP Liverpool since its visit in October 2013. Indeed the Care Quality Commission noted:

“We found since our last visit that there had been a small increase in the number of prisoners who had accessed appropriate health screens. We found that the prison regime and recent benchmarking exercises across the prison estate continued to impact on the delivery of the service but that staff within the Health Suite were proactive in their attempts to ensure that prisoners accessed appropriate health care assessments. We found that staff morale across the Health Suite was much improved and that measures had been put in place and continued to be developed to support staff and increase their access and uptake of managerial and clinical supervision. Medication management at the prison had improved and there were plans in place to develop an in house pharmacy service at the prison. We found that since our last inspection the Trust had developed its own complaints form and had provided their own complaints ‘post boxes’ on prison wings and in the out patients department.”

Given what we discuss later in this report in Section 19.7 where we set out what the new leadership team unearthed when it visited HMP Liverpool in June 2014, it is hard to understand how the Care Quality Commission reached the conclusions it did just three months earlier.
11.42 We note that the Cost Improvement Programme across the Trust impacted on the health services provided at HMP Liverpool, particularly in terms of overall staffing levels to run service safely and effectively. A specific manifestation of this was prisoners not receiving a secondary health screen which inevitably placed new prisoners at greater risk and also that no care plans were in place for patients with chronic long term health conditions. This issue was as we have noted in Section 11.24 raised by the HM Inspectorate of Prisons and in Section 11.36 and 11.37 by the Care Quality Commission. The Head of Offender Healthcare also noted as part of the Salmon process that “when the division was making a Cost Improvement Programme they removed the cost of the vacancies leaving us unable to recruit to the vacancies as the budget have been taken as part of the Cost Improvement Programme causing even more problems and poor staff morale.”

11.43 One person we interviewed described the impact of Cost Improvement Programmes on the offender health care service in the following way: “I think it was a combination of the poor management within the prison and the austerity kind of measures, the Cost Improvement Programmes. I think that was just the icing on the cake. You can only lose so much blood before the patient becomes critical, you lose a little bit you’re fine but there comes a point where actually you can’t cover it up anymore, it’s just a very very bad...it happened gradually I think but I think the kind of Cost Improvement Programmes were what sealed the deal in terms of the failure of the clinical governance system.”

11.44 Within the Prison Health Service itself, a total of 299 incidents were reported on Datix during the period of 1 April 2012 and 31 March 2014. These are summarised in Appendix 5 and show that many relate to staff feeling unsafe or not supported in their day to day roles. We have not been able to identify any evidence of follow up action or escalation within the Trust.

11.45 We also strongly believe that this was an under-reporting of the true position, given what was stated to the review team by a member of staff we interviewed: “And there were lots of issues that were escalated and I did know how to Datix and I tried to Datix prison specific issues through to the Head of Offender Health...but to be honest with you I didn’t really seem to get anywhere.”
11.46 In conclusion, this was a service provided to a high risk client group in a complex environment which should have alerted the Board to the need to apply greater scrutiny and oversight. There were also as we have set out above abundant warning signs, whether that was in the limited reporting that came to the Board or the IGQC, in the reports of external bodies such as the Prisons and Probation Ombudsman for England and Wales, HM Inspectorate of Prisons or the Care Quality Commission, alongside Datix reports from the Trust own staff, to have merited further investigation and review and was in our view a significant missed opportunity. From what we have seen, it would be reasonable to conclude that during the time period we have considered in this section of the report, a number of patients received suboptimal care at HMP Liverpool.

12 Intermediate Care Bed Based Service

12.1 In this section of the report we have looked at a range of issues and concerns within the Intermediate Care Bed Based Service. The section brings together the way risk issues within the Intermediate Care Bed Based Service were surfaced but which were then downgraded as they permeated their way upwards in the Trust, how a healthy culture of incident reporting failed to realise any significant action, why senior clinical staff who worked in the service then became the subject of disciplinary action and we explore the role of the Board in relation to these issues.

12.2 By way of background, there were some changes to the configuration of the Intermediate Care Bed Based Service after the establishment of the Trust in November 2010 but essentially by March 2012 the Intermediate Care Bed Based Service comprised four separate wards on three different hospital sites:

- Wards 9 and 11 in the Alexandra Wing at Liverpool Broadgreen Hospital;
- Ward 2a on the Royal Liverpool Hospital site;
- Ward 35 at Aintree University Hospital.
12.3 The key changes in the period between November 2010 and March 2012 are: when the Trust acquired community services for the majority of Sefton on the 1 April 2011, the Intermediate Care Bed Based Service was expanded to include Ward 35 at Aintree University Hospital; and in February 2012, Intermediate Care Bed Based Service in “Kent Lodge” on the Liverpool Broadgreen Hospital site was separated out into Wards 9 and 11 on what at the time was the new Alexandra Wing on the Liverpool Broadgreen Hospital site.

12.4 In terms of scale, from February 2012 onwards, the Intermediate Care Bed Based Service comprised a total of 101 beds, split in the following way:

- Ward 2a - 22 beds (The Trust relinquished ward 2A in October 2013);
- Ward 9 - 27 beds;
- Ward 11 - 27 beds;
- Ward 35 - 25 beds.

12.5 The aim of the service was to prevent people from being admitted to hospital if possible, to support people to return home after a recent hospital admission, and to enable people to live at home rather than in a care home, if they choose to do so. Similar care models existed then and now across other parts of the NHS and were certainly not unique to Liverpool.

12.6 By the time the changes we have set out in Section 12.2 and 12.3 had worked their way through, managerially the Intermediate Care Bed Based Service had one overall Bed Based Intermediate Care Manager and a Bed Based Intermediate Care Matron. They reported to the Integrated Care Manager who in turn reported to the Divisional Manager for Adult Services & Deputy Director of Operations and who then reported to the Director of Operations & Executive Nurse. A Nurse Consultant also worked for some of his time in the Intermediate Care Bed Based Service and he reported to the Director of Operations & Executive Nurse.
12.7 As part of our review we interviewed a number of people who worked within the Intermediate Care Bed Based Service and who had oversight of the service managerially. There was broad agreement amongst many of the interviews we conducted that the Intermediate Care Bed Based Service had faced a number of long-standing challenges. Some of these were clinical in nature, others operational, and that some of these problems predated the creation of the Trust in November 2010 and that some of these challenges were still present when the Intermediate Care Bed Based Service was expanded to include Ward 35 in 2011. There was also a broad consensus amongst the staff we interviewed that different sets of clinical and operational practices prevailed across each of the four separate wards that comprised the Intermediate Care Bed Based Service.

12.8 Indeed in our interview with the Chief Executive, she acknowledged the long-standing nature of the problems in the Intermediate Care Bed Based Service: “I think there was always a lot of tension around the role of those wards with the acute service, those staff were often under pressure to take patients that didn’t necessarily fit the criteria, you know about that, that happens everywhere, it’s no different than anywhere else. I think we also had some incidents, serious incidents that we investigated that was a while ago, a couple of falls that happened in a period of time so that was further investigation. So we had always felt that there were some challenges...around the clinical issues and about being systematic about doing intentional ward rounds and that sort of thing as well as clinical leadership but that was always compounded by the acute sort of pushing to try and get patients in.”

12.9 In one interview it was stated to us that the Intermediate Care Bed Based Service “was meant to be for patients who were medically fit for discharge and yet we had some patients on that unit that were acutely ill and actually, yeah we didn’t have the staffing, the nursing complement to support that.”

12.10 Whilst another stated that the governance model for the Intermediate Care Bed Based Service was “ill defined...in terms of medical responsibility...that was an oversight and should have been addressed at the time.”
12.11 Concerns around this issue we were told had been escalated upwards in the Trust on numerous occasions but had not elicited any significant change that had a lasting impact. Indeed one member of staff we spoke with stated: “I flagged it up with Craig [Craig Gradden, Medical Director] and with Helen [Helen Lockett, Director of Operations & Executive Nurse], in terms of pushing them to have this meeting to discuss acuity...and the response that I got back was: Craig [Craig Gradden, Medical Director] had been to the ward the day before, and wasn't happy that the toilet door didn't open in a certain way, which was potentially breaching patient's dignity. I thought that I'd just presented her [Helen Lockett, Director of Operations & Executive Nurse] with a list of patients, you know, that potentially the acuity level wasn't right for our unit. The Medical Director had been over the day before, and his feedback is: potential patient dignity risk, because of the way a door opened. And the balance there, to me is, what's the priority? Is it the actual risk around the patients' security or around...both equally as important but, surely the balance on the patients' safety was a big one?”

12.12 It was a service that received focus at both the IGQC and its key sub-committee, the Healthcare Governance Sub-Committee (HGSC). Indeed, of the twelve meetings of the IGQC that took place in 2011 and 2012, six separate reports were received on the Intermediate Care Bed Based Service. These ranged from covering complaints, to infection control to slips and falls, to improving quality within the Intermediate Care Bed Based Service. What is interesting when we look at these reports however is that whilst progress was inevitably made to improve many aspects of the clinical and operational issues within the Intermediate Care Bed Based Service, change was not sustained and from the start of 2013 concerns start to further increase about a number of aspects within the Intermediate Care Bed Based Service.
12.13 The minutes of the HGSC meeting held on the 17 January 2013 note under the “Divisional Governance Service Update” from the Adult Services Division the following: “Staffing Issues on Intermediate Care Bed Based, with the Service currently on red status” and “Sickness levels...within Intermediate Care Bed Based (11%) continue to be an issue.” The minutes of the meeting however also note that HL [Helen Lockett, Director of Operations & Executive Nurse] disagreed with the high risk rating placed on this service, with the minutes recording “Adults Workforce: HL stated that this Risk should not be rated at 20 (5x4)” and that this should be feedback to Adults Services Division.

12.14 This was clearly documented in the minutes of HGSC and therefore was reported to the IGQC, although not reported in the “Key Issues” report that provides an overview report to IGQC on the HGSC meeting.

12.15 The minutes of the IGQC meeting held on the 5 February 2013 include a matter arising from the December 2012 meeting, and states – “Item 8 Falls Update - HL [Helen Lockett, Director of Operations & Executive Nurse] has commissioned a full review of staffing levels in bed based services. BC [Bernie Cuthel, Chief Executive] highlighted the importance of getting the model right in order to meet the needs of the service and the patient. HL [Helen Lockett, Director of Operations & Executive Nurse] informed the Committee that an agreed action plan will be presented at the next meeting in April 2013.” We can find no evidence that these subsequent reports or action plans were ever brought before the IGQC and it did not appear on any further matters arising.

12.16 The minutes of the HGSC meeting held on the 13 February 2013 meanwhile noted: “Adults Services – Staffing Issues remain at 20 on the Divisional Risk Register. District Nursing and Bed Based remain on red alert and in business continuity” and “CR [Carol Rodgers, Harm Free Care Lead] undertaking a review across bed base incidents and will report back to Divisional Lead, as the issues that have been identified are significant and are seen in context against high vacancy and high sickness rates.”
At the 14 March 2013 HGSC meeting, as part of the report on the “Adult Division Risk Register” it was stated the bed based workforce risks should be reported through to IGQC as one of the high strategic risks for their consideration.

However, partly due to the timings of meetings, the report to 18 April 2013 IGQC meeting of the 14 March 2013 HGSC meeting did include the discussion to include the risk within the Intermediate Care Bed Based service on the strategic Risk Register and indeed the Divisional Risk Register was included as an agenda item at the 18 April 2013 IGQC and discussed. The relevant minutes of IGQC state: “Divisional Risk Register...requires current position and mitigating actions. If risk remains at 20 consider escalating to Strategic Risk Register.”

We can however establish no report back to IGQC on the current position and mitigating action other than the minutes of the 18 April 2013 HGSC meeting that state, “Action Complete. Risk will not be escalated to Strategic Risk Register and has been downgraded to a 16 (4x4).” It is not clear who made this decision or on what it was based in terms of controls and mitigation, as the minutes of that IGQC meeting do not provide that additional detail.

A member of staff who we interviewed and was critical to the risk in bed base being graded at 20 stated to us during their interview “So anything that was 20 or above - I think it was 16 and above really, on the Risk Register, definitely 20 should have gone into the Board Assurance Framework. It went into September/October time...members of that sub-group, said that I was over-egging the risk, it wasn’t a 20, it should have been downgraded to 16. And I absolutely said, categorically that we were in business continuity now, that we had staff being deployed from other areas...in the November meeting...it’s in the minutes of the meeting...where Helen Lockett [Director of Operations & Executive Nurse] said to downgrade the risk to 16...I went back to the December meeting and I got, basically, blasted in the meeting for leaving the risk at 20.”
12.21 The Non-Executive Director members of the IGQC and by virtue of the fact that the minutes of their meeting went to the Board meant the full Board were aware of the potential risks in the Intermediate Care Bed Based Service but there is no evidence that the Non-Executive Directors sought further assurance or challenged the downgrading of the risk without seeing the appropriate controls and mitigation that had been put in place.

12.22 The downgrading of risks is particularly surprising in our view given that just two months earlier, an internal report entitled “Intermediate Care Incident Report” (February 2013) which was as we have stated in Section 12.16 commissioned by the HGSC set out that there has been a total of 802 Datix reports submitted by staff in the Intermediate Care Bed Based Service from April 2011 to January 2013. The report also set out in detail some of the wider concerns within the Intermediate Care Bed Based Service.

Extract from the “Intermediate Care Incident Report” (February 2013)

“The Intermediate Care unit has been subject to high levels of vacancies, sickness and absence. The wards have been at business continuity for a number of months and a number of strategies put in place in an attempt to secure sufficient staffing levels to support continuity of care, safety and quality. Risk Registers reported to local health care governance have consistently been reporting staffing issues on an on-going basis and the risk rating has consistently been graded at 20 post controls.

The service lead has remained clear in the assessment of the risk and not reduced the risk scoring in relation to the staffing of the unit. In addition to the staffing matters, it is being reported on an on-going basis that the acuity of the patients being admitted to the wards has increased and the pressures to move patients out of the acute trust has resulted in patients being admitted who are not deemed by staff on the wards to be medically stable/fit for transfer to the unit. The current critical staffing problems has meant that Ward Managers, Matron and Intermediate Bed Based Manager have not had the opportunity to follow through all of the incidents reported in such a way that support lessons learnt.”
The review concluded by noting:

“*In conclusion, it is clear from the review that there is a whole system review required in relation to working practices. Critically at this point there is a requirement to review the risk assessment in relation to the staffing and consider whether the controls are sufficient to mitigate the current significant risks in the system.*

*The review has highlighted some areas where there is notable practice. Particularly in the development of the systems which have been put in place to support analysis of data. In addition and of more importance is the fact that when patients have been admitted to the wards who are not fit for transfer the staff have worked to escalate the situation in most cases and ensure patient safety.*

*The staff on the ward are to be commended for continuing tirelessly to provide care, and reporting of compromised patient care. It is clear that the staffing situation has led to intolerable practice being tolerated. There are lessons to be learnt at all levels of the organisation.*”

Just three months from the date of the “Intermediate Care Incident Report”, a Care Quality Commission visit to Ward 35 in May 2013 at Aintree Hospital confirmed that the service was meeting all five key standards (respecting and involving people who use services; care and welfare of people who use services; meeting nutritional needs; safety, availability and suitability of equipment; supporting workers). Perhaps this external report, albeit, on just one part of the Intermediate Care Bed Based Service provided false assurance to the Trust that the service was indeed improving, though it is hard to understand how this Care Quality Commission report could have drawn the conclusions it did given the concerns set out in the “Intermediate Care Incident Report.” We have not been able to ascertain if the Care Quality Commission had sight of the “Intermediate Care Incident Report” produced in February 2013.
12.25 We also heard during the course of our review from a number of people who provided some very powerful testimony of the pressures and the culture within the Intermediate Care Bed Based Service.

12.26 One staff member we spoke to stated “...they all felt like whipping boys all the time. Every time things weren’t going right bed based staff and bed base got the blame and they removed the managers.” Whilst another stated “there was a lot of micro management. I felt staff pretty much damned if they do damned if they don’t.”

12.27 Two months after the positive Care Quality Commission report into Ward 35 was published and in the light of “ongoing concerns about the Intermediate Care Bed Based Service”, on the 9 July 2013 three clinical staff who worked in or with the Intermediate Care Bed Based Service were suspended from duty. They were a Nurse Consultant, the Bed Based Intermediate Care Manager and the Bed Based Intermediate Care Matron. This action had been prompted by a number of allegations against them which included, but were not limited to, “concerns being raised by staff and suppressed by the clinical leadership team; whistleblowing allegations not being acted upon and failure to escalate and act following incidents.”

12.28 Not surprisingly, this key letter to the affected staff had a major impact on them but was then replaced by another letter issued on the 12 July 2013 which was now headed “temporary redeployment to project duties and suspension of clinical practice/leadership.” The letter also changed the nature of the specific allegations against the staff concerned to now read “concerns being raised by staff not being dealt with by the Clinical Leadership team and failure to escalate appropriately within LCH [the Trust]; failure to act appropriately to incident, concerns and issues raised; whistleblowing allegations not being acted upon.”

12.29 The private Board on the 31 July 2013 received a detailed paper from the Director of Operations & Executive Nurse setting out the concerns that had been identified within the Intermediate Care Bed Based Service and the action that the Trust had taken. Interestingly and perhaps surprisingly given their importance, the paper to the Board failed to make reference to the downgrading of the risks as set out in Section 12.19 above or the “Intermediate Care Incident Report” in Section 12.22.
The Trust commissioned an internal investigation into the three affected clinical members of staff. This was undertaken by a Business Development Manager within the Trust and this reported in October 2013.

The Care Quality Commission carried out a further inspection on Ward 35 in November and December 2013 in which the Trust failed on the following standards: care and welfare of people who use services; management of medicines; staffing; supporting workers; assessing and monitoring the quality of service provision. This reinforces our concerns about the earlier Care Quality Commission inspection which we referenced in section 12.24.

The review undertaken in the Intermediate Care Bed Based Service by the Business Development Manager became subject of a further review which was commissioned in February 2014 by the Chief Executive [Bernie Cuthel] from Sue Miller, an independent management consultant with extensive human resources experience.

When we interviewed the Chief Executive, she explained why she had decided to commission this further review: “I just didn’t feel right. We knew we had an issue, we did know there were some issues with those individuals but actually it was a bigger issue for me around how that ward operated, the way Human Resources behaved towards that ward [the Chief Executive clarified as part of the Salmon process this to mean the application of HR disciplinary policy as applied to this situation], and actually you can’t go from no sort of disciplinary action to potential serious misconduct in such a short space of time, and you couldn’t say it’s about one person because it was a collective series of factors, that was my view. And I had very clearly said we need to deal with this differently, we want a different outcome, let’s try and resolve the issue. And because that wasn’t how it worked I actually asked Sue Miller to do a complete review which would be completely objective which would give those individuals a chance to have their say and that’s what I didn’t feel had happened either. Nobody had said to them “Tell me what’s going on.” It was some assumptions, so we asked people to do an investigation but I don’t think that reflected the tell me this story from your perspective about what was happening and how you felt and all of those sorts of things.”
The Chief Executive had requested an independent review of actions taken in relation to the three affected clinical members of staff. The aims of this review were to:

- Identify the decision-making processes leading to the decision to suspend, and the investigation in terms of Trust actions in relation to the three individuals identified in the report;

- Identify whether any further, or different, actions may be appropriate in relation to the decisions concerning the individuals on the ward. If so, set out options for this where possible;

- Identify, with the participants in the review, any learning from this process for the future.

At the point Sue Miller reported her findings to the Trust in April 2014 Sue Page had already been appointed Interim Trust Chief Executive.

The Sue Miller review we found not only to be comprehensive in its scope but felt that it drew out the key issues and set out a series of conclusions and recommendations we felt were well reasoned, balanced and clear.

We found that the Sue Miller report acknowledged the concerns within the Intermediate Care Bed Based Service at the time the three affected clinical members of staff were suspended and that there had not been a suitable acknowledgment in the previous report conducted by the Business Development Manager report of the part played by those more senior in the Trust, who had been made aware over some considerable time about concerns within the Intermediate Care Bed Based Service and had failed to provide the necessary leadership to address those. Indeed the Sue Miller report noted “I do consider that it focused the spotlight on the role of those three individuals and that there were senior management responsibilities as well as wider structural and systems issues which need addressing.”
12.38 We would also concur with the view expressed by Sue Miller about the commissioning of the investigation, that allegations about each of the three affected clinical members of staff shifted over time and that the report should have specifically set these out, which allegations applied to which of the three affected clinical members of staff and addressed them in a systematic way.

12.39 We found the discourse at the Board which we refer to in section 12.29 failed to fully acknowledge the long standing nature of many of the issues within the Intermediate Care Bed Based Service and in that failed to acknowledge the extensive discussions at IGQC on this matter or the escalation of issues from the IGQC to the Board. Critically, those Board discussions also failed to adequately acknowledge the impact on the Intermediate Care Bed Based Service of the Trust’s Cost Improvement Programme. This had meant that at February 2013 there were a total of 33 vacancies and a long drawn out and complex recruitment process in place which meant that it took some four months between the identification of a vacancy and an individual being identified to take up the post. This was further compounded by a sickness rate within the service of around 11%. Indeed these issues were all present on the Divisional Risk Register for Adults from certainly 1 November 2012 onwards and as we have set out earlier in Section 12.19 the high risk rating was downgraded at the IGQC.

12.40 Our view is that if those long standing issues within the Intermediate Care Bed Based Service had been addressed earlier and decisively, it may have lessened the need to suspend three clinical leaders later down the road and all that ensued thereafter. Indeed as one senior person we interviewed commented:

“D’you know what, when that happened I was absolutely devastated because, this was anticipated the year before in September, October and November - it was all anticipated, in terms of the risks and the staffing issues. It wasn’t just devastating for those three; it was to do with the staff. Because it was okay that there were challenges within management, there were probably development needs within management. But, arguably the organisation had let the staff down through the vacancies. You know the risks within Bed Base and the way the staff were burnt out, was to do more with the amount of vacancies that was going on.”
Okay, the acuity was a challenge, in terms of what was coming out of the acute. But, you know, if they’d had got the staffing right, if there had been more medical leadership, because the medical leadership was questionable... in terms of the levels of acuity that was coming out, it wouldn't have got to that sort of state. To actually just take three senior managers out wasn’t.”

12.41 We will return to the Intermediate Care Bed Based Service in Part Two of our report and set out what progress has been made within the service since the arrival of the new leadership team in spring 2014.

12.42 In conclusion, what is clear to us is that concerns around the Intermediate Care Bed Based Service were widely known about within the Trust, and that this had been the case for some time. Those concerns were not acted upon by the Trust in a clear and decisive manner and this represents a failing on the part of those who had oversight of the service. It is clear that patient care was not optimal as a result. It also represents for the review team a further example of a poor Trust culture which sought to downplay risk and apportion blame, rather than address underlying reasons for service failings, or for those in more senior executive roles, to take accountability for their part in ensuring safe and effective delivery of care.

13 **Culture of Bullying and Harassment**

13.1 In this section of the report we set out what we have found around the culture within the Trust and how staff we spoke to described it to us. We also discuss the impact the Trust culture had on staff.

13.2 Several people we talked to spoke of a culture in the Trust where it was difficult to voice concerns about a service or about senior colleagues or where processes designed to learn from errors in service delivery were perceived by staff as threatening and oppressive. They talked about a Board focused on the pursuit of NHS foundation trust status and an Executive Team that was seen as remote and autocratic. We heard from a number of current and previous members of staff who stated that they had been the subject of bullying and harassment during their period of employment with the Trust. The bullying and harassment they referred to operated at two distinct levels.
13.3 The first was at a middle manager level. The allegation from a number of staff we spoke to was that they were the subject of bullying and harassment by people at this level within the Trust. Some of these staff in middle management positions continue to be employed by the Trust today in either the same or now more senior roles. It was suggested to us that this was a consequence of the pressures middle managers were themselves under from Executive Directors to deliver against ever more challenging financial and performance targets and in particular Cost Improvement Programme targets and that perhaps they then pushed this pressure downwards in the Trust.

13.4 The second was at an Executive Director level. These accusations were levelled principally against the Director of Operations & Executive Nurse by a number of staff we spoke with. It is alleged that some of these incidents of bullying and harassment occurred in one to one meetings over a period of time where the likelihood of witnesses would be limited, whilst on other occasions it was conducted in an environment where other colleagues must have heard and/or observed what occurred and took the form of belittling staff, raising concerns about their competency or ability to fulfil their role.

13.5 We appreciate that on occasions strong and robust performance management can be seen by some as bullying, but on this occasion we feel that this was not the case. We have heard many separate accounts which suggest that there was a systematic culture of bullying of staff lower down the organisation, and as part of our review we spoke and met with a number of staff who felt that they had directly experienced that bullying first hand.

13.6 This was in our view part of a wider culture of bullying and harassment within the Trust. Indeed as one member of staff stated “What I will say is, in that 12 month period, May ’13 to April ’14, I was astounded at the number of times I heard the words, ‘bullying’ and ‘harassment’. When I came to the organisation I was shocked to hear it in common parlance, and I consider those words to be very big words, and not easily bandied around.”
13.7 This also comes through clearly in the NHS Staff Survey results for the Trust in 2011 and 2012 which we discuss in greater detail in Section 14 and should have acted as a clear warning sign to the Board and prompted it to take action.

13.8 It also came through in a survey undertaken by the Staff Side, which comprises a number of Trades Unions and professional bodies and who represent all staff in various working groups and consultations within the Trust and work closely with the senior management of the Trust.

13.9 By way of background, following the NHS Staff Survey 2012, Staff Side agreed with the Chief Executive and Director of Human Resources & Organisational Development in late 2012 to undertake a detailed survey of Trust staff to support the organisation in identifying areas of concern and develop strategies to address them. The Staff Side survey was undertaken confidentially during the first two weeks of January 2013, on the Trust Intranet. A total of 10% of Trust staff or 314 members of staff completed the Staff Side survey.

13.10 The main Staff Side survey findings were that respondents felt that Trust had an embedded culture of bullying and harassment which originated from the behaviours of the very senior managers in the Trust. In terms of the specific findings, they were:

- The Trust has a bullying culture which originates from the Chief Executive and the Executive Team;
- That there is poor leadership and lack of management training;
- That the Trust rewards bullying behaviours;
- Staff Side are viewed as unable to challenge and influence the culture;
- 96% of respondents identified bullying and harassment as a problem within the Trust;
- The main forms of bullying and harassment reported were verbal and behavioural, although ten individuals reported unwanted physical contact;
Two thirds of respondents had witnessed these behaviours being displayed to colleagues;

62% of respondents listed stress as a direct effect of bullying and harassment.

13.11 The Staff Side survey was sent to the Chief Executive and Director of Human Resources & Organisational Development on 8 March 2013. It led to some “roadshows” with Trust staff that were led by the Director of Human Resources & Organisational Development. These confirmed staff concerns around the Trust culture. The Staff Side survey was then briefly discussed at a meeting of Staff Side and Trust management on the 16 June 2013. What is clear is that unfortunately the Staff Side survey was not shared with the wider Board, representing a further break from the principles of good governance, nor did it appear to result in any clear action plan other than the “roadshows.”

13.12 It is also regrettable that Staff Side failed to press the Chief Executive and Director of Human Resources & Organisational Development to develop an action plan or raise it with the wider Board. This is particularly perplexing given that there were monthly meetings between Staff Side and Trust management and Staff Side representatives met the Chair on a regular basis. In our view, this represented another missed opportunity to take action. Indeed, the Board was not informed of the Staff Side survey until after two Warning Notices were issued by the Care Quality Commission to the Trust in February 2014. Nearly a year after the survey had been completed.

13.13 The Trust culture also impacted on the way risks and issues of concern were escalated upwards within the Trust. A number of people who we interviewed spoke about so-called “scoping meetings.” These were designed to learn from clinical incidents. However several people we interviewed described the culture and atmosphere as being designed to find personal fault and that the presence of a representative from Human Resources at these meetings, which in our view is most unusual, further exacerbated that feeling.
One member of staff we interviewed stated “From when we’d moved over to part of Liverpool there was a lot of micro management. I felt staff pretty much damned if they do and damned if they don’t. There was a lot of scoping meetings...anything and everything would be scoped. It’s when you basically go to a meeting with senior managers and things are discussed and broken down which can be quite intimidating.” Whilst in another interview they were described as “interrogations, they weren’t investigations” and “they were carried out by clinical staff and Human Resources. Now we don’t really understand why Human Resources was in there. It wasn’t really a Human Resources issue but it was almost like staff were being told name, rank, serial number.”

The Care Quality Commission concluded in January 2014 “Staff told us about the process for ‘scoping’ following a serious untoward incident. For potential serious incidents, a meeting was held to review the incident in detail and decide upon actions to be taken. We were told that this initial meeting included a member of the Human Resource team. Staff told us and records showed that this process was very formal. Staff said they had found it very challenging and had felt intimidated by the process. They told us that they felt the process was about fault finding and blame rather than a learning and improvement opportunity. We were not assured that the approach to incident management and investigation process encouraged an open and supportive culture.” As part of the Salmon process, the Chief Executive stated “Whilst I was aware of the scoping meetings as a means of root cause analysis, I was unaware of the way in which they were conducted, which was inappropriate and unsupportive to the individual, in that they did not create the right environment for learning.”

These meetings came to an end in November 2013 following informal feedback to the Trust from the Care Quality Commission prior to the Care Quality Commission formally reporting in January 2014.
Another interviewee stated “I think people felt they couldn’t report things. I think people were perhaps fearful of reporting things and it leads to a less transparent and open culture, doesn’t it. I think people felt there was a blame culture.” Whilst another stated that the consequence of this culture was “people hide things, they were frightened to admit that they’d made a mistake. And when you’re so short of staff and you’re tired and stressed, things do happen, don’t they.”

We were told on several occasions by the Non-Executive Directors we interviewed that they undertook a regular programme of visits to “front-line” services, met staff in those areas and spent time understanding their challenges. Indeed one Non-Executive Director stated “So no. Definitely nobody shut the door, or said you can’t go there. You could speak to - and still can - whoever you want to speak to.” It is important to acknowledge that much of this work was undertaken by the Non-Executive Directors in addition to their already busy Board and Committee roles.

We have reviewed a sizeable number of reports produced by Non-Executive Directors following these visits. They highlight that Non-Executive Directors undertook a number of visits to front line services and supporting functions and the pro-forma they completed following these visits is comprehensive. Indeed in many ways the comprehensive nature of pro-forma represented good practice. Furthermore, the majority of the individual service visit reports we have seen are detailed in their coverage of positive areas observed as well as areas for further attention.

We also heard from the Chief Executive that she held monthly breakfast meetings, and as a result of these and the feedback received, took actions to address the issues raised. This was alongside other initiatives such as “back to the floor” which enabled the Board to connect with staff across the Trust.

It is difficult to explain then, given the Board was visible across the Trust, why they did not subsequently pick up any concerns about these matters through their conversations and interactions with Trust staff. This is particularly so given the widespread nature of the concerns around a negative Trust culture as drawn out in the NHS Staff Surveys and in the Staff Side survey. Indeed this has been one of the most perplexing questions for the review team.
13.22 This perhaps again reflects the point made earlier in Section 7.43 that the Non-Executive Directors needed to develop that ability to challenge and scrutinise and that they did not adopt that inquisitive approach when they undertook these visits, though we do accept that some of those visits were designed and managed by senior managers in specific service areas in such a way that Non-Executive Directors did not in reality get a true picture. Indeed phrases such as “stage managed” and “royal visits” were used by several people we interviewed to describe visits by Non-Executive Directors to front-line service areas. Indeed one member of staff stated to us “they came and we were told...to behave and be nice to them.”

13.23 This was however denied strongly by the Chief Executive who stated “they definitely weren’t set up like that and when the non-execs came back they always had the list of things that weren’t going well which is what we wanted them to do. They could ask the very obvious questions of course and would have assumed no knowledge so they definitely weren’t set up in that way and I was always very keen that we met with the front line staff...but I suppose I can’t necessarily account for how people conducted themselves at that time.”

13.24 Though another senior member of staff we spoke to stated: “it sometimes seemed to me that it became a structured type of visit, almost a set piece...it was almost like the people knew what the questions were going to be that the Non-Execs were going to ask and sometimes it felt that it would have been better to just go and talk to the staff...but I think some of the Non-Executives felt they were arriving and the Manager would greet them and give them an introduction and they had a template that they filled in and brought back to the Board.” A rare example of tangible change following one such meeting of a Non-Executive Director with front line staff was around the timescales to recruit to post. This formed part of the Trust approach to delivery of the Cost Improvement Programme. These could take anything from four months upwards between being advertised and the person being identified to take up post. As one senior member of staff we spoke to stated “And that’s what I shared with Wally [Wally Brown, Non-Executive Director]...and we walked him through the process and we said this is shocking and these are the risks and, and he said “right, leave it with me”...at the next Board meeting he formally raised it.” We can track this through the Board and the changes it elicited in the recruitment process thereafter.
13.25 The issue of a bullying and harassment culture came to the fore most powerfully in the Care Quality Commission report on the Trust which was published in January 2014 which stated that “Staff told us that they had not had access to recent performance reviews and appropriate supervision for clinical staff. Staff told us that they felt unsupported by the Trust. We received in excess of fifteen negative comments from staff prior, during and after the inspection about a culture they found unsupportive and oppressive across the Trust.”

13.26 Following the publication of the Care Quality Commission report in January 2014, the Trust approached the national organisation, the Advisory, Conciliation & Arbitration Service (ACAS) for assistance in order to review the culture within the Trust. ACAS provides impartial information and advice to employers and employees on all aspects of workplace relations and employment law. This was an important piece of work which drew out a range of issues about the views of staff in the Trust at the time. On one level it is therefore a credit to the Chief Executive that she commissioned it. However in some ways the ACAS report was commissioned at least a year too late and perhaps had it been commissioned when the NHS Staff Survey results for 2012 and arguably 2011 were published, given that they set out more clearly than the report from the Care Quality Commission did, the extent of negative feeling within the Trust, they may have led to changes which may have avoided the damaging Care Quality Commission report in January 2014 and all the subsequent events that unfolded.

13.27 A key responsibility for the senior leaders within the Trust, namely the Board, is to shape a healthy culture for the organisation and the review team feel that the Board collectively failed to do that here. Indeed the Board in our view contributed to that culture.

13.28 Furthermore that when confronted by the facts, our view was that the Board was in denial. Indeed when we look at the notes of the Board Time Out session held on 10 December 2013, we note that at this stage the Board knew the key findings of the Care Quality Commission inspection that had been undertaken in the previous month, but which publicly did not report its findings until January 2014.
The notes of the meeting stated: “BC [Bernie Cuthel, Chief Executive] commented that the informal feedback provided by Care Quality Commission had been difficult to receive. It had been highlighted that they felt LCH [the Trust] had a punitive culture and that there was a lack of integration between services in the Liverpool and Sefton areas.”

The meeting went onto note: “FM [Frances Molloy, Chair] stated that once the formal report had been received, although LCH [the Trust] may be able to challenge the facts, we would be unable to challenge the Care Quality Commission’s judgement. External PR support, from a provider with local knowledge, has been obtained by LCH [the Trust].”

The Chair went onto acknowledge “that moving forward LCH [the Trust] needed to form a relationship with Care Quality Commission on a regional level, in order to present in a constructive manner some of our own feedback around clarification of the Terms of Reference of the visit, and the potential impact on staff who were interviewed for several hours by Care Quality Commission representatives.”

Discussion followed around the possible publication date of the Care Quality Commission formal report and how best to handle the media interest and where the Chair noted “that the newly appointed PR company were primed to manage the situation.”

What we find no evidence of in these discussions is any attempt by the Board to truly understand staff concerns, the factors behind them, why the Board had failed to identify them earlier, what actions were to be taken to address them or indeed the Board’s role in bringing about change.
As one senior member of staff we interviewed stated “I think it felt very much like, at that time it was like a kick-down right from the top...and it was translating all the way back down into the Service. So it was exactly that kind of hierarchical set-up that, you know, very much a top down, you know, kick all the way down the food chain to the staff and it wasn’t really very healthy at all. In fact it’s probably the most un-healthy organisation I’ve ever worked in by some distance at that time. Just because those key individuals I think forgot what we were actually, what we’re actually here to do. You know, so we have ‘Care’ painted on the walls as one of, you know, one of the five C’s but there wasn’t any care and there certainly wasn’t any care for the staff, the staff were treated abysmally, I think we were treated abysmally throughout this process and, you know, it felt like a witch hunt, it absolutely felt like a witch hunt.”

The same person we spoke to also stated “People I think lost sight of the need to be okay with the staff, you know, to, let’s look at the way we’re treating the staff, it’s very much, I felt kicked down at the staff, it wasn’t just about, you know, let’s not make excuses for people here, this wasn’t just about ‘oh people are under pressure because of the NHS Foundation Trust pipeline’ people got treated terribly by some of those people in the Executive Team, some of those people that have gone out. And I don’t know why that was, people were under pressure yes but we’re all human beings, you know what I mean.”

In so doing, the Board ignored one of key findings of the Francis Inquiry (The Mid Staffordshire NHS Foundation Trust Inquiry, 2010) which identified “an unhealthy and dangerous culture” as a pervading cause of the failures at Mid Staffordshire NHS Foundation Trust. That culture, the Francis Inquiry report noted was characterised by:

- Disengagement by medical leaders;
- Discouragement of feedback from trainees;
- Target-driven priorities;
- Isolation;
- Lack of candour;
- Bullying;
- Low staff morale;
Acceptance of poor behaviours;
Reliance on external assessments;
Denial.

13.37 We found, almost without exception, the presence of all these factors within the Trust to varying degrees.

13.38 In conclusion, as Francis said, “It is a truism that organisational culture is informed by the nature of its leadership” and that effective leadership at Mid Staffordshire was “significantly lacking.” We regrettably found the same at the Trust.

14 NHS Staff Survey Results

14.1 In this section of the report we focus in detail on the findings of the NHS Staff Survey results for the Trust in 2011 and 2012 in particular. We feel that if they had been analysed properly and given the level of scrutiny they deserved, they would have raised the need for further questioning, analysis and action which could have been taken early in the life of the Trust. The Board in our view did not need to wait until January 2014 for the Care Quality Commission inspection report into the Trust to state that the culture was “unsupportive and oppressive across the Trust.” In our view the NHS Staff Survey 2011 showed clearly there were emerging concerns in these areas within the Trust and that by the time the NHS Staff Survey 2012 was published, it was clear that those concerns had reached quite significant proportions. That the Board focused so little time on the results of these two NHS Staff Survey results and that it took no subsequent action when they were published represents to the review team a further missed opportunity.

14.2 The NHS Staff Survey is an annual, national survey of NHS employees which began in 2003 and it is intended to collect the views of staff about working in their NHS organisation.

14.3 The NHS Staff Survey is a mandatory undertaking for all NHS trusts and the results are primarily intended for use by NHS organisations to help them review and improve staff experience so that staff can provide better patient care.
14.4 The Care Quality Commission uses the NHS Staff Survey results to monitor ongoing compliance with essential standards of quality and safety. All trusts are obliged to appoint an independent NHS Staff Survey administrator, which is responsible for selecting a minimum sample set of staff, coordinating the issue, collation and analysis of NHS Staff Survey questionnaires, and producing a full NHS Staff Survey report for the Trust. The NHS Staff Survey administrator appointed by the Trust was the Picker Institute, whose service user and staff experience programmes are used nationally and internationally, by both commissioners and providers of care, to measure and improve people’s experiences.

14.5 The NHS Staff Survey questionnaire covers five key themes relating to the working environment and individuals’ experience within the workplace. These five themes were slightly modified in each of the years we consider below but primarily they are as listed below:

- ‘Your Personal Development’ - questions about the type and quality of the training, learning and development respondents have received and the type and quality of appraisals respondents have received;

- ‘Your Job’ - questions about the respondent’s experiences of working at their organisation and in the NHS, including: team working, involvement in decision making, job satisfaction and how engaged staff are in their jobs;

- ‘Your Managers’ - questions relating to immediate managers and senior managers, feedback from management, communication and support from management;

- ‘Your Organisation’ - questions relating to the organisation as a whole, including whether training is encouraged, whether staff would recommend treatment to their friends and family, and whether soap and paper towels are available when they are needed;
Quality, safety and management assurance review
Liverpool Community Health NHS Trust

- ‘Your Health, Wellbeing and Safety at Work’ - questions about the impact of job role on health, pressure to come to work when feeling ill, witnessing incidents and errors, raising concerns at work, physical violence, and harassment/discrimination.

14.6 The minimum sample size for NHS trusts whose workforce exceeds 3,000 staff is 850, although organisations may elect to apply the NHS Staff Survey to more than this number. The minimum sample size (or ‘Basic Sample’) is ‘randomly’ selected from the full staff list (at 1 September in each year) by the NHS Staff Survey administrator. The random selection methodology is such that the Basic Sample is statistically representative of the entire substantive workforce. The NHS Staff Survey is then conducted between October and December each year and the full results provided to the Trust in the February of the following year.

14.7 However, as the Basic Sample represents a relatively small section of the overall Trust workforce, for each NHS Staff Survey since 2011, the Trust elected to extend the NHS Staff Survey to all substantive members of staff. This provides for:

- A greater level of confidence in the validity of the NHS Staff Survey outcomes;
- More effectively highlights key themes;
- Better informs responses to particular areas of concern.

14.8 The NHS Staff Survey 2011 for the Trust was sent to a total of 3,008 employees of which 1,474 were completed; a response rate of 50.4%. This compared to an average response rate of 53.3% for other community NHS trusts nationally. In a number of areas the Trust results were not as positive when compared to the average for community NHS trusts nationally as the table below shows. In each of the NHS Staff Survey questions, staff are asked to “agree” or “disagree” with each of the statements that are provided and in the table below the Trust results are compared to the position in a number of other similar community NHS trusts nationally.
### NHS Staff Survey Theme and Questions

<table>
<thead>
<tr>
<th>Theme</th>
<th>Trust</th>
<th>Community Trust Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work-Life Balance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust not committed to staff work/home balance</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>Immediate manager does not help me find good work-life balance</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td><strong>Your Job and Organisation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not involved in deciding changes that affect work</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td>Dissatisfied with recognition for good work</td>
<td>28</td>
<td>24</td>
</tr>
<tr>
<td>Dissatisfied with freedom to choose own work method</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Do not get feedback about how well I am doing my job</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>Senior managers do not try to involve staff in important decisions</td>
<td>44</td>
<td>38</td>
</tr>
<tr>
<td>Communication between senior management and staff is not effective</td>
<td>43</td>
<td>39</td>
</tr>
<tr>
<td>Senior managers do not encourage staff suggestions for improving service</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td>Do not know who senior managers are</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Not encouraged to develop own expertise</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Not able to make suggestions to improve the work of my team/department</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Opportunities to show initiative infrequent in my role</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Not able to make improvements in my area of work</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td><strong>Errors, Near Misses and Incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In last month, saw errors/near misses/incidents that could hurt staff</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>In last month, saw errors/near misses/incidents that could hurt patients/service users</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Trust does not treat fairly staff involved in errors</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Trust blames/punishes people involved in errors/near misses or incidents</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td><strong>Violence, Bullying and Harassment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harassment, bullying, or abuse from patients/service users, their relatives or members of the public</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Harassment, bullying or abuse from manager / team leader or other colleagues</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Trust does not take effective action when staff physically attacked by the public</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Trust does not take effective action when staff bullied/harassed/abused by the public</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td><strong>Health and Well-Being</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate manager does not take a positive interest in my health &amp; well-being</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>In last 3 months, have come to work despite not feeling well enough to perform duties</td>
<td>63</td>
<td>60</td>
</tr>
<tr>
<td>Felt pressure from manager to come to work despite not feeling well enough</td>
<td>32</td>
<td>23</td>
</tr>
</tbody>
</table>
The verbatim comments from Trust staff for the NHS Staff Survey 2011 were not many. Indeed they numbered less than 50 in total. However within them we detected worrying signs of emerging concerns amongst staff. We have included some of these verbatim comments below so as to provide a flavour of the concerns that staff had expressed even at this early stage in the life of the Trust. Where there were typing errors in people’s comments we have corrected those for the benefit of this report and for ease of reading.

“In the past 12 months our team of managers were bullied by an interim manager who highlighted issues we as ward managers had continuously highlighted but had been ignored. We were blamed and were given no opportunity to defend ourselves and this interim manager was allowed to continuously intimidate and bully us, senior management ignored all our concerns and allowed this to continue.”

“No senior management of the Trust come to see how we work (prison service address).”

“Staffing levels are constantly compromising patient care and staff safety, despite managers attempts to have these reviewed with senior management no improvements are made. The levels of stress on the work environment are detrimental to patient care.”

“A negative, borderline bullying style of management is taking root in this organisation at executive level, which is permeating. This is engendering a climate of anxiety and fear among subordinate managers, which, because of its source leaves those affected feeling personally vulnerable and powerless to object. It is for that reason that I would seriously advise anyone I knew considering applying for a vacancy here to think carefully before doing so.”

“There is a lack of leadership and direction within the Trust. Priorities are constantly changing and staff are often put under unreasonable pressure to perform and their expertise and advice is regularly ignored. There is a strong and persistent culture of bullying and harassment…from the Chief Executive downwards.”
“A chasm exists in this organisation between clinical staff and operational management. This style of reactive operational management appears to prefer punitively pursuing investigations via relentless scoping meetings etc. in relation to incidents rather than developing a proactive approach with insight into the causes of such incidents and becoming aware of the key issues such as poor staffing levels/skill mix or the day to day pressures of clinical work in community-based settings.”

14.10 These results were received into the Trust in February 2012 but they were not even brought to the attention of the IGQC until December 2012 - a full ten months after being received. There is no explanation in the paper provided to the IGQC to explain this delay, nor is there any evidence that the IGQC chased the NHS Staff Survey results. They were presented to the IGQC meeting held on the 18 December 2012 under the heading “Staff Survey 2011 Update.” The paper to the IGQC noted “The full report was analysed over a series of meetings and discussions, involving Staff Side representatives. A number of key themes were identified that would require attention over the next 12 months. These are outlined in the Action Plan (and aligned with the relevant Corporate Objectives). The Action Plan provides a high level dashboard of key issues. Individual action plans will need to be developed by the appropriate lead teams.”

14.11 The subsequent minutes of the 18 December 2012 IGQC minutes recorded the following “Staff Survey Action Plan Update: MP [Michelle Porteus, Director of Human Resources & Organisational Development] stated that the paper reflected last year’s survey as the results would not be received for this year’s until February. It was noted that good progress had been made in most areas, but that more focus was required in developing staff ideas and innovation and in improving training levels Action: MP [Michelle Porteus, Director of Human Resources & Organisational Development] to report back in April 2013 on this year’s survey results and action plan.” There is no evidence from the minutes of any scrutiny whatsoever being applied across any of the NHS Staff Survey 2011 findings by the IGQC and no subsequent discussion at the Board either.
We observed that the full report into the Trust NHS Staff Survey 2012 results was considered at the IGQC meeting on the 5 February 2013. The minutes of the meeting note “It was reported that the results of this year’s Staff Survey indicate that where the organisation had targeted actions last year there had been an improved response. MP [Michelle Porteus, Director of Human Resources & Organisational Development] informed the Committee that some of the points raised by staff were around not feeling trusted and valued, not being able to give the highest standard of care and about there not being enough staff to do the job. As a result of the findings, working groups are being set up with staff in order to focus on identified problem areas and action plans are being developed in conjunction with Staff Side. BC [Chief Executive] highlighted the importance of improving low morale and focussing on what the organisation does well.” The Committee resolved that the “Executive summary on the results of the Staff Survey to be submitted to the Board in April along with an action plan.”

No such report was ever subsequently submitted to the April 2013 Board meeting, despite which the Chief Executive stated that “We did have issues with the action plan, the action plan for the staff survey, I remember that. It seemed to take a long time to produce” but also added “we did take them seriously and Michelle Porteus [Director of Human Resources & Organisational Development] and I did a series of road shows with the staff and we talked about bullying and harassment and sort of putting it out there and saying this is actually some of the issues and these are some of the behaviours we would – this is what we would expect to see and how you should behave towards each other.”
14.14 At the same time the Chief Executive also raised a point around whether due attention had been given to supporting staff when the Trust acquired community services for the majority of Sefton from the 1 April 2011. She stated “I do feel that particularly Sefton there wasn’t sufficient work done around the – we’d done integration through the managerial integration and we’d ensured…Sefton were part of the senior management team but what we may not have done well enough is to integrate those staff who had been moved around a lot so these are a group who had been moved again – these staff had been moved on multiple times in Sefton because they were a smaller group of staff. So there were two PCT’s, there was one PCT, then they were moved to LCH [the Trust] so this is a group of staff that over time have been moved around organisations…so they are not starting off on a very strong constructive platform.” Whilst we do not on balance think it played a significant part it highlights that these issues do need to be attended to during such programme of change.

14.15 The results of the NHS Staff Survey 2012 showed that the Trust had a response rate of 56.2% (1,515 out of 2,697 eligible staff completed the survey). This compared to an average response rate of 54.6% for other community NHS trusts nationally.

14.16 Some of the key findings for the Trust and how they compared to the position in other similar community NHS trusts nationally are shown below. Perhaps most telling of which is that when compared to the NHS Staff Survey results for 2011, the 2012 survey showed that on the specific question of “Harassment, bullying or abuse from manager/team leader or other colleagues” the 2012 figure showed that 23% staff agreed with that statement compared to 13% the year before.
<table>
<thead>
<tr>
<th>NHS Staff Survey Theme and Questions</th>
<th>Trust</th>
<th>Community Trust Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Personal Development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No training in how to deliver a good patient / service user experience</td>
<td>30</td>
<td>24</td>
</tr>
<tr>
<td>Appraisal/review not helpful in improving how do job</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td>Appraisal/Performance Review: left feeling work not valued</td>
<td>45</td>
<td>38</td>
</tr>
<tr>
<td><strong>Your Job</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never/rarely look forward to going to work</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>Dissatisfied with extent organisation values my work</td>
<td>34</td>
<td>29</td>
</tr>
<tr>
<td><strong>Your Managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication between senior management and staff is not effective</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Senior managers do not try to involve staff in important decisions</td>
<td>41</td>
<td>36</td>
</tr>
<tr>
<td>Senior managers do not act on staff feedback</td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td><strong>Your Organisation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would not recommend organisation as place to work</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td><strong>Your Health, Well-being and Safety at Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My job is not good for my health</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Felt pressure from manager to come to work despite not feeling well enough</td>
<td>36</td>
<td>29</td>
</tr>
<tr>
<td>Felt unwell due to work related stress in last 12 months</td>
<td>45</td>
<td>40</td>
</tr>
<tr>
<td>Organisation does not treat fairly staff involved in errors</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Organisation blames/punishes people involved in errors/near misses or incidents</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Harassment, bullying or abuse from manager/team leader or other colleagues</td>
<td>23</td>
<td>18</td>
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</table>
Furthermore the verbatim comments from Trust staff that completed the Survey are telling in themselves. Across seventeen pages of verbatim comments there are just five comments which we would deem positive. We have included some of the verbatim comments below so as to provide a flavour of the concerns that staff had expressed. Where there were typing errors in people’s comments we have corrected those for the benefit of this report and for ease of reading.

“Poor staffing levels, assumption now that staff work through their dinner hour, which is a regular occurrence. Management inform that this is poor time management. Not allowed to put the fact we have worked through our lunch. Wake each morning at 4am worrying about the day ahead. I have never been as unhappy in work as I am now. I wish I had never come into nursing.”

“Over the last 12 months the organisation has lost sight of why it exists. It is only interested in achieving foundation status to the detriment of patient care. We are somehow managing to provide a service without any guidance from managers. It is an appalling state of affairs that I’m sure the public would be shocked to discover.”

“Senior managers and the executive team are unapproachable, cold, un-caring and only focused on achieving FT status. Communication between clinical staff and senior managers/exec (in both directions) is severely flawed. Most staff go above and beyond to keep the service running and patients’ safe but this is never recognised and it then becomes expected. The Staff Awards system is meaningless.”

“As with all organisations within the NHS the pressure to perform with rapidly diminishing resources is putting a huge strain on the well-being of staff. The onus of the organisation is to meet financial targets, not provide high quality care. These things combined are a ticking time bomb for the staff who will either leave voluntarily or leave due to ill health. A very sad state of affairs.”
“I feel that LCH [the Trust] are more concerned about achieving targets without any due consideration to the pressure this is placing on clinical frontline staff. The organisation does not care about its staff anymore; it is driven as a business.”

“This organisation is going through major change. I lead a large clinical team and I personally feel that the views and experience of clinicians are not regarded or valued. The focus is the business, and patients are rarely mentioned. The attitude is that front line staff should see patients and should not be involved in decision making at any level, and that managers always know best concerning a service, even when this is patently not true. I have been in post 3 years and have had 5 different managers to report to in that time. Lines of accountability are unworkable e.g. my business support manager does not report to me as head of service, which leads to major conflicts of interest. The organisation has a structure which actively excludes senior clinicians, and does not listen to the views of clinicians or accept the contribution their expertise and experience can make to the organisation. The culture of the organisation is confrontational and directive and there is an aggressive and bullying management style at the very highest levels. This culture has got noticeably worse in the last 12 months. There are constant demands for information and completion of complex documentation with impossibly short timescales. I have complained about the management style and the basic lack of courtesy or respect which is shown in many interactions. The levels of stress within the staff group I manage are unprecedented. I have escalated my concerns via both the human resources route and the management route to no discernible effect and have received no formal response either verbal or written. I personally have had to seek counselling to help me cope with the culture of the organisation and the demands made on me in the last 12 months. The current change demands are additional to delivery of a large and complex service. There is an expectation that managers should give considerable amounts of personal (unpaid) time to enable the job to be done. It is not unusual for me to receive work related emails late in the evening or at weekends. This level of commitment is expected and is viewed as normal and seriously affects the work life balance of staff. I feel that the organisation spends time ticking boxes but that the expressed values of the organisation are not what the majority of staff experience.
“This organisation has decreased the number of nurses and increased the work load; This makes it impossible to do ones job; Majority of staff moral has deteriorated, nurses have left and everyone is stressed with work. The increased paperwork is affecting all areas of work, and senior managers have no idea about the work ground staff are doing.”

“Given the choice I would not work for this employer. Staff are being pressurised terribly to perform harder and faster with no consideration given for the well-being of staff or patients. Since the push for Foundation Trust Status the higher echelons of the organisation seems to have lost sight of why we are here and who really matters namely the patients. Over the last few years I have attended several development meetings with senior managers where at no point have patients even been mentioned. The job has become solely target driven with no room for patient care.”

14.18 These are only a very small number of the total comments received but they clearly represented a worrying position for the Trust.

14.19 The verbatim comments were not provided in the report to the IGQC. However they could be accessed by following a link to the Picker website and this link was provided in the full report presented to IGQC. Present at the IGQC meeting were both Non-Executive and Executive Directors.

14.20 From our conversations with Board members, it would appear that those details were not looked at by any Board member we spoke to, and indeed until more recently despite that reference in the paper to the IGQC in February 2013. The issue also did not make its way to the Board despite the IGQC agreeing that as a follow up action.
During the Salmon process, the Chair of the IGQC at the time stated “As the Committee’s focus was mainly on quality and clinical effectiveness, HR issues tended to get left until near the end of the meeting when there was little time to deal with them. However, we did see the results (though were unaware of the existence of the verbatim comments) and even though we were told of all the initiatives that were in place to improve things, we were alarmed enough to escalate the matter to the Board and require a report to be provided...having required it to be escalated, I had no reason (without the benefit of hindsight) to think the action would not be completed.”

Had it done so, and had the Board delved into the issues earlier, we are sure that it would have raised warning signs that would have led to further analysis and review. That it did not was a fundamentally missed opportunity, and allowed areas highlighted as causes of concern by staff to go unchecked.

By the time the NHS Staff Survey 2013 was published in February 2014 this was just prior to the departure of the Chief Executive, Director of Operations & Executive Nurse and Director of Human Resources & Organisational Development but those who completed the survey will have done so based on their experiences in 2013. We have already set out the sustained drive towards achieving NHS foundation trust status and alongside it the focus on Cost Improvement Programmes. It is little wonder then that the NHS Staff Survey 2013 results were poorer than in the year before. Indeed nationally, they were in the worst performing quartile.

The results of the NHS Staff Survey 2013 showed that the Trust had a response rate of 60% (1,503 out of 2,520 eligible staff completed the survey). This compared to an average response rate of 58% for other community NHS trusts nationally. Some of the key findings included:
### NHS Staff Survey Question

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>2012 Trust Results</th>
<th>2013 Trust Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>No appraisal/KSF review in last 12 months</td>
<td>16 %</td>
<td>20 %</td>
</tr>
<tr>
<td>Appraisal/performance review: training, learning or development needs not identified</td>
<td>20 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Cannot meet conflicting demands on my time at work</td>
<td>45 %</td>
<td>49 %</td>
</tr>
<tr>
<td>Dissatisfied with quality of care I give</td>
<td>7 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Do not feel my role makes a difference to patients/service users</td>
<td>2 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Do not know who senior managers are</td>
<td>8 %</td>
<td>11 %</td>
</tr>
<tr>
<td>Communication between senior management and staff is not effective</td>
<td>35 %</td>
<td>39 %</td>
</tr>
<tr>
<td>Organisation does not act on concerns raised by patients/service users</td>
<td>6 %</td>
<td>8 %</td>
</tr>
<tr>
<td>Would not know how to report fraud, malpractice or wrongdoing</td>
<td>6 %</td>
<td>8 %</td>
</tr>
<tr>
<td>Would not feel confident that organisation would address concerns about fraud/malpractice/wrongdoing</td>
<td>11 %</td>
<td>14 %</td>
</tr>
</tbody>
</table>

In fact the Trust results were significantly worse than the average for other community NHS trusts nationally for the following questions:
<table>
<thead>
<tr>
<th>NHS Staff Survey Question</th>
<th>Trust</th>
<th>Community Trust Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Personal Development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No training in how to deliver a good patient / service user experience</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>No appraisal/KSF review in last 12 months</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Appraisal/performance review: left feeling work not valued</td>
<td>46%</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Your Job</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not involved in deciding changes that affect work</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>Not able to make improvements in my area of work</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>Dissatisfied with recognition for good work</td>
<td>28%</td>
<td>23%</td>
</tr>
<tr>
<td>Dissatisfied with extent organisation values my work</td>
<td>35%</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Your Managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication between senior management and staff is not effective</td>
<td>39%</td>
<td>31%</td>
</tr>
<tr>
<td>Senior managers do not try to involve staff in important decisions</td>
<td>44%</td>
<td>35%</td>
</tr>
<tr>
<td>Senior managers do not act on staff feedback</td>
<td>36%</td>
<td>30%</td>
</tr>
<tr>
<td>Senior managers are not committed to patient care</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Your Organisation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of patients/service users is not organisation’s top priority</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Organisation does not act on concerns raised by patients/service users</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Would not recommend organisation as place to work</td>
<td>26%</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Your Health, Well-Being and Safety at Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt pressure from manager to come to work despite not feeling well enough</td>
<td>35%</td>
<td>30%</td>
</tr>
<tr>
<td>Felt unwell due to work related stress in last 12 months</td>
<td>48%</td>
<td>43%</td>
</tr>
<tr>
<td>Organisation does not treat fairly staff involved in errors</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Organisation blames/punishes people involved in errors/near misses or incidents</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Staff not given feedback about changes made in response to reported errors</td>
<td>28%</td>
<td>23%</td>
</tr>
<tr>
<td>Would not feel safe raising concerns about fraud / malpractice / wrongdoing</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Would not feel confident that organisation would address concerns about fraud / malpractice /wrongdoing</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Harassment, bullying or abuse from manager/team leader or other colleagues</td>
<td>24%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Of the 260 or so verbal comments, the overwhelming majority are negative. They refer to a poor culture in the Trust, staff feeling the pressure of service re-design imposed upon them, the impact of Cost Improvement Programmes, lack of support from senior management, lack of visibility of senior leaders in the Trust and concerns around delivering safe and effective care. The comments below are simply a flavour. We have edited them to address spelling mistakes so that it is easier for our report to be read.

“My department is currently undergoing a service redesign. We were told 8 months ago that we were facing an almost 50% cut to our budget but as of this week we have had no further information. The level of stress in the department is stratospherically high & staff morale is at an all-time low. There has been no support offered & we have had no information of how the redesign is progressing other than that there is no info to give. LCH [the Trust] should be ashamed that they are allowing this situation to persist & the conditions they are expecting their loyal staff to work under. Our department has consistently offered a high quality service to the most vulnerable members of society but no one outside our directorate has bothered to come & see what we actually do - figures on a sheet of paper cannot describe how hard the staff work & how dedicated they are. The staff have suffered. The patients have suffered. Shame on you.”

“Execs spend a lot of time engaging staff.... But then fail to demonstrate positive changes. As a service manager the focus is Cost Improvement Programme delivery with no consideration of long term aims of trust quality and compassion towards staff. The trust is overrun with ever increasing support staff - 13 in Programme Management Office alone all that has happened is delays from filling jumping through hoops and no positive changes. Clinical engagement appears to be a token if clinical staff disagree they are stubborn and awkward or resistant to change no stepping back to ask why they feel the change is negative.”
“It is more difficult to work for this organisation as the main impetus seems to be saving money as opposed to anything else. In all the conversations I have had as a manager re: cost savings, safety and quality has never been mentioned or pushed. I feel we are heading towards being unsafe in my service and this worries me.”

“The levels of stress currently being experienced by staff in School Health and Health Visiting has been caused by management totally mishandling the reorganisation of these services. They have behaved indiscriminately, unprofessionally, unfairly; against the organisations own policies and procedures and employment law, with a total lack of care and consideration to people’s health and wellbeing. Senior Management couldn’t have upset more people to the extent that they have even if they had planned it. I really, really hope they have learnt lessons and not only communicate far better but actually listen to staff. I have become so disillusioned with Children’s Services that after over 12 years’ service I am changing my job role.”

“LCH [the Trust] as an organisation is committed to obtaining foundation status- regardless of how staff feel about it. They have become a blame finger pointing employer who address issues and patient concerns by blaming individual staff members so that the organisation abdicates any responsibility for mistakes and errors. Not a fair blame organisation more a not left responsibility. This change of culture is damaging and in all the time I have been in the NHS (over 30 years) feel this lies at the head of the organisation. Morale is at an all-time low and many of my colleagues are looking elsewhere for other jobs. I have never seen chief nurse or noted any positives given to staff only negative and blaming emails...please note that this is written with a heavy heart.”
“There seems now to be more of a concern with saving money and achieving Foundation status than delivering patient care. There seems to be a greater emphasis on employing project managers” than clinical staff to deliver the care. Communication within this area of LCH [the Trust] is acceptable, the communication from Senior Management seems remote - glossy blogs and screen savers, but little attempt to reach staff on the ground. For instance the Mandatory training is generic and non-transferable to a great degree meaning that valuable clinical time may be lost. This may be better if even a basic assessment of learning need was attached to Mandatory training. There are exceptions, but a significant amount of it feels "tick-box" in content and standard of delivery. I have worked for this organisation and its forerunners for many years and whilst I love my job and respect my immediate and wider clinical teams, I do worry about the ethos of the higher echelons of LCH [the Trust].”

14.27 Many we spoke to at a senior level in the Trust said they were taken by surprise when the Care Quality Commission published their report including the Chief Executive who stated “it came completely out of the blue” but as we have stated already, the warning signs were there long before. The Board in our view simply missed them.

14.28 It is also worrying that those charged with external oversight of NHS Staff Survey results – the North West Strategic Health Authority at the time owned the NHS Staff Survey results for trusts in the North West and the Care Quality Commission use it in their quality monitoring of Trusts – did not, to the best of our knowledge, follow up the NHS Staff Survey results, for 2011 and more so for 2012.
14.29 In conclusion, we feel that if the NHS Staff Survey results in 2011 and 2012 had been analysed properly by the IGQC and the Board, they would have signalled the concerns of staff about for example, a negative Trust culture, bullying, harassment and the impact of Cost Improvement Programmes on front-line staff. This we feel should have led to further analysis and action which could have been taken early in the life of the Trust. If that had happened, it may have avoided subsequent events that unfolded in the Trust. That the Non-Executive Directors of the Board were not made aware of the Staff Side survey results is hugely regrettable and constituted an erosion of good governance in the Trust. That the Board focused so little time on the results of these two NHS Staff Surveys and that it took no subsequent action when they were published represents to the review team a further significant missed opportunity.

15 Investigation of Grievances

15.1 In this section we examine the processes and procedures used to investigate grievances and whether they were consistent with Trust policy and procedures.

15.2 Several of the individuals we interviewed had raised formal grievances with the Trust but their subsequent investigation we found wanting.

15.3 For example an investigation in to the grievance made against the former Chief Executive by a member of her support team was undertaken by the then Company Secretary/Head of Governance. The matter though was not bought to the attention of the Chair until the member of staff in question had left the employment of the Trust – which again we find unusual since this was a complaint against the Chief Executive and should therefore have been notified to the Trust Chair to whom the Chief Executive is accountable.
The Company Secretary/Head of Governance stated to us “I didn’t tell her because I didn’t feel it was my position to tell her when normally Bernie [Bernie Cuthel, Chief Executive] would’ve told her, so it never crossed my mind that Bernie hadn’t told her.” She also added as part of the Salmon process that “It was custom and practice for the Chair and the Chief Executive to have regular one-to-one meetings, to discuss all issues including any areas of concern, where there was the opportunity to raise this case. The Company Secretary did not attend these meetings.”

In another instance where a member of staff who was the subject of disciplinary action described their experiences to us in the following terms:

“So she [Helen Lockett, Director of Operations & Executive Nurse] was taking me out of Bed Base. She was gonna take that out of my portfolio and investigate. She talked about an investigation, so there was no formal HR process here, so she was outside of any HR process. And when I asked in terms of what was going to happen, that she’d taken me out of my role, I asked if she was applying some sort of disciplinary process. She said that it was not an investigation that it was a review...And actually I was never interviewed by the investigating officer as part of that process until I actually said...when someone told me it was concluding on the Friday, I said that I still hadn’t been interviewed yet....Actually she emailed me, she said that she would come and meet me on Friday, her report was due in on the Friday. She came and met with me in Innovations [Innovation Park, Trust Headquarters] and she didn’t have any notes with her, she didn’t have any paperwork with her, she didn’t have a pen and paper with her, she didn’t have a microphone with her. She said that she hadn’t interviewed me as yet, so she would just ask me a couple of questions. I can’t even remember the questions she asked me. She didn’t make any notes and just said that it was fine, that she had to have the report finished by five o’clock. So, there was nothing from me, as far as I was concerned, that went into that report.”
Whilst in other instances, staff who were interviewed as part of an investigation by the Business Development Manager into the three clinical members of staff within Intermediate Care Bed Based Service, which we referred to in Section 12, told us that terms of reference were not shared with them and what they said was taken out of context or misreported in the final investigation report, though we have not been able to prove or disprove this claim. For her part the Business Development Manager stated to us as part of the Salmon process “Witnesses from the wards would not have seen the terms of reference. Staff were invited to meet with me having been told that the review was in progress. When I met with staff I explained the purpose of the review, explaining the concerns of senior members of the organisation. I explained I was reviewing the management, clinical leadership, support, training and development they received. All staff interviewed appeared to welcome the intervention, opened their hearts and were very open. From the report it is very clear that many staff were concerned.”

In other instances we are left with a confused picture at best. The Director of Operations & Executive Nurse as part of the Salmon process stated that she was aware of a complaint made by one member of staff against her. However the Chief Executive stated to us that there were two formal grievances received regarding the Director of Operations & Executive Nurse and that both were investigated under the Trust disciplinary policy. Whilst a further set of grievances were bought by three members of staff from the Intermediate Care Bed Based Services which then led to the external review undertaken by Sue Miller which we have mentioned in Section 12. The Chief Executive states that the formal grievances lodged against the Director of Operations and Nursing were shared with the Chair and one in particular was discussed with Non-Executive Board members in an informal private session in early 2014 so they were aware. The Chair for her part stated to us that she was not made aware of these matters. Whilst we cannot say what the true position was, what we can be certain of is that there is no record of these matters in the minutes of the Remuneration Committee, which we would have expected to see given the seniority of the Director of Operations & Executive Nurse.
15.8 We would also have expected that there would be some formal record in the personnel file of the Director of Operations & Executive Nurse regarding these grievances but upon a review of the file which is held at the Trust headquarters, we found the paperwork to be limited.

15.9 On a wider level, we mentioned in Section 10 the review commissioned in summer 2014 by the Trust with the support of the NHS Trust Development Authority and which was undertaken by Liz Craig and June Goodson-Moore. This review also noted that between “April 2013 to March 2014 there were 332 employee relations cases recorded by Human Resources which seems high and also may not be an accurate record given that they were not all lodged with the Human Resources team. Of this number the breakdown is as follows: bullying and harassment 8; disciplinary 111; grievance 26; whistle-blowing 1; capability 20; sickness sanctions 166.”

15.10 One member of staff we spoke to stated in their view “I just felt that everything was quick to jump to a disciplinary, and maybe things should have been looked in a bit more depth, about what some of these problems were, and where they were coming from.”

15.11 It is perhaps not surprising that the Care Quality Commission Report published in January 2014 stated:

“Staff told us that they were aware of the trusts whistle blowing policy, however most staff told us they did not feel confident about using it and would be scared to. Staff comments included "I feel scared", "I would not be confident about using it." In excess of fifteen negative comments from staff prior, during and after the inspection about the unsupportive, oppressive culture did not assure us that the provider was able to support staff to deliver care to an appropriate standard.”
15.12 We have concluded that there was little adherence to Trust policies and procedures when it came to investigating grievances and concerns when they were made about senior Trust staff and that elsewhere in the organisation the grievance process was resorted to far too quickly without exploring other options first and consequently further contributed to the negative culture within the Trust which we discussed at length in Section 14.

16 Corporate Governance Arrangements in the Trust

16.1 We now turn in detail to the prevailing corporate governance architecture in the Trust during this period and in particular draw out those areas which we feel were not consistent with good governance practice.

16.2 Our review of the documents from 2011 confirms that the Board met monthly and that this included a public meeting followed by one in private. These arrangements were consistent with good governance practice at the time and indeed now.

16.3 Agendas since 2011 reflect largely what we would expect to see at the Board with a focus on finance, performance, quality and safety, risk and governance, though at the same time, we observed variances from good governance practice.

16.4 Accepted practice elsewhere in the NHS at the time was that quality and safety would be placed far higher up the agenda alongside the receipt of an integrated performance, quality and finance report. Yet at the Trust, whilst the Board received a “patient story” in public in the early part of the meeting, a practice we would endorse, this was then not followed through with a strong subsequent focus on quality and safety in the rest of the meeting. We also found an absence upon the review of Board agendas since 2011 of any review or discussions of Patient Survey findings.

16.5 The review team particularly noted that an update on the NHS foundation trust programme was more or less the first substantive strategic agenda item at almost every meeting of the Board from March 2011 until February 2014. Indeed, it would almost seem to be the case from the way this item was positioned at the Board that to become an NHS foundation trust was the primary strategic aim of the Trust.
16.6 It is also the case that through this period the Board received separate performance and finance reports – reinforcing the separation between these key related agendas and not enabling the Board to see a clear connection between the areas of quality, performance and finance.

16.7 We also note that an “Integrated Performance and Quality Dashboard” was a regular item at the Board from 2011 onwards until October 2012 after which this changed in content and format and was called the “Strategic Performance Dashboard.” Both reports gave a very high-level overview of performance against national and local standards and quality and safety. The report was presented graphically to show Trust-wide trends, with some explanatory text. The quality and safety section dealt with performance against national standards, such as infection control standards, waiting times standards and captured trend information.

16.8 In our view, the change in the title of the reports also signalled an important change in content in one respect. The “Integrated Performance and Quality Dashboard” provided the Board with information that enabled the Board to see performance against a narrow range of human resources metrics – sickness rates, mandatory training rates and Performance Development Reviews or PDRs. These reports contained no other workforce data whatsoever – so the Board saw no data on the number of staff employed within the Trust, the number of vacancies, turnover rates, the number of staff on maternity or carer leave or the number of grievances lodged. Secondly, it also as a report lacked depth, containing no benchmarking data whatsoever.

16.9 When the Trust moved to the “Strategic Performance Dashboard” the limited human resources metrics that the Board previously saw were not a feature of the new report, meaning that from November 2012 onwards that data was never bought to the Board. Regrettably, this change also coincided in November 2012 with the Human Resources & Organisational Development Committee being deemed too operational (by an external governance review, though the decision to abolish the Committee was taken by the Board) and its work being subsumed into that of the Finance & Commercial Committee.
16.10 Effectively this meant that through two separate and unrelated changes in a single month from that point onwards the Board as a whole had very little means of really understanding what was going on within its biggest resource, its workforce. The IGQC did receive a dashboard of human resource metrics from 2013 onwards at its bi-monthly meetings across a limited range of metrics.

16.11 It is also noteworthy that from November 2012, we start to see a noticeable shift towards less transparency at the Board level, with far more business being conducted in the private part of the meeting, as opposed to in public. Normally one would expect the private part of the Board meeting to be reserved for matters of a commercially sensitive nature or those which are particularly sensitive to an individual employee. From this period onwards though, we also start to see a separate more detailed report on finance and performance being presented to the private Board meeting, in addition to the separate reports that were presented in public. This is not consistent with good governance practice and the Trust should as a public body have been discussing these issues in full in the public part of the meeting.

16.12 In our interviews with Board members there was plenty of reference to challenge and scrutiny being applied at both the Board and at Committee level as we have stated in Section 7.

16.13 Unfortunately we saw very little evidence of that in the public Board meeting minutes that we looked at from 2011 onwards. Challenge across a range of topics was more evident in private Board meetings during this period, principally from the Chair and from one of the Non-Executive Directors, Wally Brown. We acknowledge in making this comment that the Non-Executive Directors of the Board state that there was challenge, discussion and debate and that they are simply not reflected in the minutes. Regrettably, we have largely concluded otherwise. Even if the minutes do not record all the challenge that was made, it is clear that a number of key issues were not identified and followed up appropriately as they would have been, had sufficient scrutiny and follow through taken place.
One senior clinical member of staff we interviewed, not a Board member but who observed a Board meeting in early 2012 made the following comment to us: “I was just there was the public part of the meeting and it was chaired at the time by Eileen Quinn [Non-Executive Director] because Frances Molloy [Chair] was not available and I can remember just sitting there and thinking they’re just being spun a whole load of rubbish, basically. I could just tell how everybody were... I mean; they were just nodding and taking it all in. I can’t remember specifics, but that was my overwhelming impression. I just thought you haven’t got a clue what’s going on and that was at that stage, so they either wanted to believe everything that they were being told or were so bamboozled by the executives.”

The Board committee structure comprised the IGQC, the Finance & Commercial Committee and the Human Resources & Organisational Development Committee. There was in addition to these an Audit Committee and a Remuneration Committee. As we have stated earlier, following an external review of committee effectiveness, it was determined that the Human Resources & Organisational Development Committee was too operational in its focus and its work was subsumed into that of the Finance & Commercial Committee in November 2012. The Finance & Commercial Committee itself was renamed the Strategy & Performance Committee in August 2014.

As part of the Salmon process, the Chair of the Committee during this period commented “This Committee had a huge agenda and meetings invariably overran. The work of the Healthcare Governance Sub-Committee was frequently re-arranged in the hope that this would allow the IGQC to work more strategically but this had limited success. When the HR and OD Committee was disbanded (on the advice of an external review) in November 2012, the IGQC took on some of the work of that Committee, which made the situation worse.”
16.17 We have extensively reviewed minutes and papers of the IGQC, the Finance & Commercial Committee, the Human Resources & Organisational Development Committee and there are several issues that particularly can be drawn out: one was the operational and not strategic focus of each of these Committees; the lack of any real challenge or scrutiny as evidenced by our review of the minutes; the lack of follow through (for example, matters due to be escalated to the Board fail to happen or matters to be discussed at subsequent Committee meetings fail to happen); and the real lack of connectivity between the Committees with very little ever identified for consideration from one Committee to another or for escalation to the Audit Committee. Our review of Audit Committee papers from the inception of the Trust until early 2014 shows far more evidence of challenge and scrutiny than in the other Board Committees we looked at and indeed was to the level we would have expected. There was also discussion of the IGQC annual reports at Audit Committee meetings in September 2012 and September 2013 though these did not surface any deficits around the functioning of the IGQC which we have drawn out in Section 17.

16.18 It is also the case that the frequency of the IGQC meetings at every two months was not consistent with practice that prevailed across many other NHS trusts at the time where the quality focused committee of the Board meets monthly. It was also the case when we look at the IGQC that the agenda for its meetings was far too substantial to cover in the time allotted for the meeting, further reinforcing the view that monthly meetings would have been more advantageous. Indeed as one Committee member stated to us: “The Quality Committee, to me, had a huge agenda, and I did voice this, and it was, well, that’s what it is. Impossible. Impossible to just even get through the items on the agenda, let alone have a discussion, really, about anything, I think.”

16.19 We also as part of our review considered the processes and procedures for individuals leaving the Trust and concluded that based on the information available at the time, the departure from the Trust of a number of the Executive Directors of the Trust in early 2014 was reasonably handled and documented in the minutes and papers of the Remuneration Committee.
What we have highlighted are some significant deficits in the corporate governance architecture of the Trust. They contributed in our view to ensuring that the Board and its Committees lacked rigour in a number of ways and helped to create the climate that allowed failings or concerns to go undetected. Good governance systems and structures can help to create the climate for effective scrutiny and oversight, but where they have deficits they can also create the climate for those failings and concerns to go unchallenged, as was clearly the case here.

Clinical Governance Systems in the Trust

The independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013 (The Report of the Morecambe Bay Investigation, March 2015) sets out a helpful context around clinical governance. It states:

“Clinical governance was introduced formally to the NHS by the Department of Health White Paper The New NHS: Modern, Dependable in 1998. This was the first time that the demonstration of formal systems of assurance and scrutiny in relation to clinical quality and safety issues had been an explicit requirement of NHS Trust Boards.

Effective clinical governance in organisations has a number of characteristics:

- Organisational systems and processes consisting of policies, procedures and strategies to describe how staff are expected to: identify and report risks, ensure compliance with the most up-to-date and effective clinical treatments, participate in audits of the quality of service provided to demonstrate continuous improvement, and engage in education and training activities in order to remain up to date in clinical knowledge;

- Engagement and ownership of frontline staff to ensure compliance with the policies, procedures and strategies of the organisation, in order to generate robust and meaningful information to provide assurance about organisational quality and safety;
Quality, safety and management assurance review
Liverpool Community Health NHS Trust

- Effective committee and reporting structures which communicate this information from the front line to the Board;

- Resource to provide the required expertise and administrative support to manage the governance system effectively at all levels in the organisation.”

17.2 The above has provided a helpful context for our analysis in this section.

17.3 We were provided with details of the clinical governance structure for the Trust from 2011 onwards.

17.4 In examining the clinical governance arrangements in place in the Trust during this period, we have focused on the two principle clinical governance committees; the IGQC, a committee of the Trust Board and the HGSC, a sub-committee of IGQC.

17.5 The IGQC was chaired by a Non-Executive Director, and included one other Non-Executive Director. Executive Director Membership fluctuated over time but ostensibly it included the Director of Operations & Executive Nurse, Director of Finance, Medical Director, Chief Executive and Director of Human Resources & Organisational Development. Just having two Non-Executive Directors on a Board Committee, of which one is the Chair was not consistent with practice elsewhere in the NHS and will in our view have limited the ability of IGQC to scrutinise the agenda. Also having so many Executive Directors on the IGQC will in our view have created an imbalance, in favour of Executive Directors on the IGQC, something which was not consistent with good governance practice. This was raised as an area of concern in the Monitor letter to the Trust dated 4 July 2014 which we refer to in Section 19.3.

17.6 The HGSC was essentially an executive led Sub-Committee, chaired by the Medical Director though that was not always the case. Indeed as one member of staff we interviewed pointed out “they never agreed amongst themselves who it was gonna be. One minute it would be Gary [Gary Andrews, Director of Finance], the next minute it would be Craig [Craig Gradden, Medical Director] and the next minute it would be Helen [Helen Lockett, Director of Operations & Executive Nurse]. Every meeting it was somebody else’s responsibility.”
17.7 At a Divisional level there were monthly clinical governance meetings. Meetings broadly covered the issues we would have expected them to, including a review of the Divisional Risk Register and incidents reports. Attendance covered the breadth of the services the Divisions were responsible for and there was then a clear onwards escalation to the HGSC. Indeed, as one senior member of staff we spoke to noted: “I feel we had quite a tight structure. So we had weekly meetings, and they were rotated over four weeks with different titles, but one of those meetings on the four weekly cycle would have been governance. That was where we could produce governance pro-formas as well at that time, so section reports for our services. And we discussed at great lengths complaints, issues and our Risk Registers - in quite minutiae detail at times.” Whilst another member of staff we spoke to stated “All the service managers would come...so the monthly meeting on governance would get into every detail regarding the Risk Register, we’d go through the Risk Register, and we’d go through all the incidents - any sort of incidents, never events, complaints and complements - really down to the detail. Because there was a key issues report that we had to feed into healthcare governance on a monthly basis, so we would feed into them and populate that report that went into healthcare governance, provide assurance.”

17.8 When the IGQC was established in November 2010, the Director of Finance retained the portfolio for clinical governance (in spite of the fact that the Trust had a Medical Director and Director of Nursing & Therapies) until the arrival of the Director of Operations & Executive Nurse in spring 2012. This is most unusual given he had no background or prior knowledge or experience in this area. It is a point we have covered earlier in Section 7, including the rationale given for it by the Chief Executive and further clarification from the Director of Finance. For his part, the Director of Finance stated to us “I was not clinical I just followed the route of holding people to account and using the clinical people within there to say, if this is a risk what are you doing about it, when do you expect the risk to change and then saying, you know, what are you doing to give us assurance that that risk is going down.”
17.9 The Director of Finance was the lead director for the IGQC throughout 2011 and the very early part of 2012 and reported to the private part of the Board on Serious Untoward Incidents. This only changed from March 2012 when responsibility passed to the Director of Operations & Executive Nurse, though public reporting on Serious Untoward Incidents only happened from October 2013 onwards.

17.10 The Board received in public, minutes from the IGQC meetings and indeed other Board Committees.

17.11 The Board also received in private from December 2012 onwards the report from the Medical Director of the highlights from the “Weekly Meeting of Harm.” This was established soon after he came into post in September 2012 and was designed to do the following:

- Identify trends or themes;
- Identify specific individual serious events;
- Ensure consistency of risk scoring;
- Ensure appropriate investigations and actions being undertaken;
- Provide direct feedback and assurance to Executive Team and Board.

17.12 We would question why these went to the Board in private. Often they covered matters of quite an operational nature whilst on other occasions; they covered issues which in our view would have been better escalated to the IGQC or to one of its sub-committees.

17.13 The presence in private of both the Serious Untoward Incident report and the report on the “Weekly Meeting of Harm” also in our view lacked transparency both internally to staff within the Trust and externally to patients, the public and partners.

17.14 There is also little evidence in both reports of a focus on the learning from specific Serious Untoward Incidents or reported incidents of harm. Indeed the Board in our view was left none the wiser as to what action has been actually taken to rectify the situation and how future incidents of that nature were to be avoided or the likelihood minimised.
17.15 There were periodic concerns expressed around the clinical governance agenda during this time at the Board.

17.16 For instance, the private Board minutes of the meeting held on the 15 March 2011 record: “Significant incidents: The Chair called for clarity of actions and improvement in the length of time being taken to resolve Serious Untoward Incidents which was currently hindered due to the time taken up by investigation processes. BC [Bernie Cuthel, Chief Executive] had spoken to HL [Helen Lockett, Director of Operations & Executive Nurse] with regard to influencing cultural changes which would ensure the emphasis was placed on the prioritising of prevention of harm as opposed to awaiting the outcome of investigations. FM [Frances Molloy, Chair] also called for accountability and responsibility to be clearly recorded.”

17.17 Indeed at the IGQC meeting on the 4 October 2011 the minutes recorded “Questions were raised regarding the level of detail and how and what was reported to the Committee and the Board. It was felt that the Committee was not receiving full assurance on some aspects of patient quality and safety despite the amount of data presented.”

17.18 The rest of our review of the IGQC in 2011 and 2012 highlights very much the unremarkable nature of the conversations. We see some focus in 2012 on prison health services and on Cost Improvement Programmes but the IGQC often appear to be simply the recipient of information and updates. Indeed the overall perception from the minutes is of a very operational focus, without any real evidence of scrutiny and challenge. There is also no evidence of deep dives which would have perhaps enabled IGQC to really get into the detail of a topic and draw out the areas where it felt assured as well as those it was not. These would have also been consistent with good governance practice. In relation to some of these issues, we do not feel that the IGQC was effectively supported by the HG SC, given it did not in our view undertake the detailed review of the quality agenda that it was required to, thus leaving the IGQC unable in turn to focus on the strategic issues.
During the course of our interviews, it was stated to us that with regards to the HGSC a “perceived lack of importance impacted on attendance negatively, which was always variable...there was always a sense of trepidation, I think, taking something because the challenge would come back, essentially being blunt as “if you have a serious risk, you’re not managing the service properly.”

There were also concerns expressed around feedback from discussions that took place at the IGQC. One interview said “I don’t recall any feedback. It would go beyond and it would be lost in the ether then.”

The IGQC meeting was scheduled for 1.5 hours and had a significant workload and therefore it is not clear the level and depth of discussion that took place on each agenda item. Under “Any Other Business” in May 2013, the minutes stated the meeting would move to two hours; however all of the agendas for the rest of the year remained at 1.5 hours duration. In our view given the size of the agenda for the IGQC meetings, that we have looked at, there is simply no way the IGQC could have given those items on the agenda the due attention required.

IGQC met every two months and received the minutes and an overview report of the two HGSC meetings that had taken place between each IGQC meeting.

In practice there appeared little synergy between the two meetings – agendas were very different which on a positive note meant there was little duplication. However, it was rare for the IGQC to direct HGSC to carry out work and report back or for it to seek further assurance on matters reported to it. In this respect, it appears the IGQC and HGSC were almost working in tandem, with different agendas, rather than the sub-committee (HGSC) being used to carry out specific or more detailed pieces of work for reporting for assurance purposes to the parent committee (IGQC). The reports covering the HGSC meetings that were provided to IGQC are also all somewhat superficial but they do draw out key risks and assurances in a clear manner, and minutes of the meetings are provided.
17.24 During 2013 (around April, but it is not absolutely clear from the paperwork we have reviewed) the HGSC established four Governance Groups; Clinical Effectiveness, Patient Experience, Patient Safety and Technology, Innovation and Intelligence Group. These were intended to carry out work on behalf of HGSC and would report to it. These groups took some time to establish but of particular concern is the Patient Safety Group. The report from Patient Safety Group to HGSC in May 2013 and June 2013 were virtually identical and were still largely covering the governance and establishment of the group. There was no report in July 2013 and August 2013. It appears the Group was suspended in September 2013, there was no report in October 2013 and whilst seemingly re-established, the reports to the HGSC in November 2013 and December 2013 were not discussed as the Chair of the Patient Safety Group was not at the meeting and therefore unable to present.

17.25 This is of serious concern, not only was there no effective Patient Safety Group or committee, there was seemingly no patient safety reports or data being reported to the HGSC for onward assurance to the IGQC. It is not clear what action the Chair of HGSC took in respect of this and whether the Executive and Non-Executive Directors were concerned at receiving no real assurance on patient safety at IGQC. During 2013 the Patient Safety Group met just three times (or at least there are only documented minutes of three meetings, even though the HGSC seemingly received four reports). There are just eleven pages of notes in total covering meetings of this group for the whole year. They in our view represent at best limited assurance that this key agenda was being effectively discharged within the Trust during this time.

17.26 It is unclear to the review team from examining; the notes and minutes of the HGSC, the organisation structures and the notes of the Patient Safety Group meetings in 2013/14:

- Exactly where the accountability for patient safety sat?
- Who was responsible for monitoring, co-ordinating and driving Patient Safety and improvement on a daily basis?
- How the link with Harm Free Care, the Quality Improvement, Quality Standards and the Risk and Governance functions worked?
- Exactly what the role of the Risk and Governance function was and that of the manager?
17.27 In short the Patient Safety Group should have been providing key assurance to the HGSC and the IGQC and it clearly was not. Indeed, there seems little evidence in the minutes of the two senior committees (the IGQC and HGSC) that suggest they were concerned about this and that they actively tried to improve the output of the Patient Safety Group. Further evidence we feel of the low level of importance attached to this agenda in the Trust at the time.

17.28 The IGQC did receive a regular report on Harm Free Care from the Director of Operations & Executive Nurse; this included just six patient safety metrics. As stated above however, it is unclear how the Harm Free Care ‘function’ which sits under the Director of Operations & Executive Nurse worked with the Risk and Governance function that sat under the Company Secretary/Head of Governance. As such therefore, the reporting of patient safety outcomes, learning and improvement throughout the organisation and up to Board seemed to the review team to be fragmented, un-coordinated and insubstantial.

17.29 We can also in this period find no systematic method of reporting Serious Untoward Incidents to any of the Governance Committees, be it the pure numbers, the nature of the incidents or the outcomes and learning of any investigation. On questioning, the Risk and Governance Manager could not recall if Serious Untoward Incidents were reported to the IGQC in any form, even though he stated he was largely responsible for compiling the papers for the IGQC. It is apparent from minutes of the IGQC that members, and by that we mean Non-Executive Directors, were aware of incidents happening in the organisation via the Medical Directors “Weekly Meeting of Harm” reports to the private Trust Board but there appears to be no drive to receive information/data on clinical incidents at IGQC and in particular no assurance on the incidence, management and outcomes of Serious Untoward Incident’s during 2013.
17.30 Due to the various incidents and inspections that had taken place during the latter part of 2013, the IGQC established a sub-group, the Quality Action Plan Assurance Sub Committee. The first meeting was held in December 2013 and reported to the IGQC in February 2014, together with the minutes of the meeting held in January 2014. Members of this group were two Non-Executive Directors [Sue Ryrie and Deborah Morton], Bernie Cuthel [Chief Executive], Helen Lockett [Director of Operations & Executive Nurse] and Anne Rosbotham-Williams [Trust Secretary/Head of Governance]. It does in the minds of the review team seem unusual not to include the Medical Director in such a group. This further highlights to the review team that the Medical Director regretfully did not appear to have a high profile role in quality governance within the Trust. However, we think it good practice to have established such a group albeit the membership seems particularly small and exclusive.

17.31 At the IGQC meeting in March 2014 minutes of the Quality Action Plan Sub Committee were received. There was a very brief report with no detailed update on the action plan itself and the item itself was scheduled for five minutes. However, clearly the Quality Action Plan Sub Committee was meeting regularly and seemed to be operating at an appropriate level of detail. Our concern here is that it is not clear if the full external reports and related actions plans were ever seen by the wider Board members at either the IGQC or Board. Whilst the Quality Action Plan Sub Committee clearly had Executive and Non-Executive Director membership, as stated above it was a small exclusive group. In our view there does not appear to be a report to IGQC that provides assurance that the action plans were delivering improvements in care in the areas requiring improvement. There appears to be no specific monitoring and provision of data looking at patient safety incidents, patient experience or staff experience to assess the impact of the action plans.

17.32 An overriding impression is that this was not truly a listening organisation; it strove to get the right governance in place (but not in all areas, in particular patient safety) but then did not use the data and intelligence in such a way that it would lead to action, learning and therefore real improvements in safe and high quality care. It is also our view that multiple groups and meetings failed to connect with each other in any meaningful way to then make a coherent whole.
In summary over this period, it would appear that at a Divisional level there were monthly clinical governance meetings and that meetings broadly covered the issues we would have expected them to, including a review of the Divisional Risk Register and incidents reports. However at a corporate level, reporting from the HGSC into the IGQC was somewhat superficial but they did draw out key risks and assurances in a clear manner. The IGQC for its part met too infrequently, was overwhelmed by the size of the agenda and the overall perception from the minutes is of a very operational focus at meetings, without any real evidence of scrutiny and challenge.
18 Key Review Themes: Phase Two

18.1 Part Two of our report is very much focused on the period since the appointment of the new leadership team in spring 2014. We questioned interviewees about current practice, systems and culture and asked them where possible to compare this with how things were done prior to the arrival of the new leadership team. We also looked at Trust documentation that would show how the corporate and clinical governance structures have developed and fit together and we questioned where it was relevant, those we interviewed on what lessons they had learnt from previous events, how they had sought to improve quality as a result and how they gained assurance that services are safe, effective and caring and staff are valued today.

18.2 The composition of the Board during this period is shown at Appendix 3.

19 Addressing an Inherited Agenda

19.1 We start Part Two of our review with the way the new leadership team addressed some key individual issues which it inherited when it was appointed in April 2014. The scale of the task they inherited was summed up by the Interim Chief Executive who stated to us:

“We came in together and we decided to do a three month diagnosis which would go way beyond the inspectors [Care Quality Commission] week but we would use them as an opportunity to get even more information. So we were very structured in criss-crossing this entire organisation from top to bottom and out of a three-month diagnosis we put together a three-phased plan. The key thing here is the first phase was engaging all the staff and all the managers. Everybody who worked here and all our stakeholders in a conversation about services that were on the critical list that needed sorting out and it became very quickly apparent, even within the first two weeks as we were criss-crossing when I was entering teams, for instance, the district nursing team in Sefton.”
One example, just on a visit “How are you?” everyone sat in a room talking about what they did. The tensions were just rising and I would very often end up with teams in tears in desperate states pouring their heart out saying that there were ten members of staff in their team. Five were away, either on sickness absence, not recruited to...so I began to pick up an evidence base coupled with pulling the evidence off our systems here, trying to pull evidence off the system for how many staff are on long term sick.

It took me six weeks to get the full list of staff who were on long term sick and there were over 100 and they had been off sick for a long period of time. I then tried to get the disciplinaries, the grievances and with the combination of my visits and gathering the data, particularly around the Prime Minister's Question which was all around HR, so we began to get a real HR dashboard. When coming across grievances that were in the system that some of them were two or three years out and not resolved. I came across individual members of staff who had been on suspension for up to nine or ten months and the full time officers couldn’t even tell me why they were suspended. So, we began to really sort of criss-cross this and if you look at our Improvement Plan, the original one that we put together in June, you will see a full list of all those services that we evidence based. That’s the other thing about this organisation I quickly came to realise that it didn’t work on evidence. It worked because it was very similar to Morecambe Bay. It was heading for NHS foundation trust status. I didn’t know why, but that’s what it was doing. So, everything was on a track to hit the targets to get to FT status. So, the critical list was district nursing. You’ll see the full list. Some of the issues that I was dealing with individual members of staff because we set up an ask Sue box to get the staff to come directly to me, open my door up and at one point...one Friday I went home and I thought I can’t take any more psychological...I couldn’t take any more of the cases that we were dealing with were just so appallingly managed that I realised particularly during that period of diagnosis that I had never come across this in my entire life.”
The Interim Chief Executive went on to say:

“I was told in the first week with the Audit Committee when I went to the Audit Committee that and on my first day in post when I saw all the Non-Executive Directors that this was a very strongly financially managed organisation. Brilliant. You wouldn’t find anything wrong in the finances. Well, of course, if was all skewed because when you got out onto the service, there was underspending by £3m on district nursing. These teams were devastated because they weren’t allowed to recruit some of them down to 50% and it was erratic but it wasn’t that everyone lost a post. It was completely erratic. So, the Sefton team had lost 50% of their staff. When you then looked at the incidents the Datix... just the basic grade 3 & grade 4 pressure sores, you were beginning to see the impact that it was having on quality and nobody was putting that together.”

1 The Director of Finance provided clarification on this point as part of his response within the Salmon process. “The report references a quote that District Nursing was underspending by £3m. This figure has been misquoted since a member of the Finance Team presented it in an initial draft service line reporting table internally in LCH [the Trust]. This draft report matched contract income by service against expenditure in the latest budget, to demonstrate which services were contributing to surplus and which were generating a deficit. It was quickly established that the income for district nursing had not been adjusted and matched for expenditure lines that had been moved in operationally led budget re-alignments to reflect reporting accountability. The original contract income covered District Nursing, Night Nursing, PDMs and some other specialist nursing teams, but in the first draft was matched only to district nursing expenditure: thus showing a big surplus for district nursing but costs for the other services with no income to match to it, and such an equal and opposite deficit position. This draft report prompted the commissioning of a comprehensive review of expenditure by service line, by commissioner with a full audit trail from the original establishment of income lines when the NHS Trust was formed (known internally and to commissioners as “The single version of the truth”). Commissioners had agreed to re-baseline current income to match expenditure to form a baseline for future investment decisions. To put this comment into context there was a significant underspend against internal budgets for 2013/14 (not sure of the exact figure but I think it was around £1m), mainly due to the inability to recruit to vacancies through poor processes and management of a third party provider. This represented about 50 WTEs, approximately 10% of the budgeted workforce. Non recurrent savings from vacancies were never recorded as Cost Improvement Programmes, and in 2013/14 did not contribute to delivering planned surplus but enabled the recording of a provision for future liabilities, which can be corroborated in the annual accounts.”
19.3 The scale of the challenge the Trust inherited was furthermore in our view clearly set out in a letter the Trust received on the 4 July 2014 from the independent regulator for NHS foundation trust, Monitor. The letter set out the outcomes of the “Pilot Review of Quality Governance – Liverpool Community Health NHS Trust.” By way of background, between January and March 2014 the Trust participated in a pilot review by Monitor of quality governance against Monitor’s Quality Governance Framework, as part of the then Trust application to achieve NHS foundation trusts status. The preliminary findings were sent to the Trust on the 31 March 2014 – which was the period that saw the transition from the previous management team to the new leadership team – and a ‘feedback and challenge session’ was held with Monitor and the new leadership team on the 23 June 2014 to discuss the findings of the review. In that sense this report is about the period prior to the arrival of the new leadership team and sets out in our view not only an assessment of the direction of the Trust prior to the arrival of the new leadership team but also set out clearly a range of actions the Trust needed to take going forward to address the quality governance concerns in the letter. Given we believe its significance; the letter is produced in full in Appendix 6.

19.4 The review team note that some really strong work has been undertaken in this early period by the new senior leadership team to get to grips with the enormity of the agenda it had inherited.

19.5 We have already talked in detail in Section 10 about the assault on the health care professional that took place in spring 2013 and how this was addressed by the Interim Chief Executive and Interim Director of Nursing, which then resulted in a comprehensive paper being presented to the Board on the 23 September 2014, setting out the actions taken thus far and those that were further planned to address that matter.

19.6 Below, we focus initially on the work of the new leadership team in addressing concerns within HMP Liverpool which we previously covered in Section 11.

19.7 The Interim Chief Executive described her first visit to HMP Liverpool shortly after she arrived at the Trust in the following way to the review team:
“I took three weeks to get clearance to get into the prison because you have to go through a whole load of stuff and I went in and he got all the staff together and Jill Byrne [Interim Director of Nursing] and I, who I’m sure you will interview, and it was a day in my life I would never ever want to repeat because this team were just completely . . . if I thought I had seen bad things in dental and podiatry and district nursing and health visiting and everything else, I walked in there and there was a team of completely disillusioned unsafe staff who started to say things to Jill and I like “Well, you know hand these drugs out and then someone comes along the next day and authorises them.”... So we were sort of working through and we thought “Jesus Christ!” and Jill stood up and said “Right, that has to stop, now. We cannot go on . . .” So, we went through the whole day with these staff and it was quite clear there was bullying harassment, there was no leadership...what we uncovered in the prison was just dreadful. We raised it to 25 on the Risk Register immediately.”

19.8 Following visits to HMP Liverpool by the interim leadership team and further investigation and triangulation of the evidence a meeting took place on 23 July 2014 to review all the information and plan a way forward. At this meeting, the collective decision was taken to increase the risk to 25 on the Trust Risk Register owing to the nature and breadth of the concerns and escalate this level of risk to the NHS Trust Development Authority and the NHS England Local Area Team on 24 July 2014.

19.9 The Board subsequently at its meeting on the 29 July 2014 received an extensive paper from the Interim Director of Nursing setting out the range of concerns the new leadership team had started to uncover at HMP Liverpool and the actions taken at that stage to address the areas of concern that had been identified.

19.10 The concerns set out for the Board on the 29 July 2014 were extensive and worrying at the same time and included the following:

- A lack of clear management and leadership of the offender health services;
- A lack of openness and escalation of a range of issues and incidents;
A lack of care and compassion towards offenders. Three specific incidents were highlighted:

- *Incident 1*: A prisoner recently sent into custody stated to the nurses he was unwell: spitting up blood; having difficulty swallowing and losing weight. The nurse stated she would get a doctor to see him. The offender DNA’d [Did Not Attend] the following 5 appointments (usually meaning a prison officer did not bring the offender to the healthcare centre). The nurse did not follow this up at all. When the offender did eventually see a doctor about this and had appropriate investigations he was diagnosed with advanced cancer. Post diagnosis, the level of pain relief offered to this offender was inadequate to meet his needs and poorly organised;

- *Incident 2*: Patient awaiting a nephrectomy not given basic nursing care - ensuring intake of fluid was appropriate; instigation of fluid balance chart or monitoring of bowel movements;

- *Incident 3*: Offender had previous RTA [Road Traffic Accident] which resulting in eye damage, and he was awaiting removal of the eye. Until that procedure he needed specific eye drops to alleviate the pain and inflammation felt. The healthcare team consistently failed to obtain an adequate supply for over a month with inadequate dosage.

A range of workforce issues included but not limited to incorrect skill mix, recruitment and retention issues, no evidence of clinical supervision or peer review, and no effective handovers from shift to shift;

A range of governance concerns, which included no lessons learnt or action plans shared following incidents or serious untoward incidents, lack of standard operating procedures and clinical guidelines in place, lack of governance procedures and policies, serious incidents not being recorded on Datix or investigated, serious concerns regarding the level of documentation that could affect patient safety including fluid charts not completed properly, and delays in provision of medication and missed diagnosis;
- Infection control issues, which included eight standards relating to infection control are not being met and 28 areas within the standards not being met including hand hygiene, safe handling and disposal of sharps and departmental equipment being unclean;

- Medicines management concerns, including insufficient stock control on wings leading to delay in ordering, controlled drugs administration failings, medicines left out of boxes and used for a number of patients and named medication used for various patients.

19.11 The process which followed the receipt of this paper by the Board included monthly risk summits (chaired by NHS England North) and fortnightly task and finish groups chaired by the NHS England Lancashire Area Team. There were in addition, weekly internal progress meetings designed to mitigate identified risks. A detailed risk register and associated action plan was monitored each week with work-stream leads for each risk area. The risk register was used as a basis for the external scrutiny meetings and formed the strategic assurance framework by which the Trust was monitored by commissioners.

19.12 Although progress was made in reducing risks, the Trust recognised that it needed specialist interim management support which was gained through an initial secondment from a senior manager within Pennine Care NHS Foundation Trust; and subsequently the secondment of an experienced offender healthcare manager from Lancashire Care NHS Foundation Trust from September 2014.

19.13 Following a risk summit in August 2014 the Trust commissioned an independent review of governance within HMP Liverpool which was undertaken by Spectrum Community Health Community Interest Company (referred to hereafter as the “Spectrum Report”). The experienced review team comprised Dr Linda Harris, GP and Chief Executive/Clinical Director at Spectrum Community Health; Maggie Wood, Independent Consultant, Offender Health Needs Assessment and Clare Shepherd, Independent Consultant, Safe Offender Healthcare. They agreed their terms of reference with the Trust in September 2014 which were:
To review current service provision and identify of any risks within the current service provided;

Triangulate the identified risks against the known risk already identified by the Trust and any other external reviews undertaken within the last 12 months;

Quantify any previously unidentified/unknown risks within the current service provided to make recommendations, as to the immediate actions required to rectify the identified risks, in order to ensure that the service will deliver the minimum safe standards of care as soon as possible.

The final report was presented to the Trust in January 2015 and concluded that the reporting structure of the prison health services up and into the Trust at a corporate level was “complex with multiple reporting pathways.”

The Spectrum Review also noted that “senior management meetings were held weekly with a selection of minutes provided from February to July 2014. The meetings were attended by Head of Prison Healthcare at the Trust, the operational and projects managers and senior clinical leads. From the 28 April 2014 meeting, the meeting followed a set agenda linked to governance and performance. Care planning, staff debriefing, reviewing meeting structures, identifying audit plan, handover, and clinical supervision were raised with clear actions and named leads.” Each meeting the actions were discussed however the Spectrum Review concluded that “there was little evidence that the actions were completed in the six months of minutes.”

The Spectrum Review drew out a range of other concerns including:

“Medicines administered from a number of areas within the prison and nurses expressed concerns that there were sometimes not enough nurses to cover each of the areas, requiring nurses to administer medicines in more than one area and treating feelings of anxiety and pressure;

There appeared to be no formalised embedded processes for learning from incidents and for sharing lessons learned;
It was reported that staff shortages were impacting on the ability to meet day to day service delivery and national health screening targets;

From the information accessed and the discussions that took place with available staff it appears that many systems and processes have been in place for some time at HMP Liverpool. However, these have not been implemented and monitored robustly, leading to a superficial ‘veneer’ of clinical robustness which becomes transparent upon close scrutiny;

Themes from deaths had been identified, though again not systematically and not addressed.”

19.17 Considerable managerial and operational support was released by the new leadership team to enable the risks to be mitigated and reduced. Notwithstanding this vast amount of additional support, the specialist nature of the service, the long-standing nature of the issues, and security difficulties around access to HMP Liverpool hindered the Trust’s ability to reduce the risks to a predetermined timescale.

19.18 The Trust recognised that offender health services are an increasingly complex and specialist area which required specialist leadership to reflect the changing and challenging nature of the patient population. The Trust also recognised that it needed to make sure that offender health colleagues always had the best support possible from specialists with a proven track-record in running complex offender health services.

19.19 Given the above, but prior to the publication of the Spectrum Report, the Trust Board took the decision with the agreement of NHS England (as the commissioner) on 21 October 2014 to transfer offender health services to another provider.
19.20 We heard during the course of a number of interviews that to not tender for these services was a difficult decision to make, but was one that will ultimately help to ensure that patients and staff are put first and the improvements starting to be made in offender health services at HMP Liverpool are sustained and taken forward for the long-term.

19.21 The NHS England Lancashire Area Team appointed Lancashire Care NHS Foundation Trust as the main interim provider of healthcare service for HMP Liverpool.

19.22 The Trust has been working collaboratively with both Lancashire Care NHS Foundation Trust and Mersey Care NHS Trust (with oversight from NHS England Lancashire Area Team) to ensure a smooth transition to new providers. The Trust formerly handed over provision of the services on 31 December 2014 but have continued to work closely with both providers since then on a range of legacy matters.

19.23 Any remaining involvement with prison services in HMP Liverpool by the Trust is in relation to Deaths in Custody, prior to 31 December 2014, where the Trust needs continued communication with staff regarding attendance at inquests as directed by the Coroner. These specific issues continue to be reported into the Board.

19.24 In conclusion, given what was unearthed after just the first visit by the new leadership team to HMP Liverpool, it seems difficult to comprehend that some of the areas of concern around health services provided at HMP Liverpool were not therefore known to either the Divisional Manager for Primary Care and Public Health or the Director of Operations & Executive Nurse, or both and why visits by Board members had failed to pick those issues up in the period before April 2014. We have also highlighted the robust nature of the actions taken by the new leadership team in relation to this service since April 2014.

19.25 We next cover the issues in the Intermediate Care Bed Based Service and how these have been progressed since the arrival of the new leadership team.
This was an area we covered extensively in Section 12 of our report, where we focused on the period prior to the arrival of the new leadership team. The new leadership team were the recipients of the Sue Miller review commissioned by the previous Chief Executive of the Trust as we set out in Section 12.32.

The review by Sue Miller was received by the Interim Chief Executive shortly after her arrival. On the basis of what was contained in the Sue Miller report, one of the early actions of the Interim Chief Executive was to reinstate back to clinical duties the three clinical leaders that had been the subject of disciplinary processes which we referred to in Section 12.27 and to issue them with a formal apology on behalf of the Trust.

The wider actions around the Intermediate Care Bed Based Service have included but are not limited to establishing staffing levels in line with acuity across the Intermediate Care Bed Based Service, recruitment of advanced nurse practitioners, implementation of a new discharge policy and a new operational policy, a review of the strategic direction for the Intermediate Care Bed Based Service in conjunction with commissioners and acute care providers in Liverpool and Sefton and greater executive director visibility within the Intermediate Care Bed Based Service as a whole. This is not to say of course that all the issues within the Intermediate Care Bed Based Services have been resolved. Indeed the “Improvement Plan Quarter 1 Progress Report for 2015/16” which was presented to the Board meeting held on the 22 September 2015 continues to rate the Intermediate Care Bed Based Services as “remains critical” and sets out the areas of concern and further actions taken and those planned. Certainly a positive position in our view is that the whole Board is now fully sighted to these issues, though clearly more work is required in this key service area if there is to be sustained progress.

A final area in this section we wanted to focus on is Cost Improvement Programmes and Quality Impact Assessments. We covered this subject in Section 9 of our report.
19.30 An early action was the handover of the Quality Impact Assessments process in the Trust from the Programme Management Office back to the Quality Improvement Team in the Trust. This coincided with a clinically led review of all Cost Improvement Programmes and service improvement projects undertaken to ensure that the projects supported the following four key principles:

- The business needs of the Trust;
- Commissioning intentions;
- Quality of care to patients and the public;
- Staff wellbeing.

19.31 The Improvement Plan provided a detailed assessment of all Cost Improvement Programme schemes which were subject to a full clinical review and re-profiling within a wider Financial Recovery Programme for the Trust and progress against Cost Improvement Programme is also being provided to the Board through the Financial Performance Report.

19.32 Significant lessons were learnt from the clinical review of projects which prompted the Trust to review the Quality Impact Assessment process. The lessons learnt are listed below:

- Assumptions should not be made about the service without their engagement;
- The right skill mix is required at Quality Impact Assessments to aid staff engagement, communication and improve mitigation. Early engagement will also assist staff morale and aid retention/attendance during periods of change for services;
- Quality Impact Assessments should have been reviewed regularly, including at milestones and also reviewed against the position of the Strategic Enablers. Strategic Enablers should be referenced in Quality Impact Assessments;
- Improved process needed for escalating Red/Amber risks;
- Quality Assurance must be timely, there must be little or no delay between the Quality Impact Assessments being completed, quality assurance by executive leads and communication back to the services;

- A number of projects did not have a Quality Impact Assessments – process needed to assure consideration of both Quality Impact Assessments and Equality Assessment, e.g. a project checklist at outset.

19.33 The process of Quality Impact Assessments has therefore been revisited and an interim process was established during the period of transition to locality working. As localities become established, the process will be further reviewed in line with future governance arrangements. The key changes to the process are as follows:

- The Quality Impact Team will facilitate any Quality Impact Assessments or Quality Impact Assessments reviews undertaken – this will reduce subjectivity and support a consistent approach to Quality Impact Assessments throughout the organisation;

- It is proposed that divisions discuss the Quality Impact Assessments at both governance and/or forums at which Divisional Improvement Plans are discussed;

- It is proposed that Quality Impact Assessment risks/issues be reported to the Business Development Group in addition to the HGSC which is current practice.

19.34 The whole area of Cost Improvement Programmes and Quality Impact Assessments as we described in Section 9 of our report had a very negative impact within the Trust. The early focus therefore of the new leadership team in this area is something the review team welcomes, particularly as it has ensured that going forward, the process is clinically led and creates the correct balance between quality, business change and addressing the financial pressures facing the Trust.
The Corporate Governance Arrangements in the Trust Today

We now consider the corporate governance arrangements within the Trust since the appointment of the new leadership team in April 2014 and have drawn out areas where we feel progress has been made and those that in our view require further focus and attention.

We have been mindful of the need to consider whether improvements in actual ways of working have been underpinned by the necessary systems and structures and the extent to which they have been fully embedded.

The view that has emerged is one where the Trust has moved forward considerably to one that is stronger, but by no means complete. Given the starting point and what the new leadership team inherited in April 2014 and the absolute need to initially prioritise the delivery of safe and effective care; that is perhaps not a surprise.

At a senior level, the new leadership team continues to change and evolve. On the Non-Executive Director side, there has been the appointment of a new Chairman in May 2015 and new Non-Executive and Associate Non-Executive Directors in August and October 2015. Whilst most recently amongst the Executive Directors, the Trust had made two new appointments - a new Interim Director of Nursing, Director of Infection Prevention & Control was appointed in August 2015 and a new Director of Finance was appointed in October 2015.

The appointment of a new Chairman and the more recent appointment of new Non-Executive Directors will inevitably strengthen the Board. The extensive skill set of the newly appointed Chairman and Non-Executive Directors will, we feel, also be crucial as the Trust moves forward through what inevitably will be a difficult period.
The new leadership team have since their arrival been systematically working their way through the agenda it inherited using an Improvement Plan which was presented first to the Board in July 2014 and after some amendments, was approved at the September 2014 Board. This is to be delivered over the next two years and comprises three key phases:

- Fix critical operational delivery;
- Match clinical services to commissioning intentions;
- Service transformation to a new organisation.

The Improvement Plan is intended to incorporate within it recommendations made in the letter to the Interim Chief Executive from Monitor dated 4 July 2014, which we referred to in Section 19.3.

Phase 1 and Phase 2 of the Improvement Plan were progressed during 2014/15 and focused on addressing a range of critical service issues, alongside the development of a new model of care that has clinical leadership at its core and fosters greater integration between community, primary and social care provision on a locality footprint.

Phase 3 involves securing a new organisational model in line with the Trust Board’s decision to leave the NHS foundation trust pipeline in January 2015. The identification of a new organisational model is in line with recommendations set out in the Dalton Review (Examining New Options and Opportunities for Providers of NHS Care: the Dalton Review, Department of Health, December 2014) and the strategic direction of the NHS Five Year Forward View (NHS England, October 2014).

Progress against the key elements of the Improvement Plan are provided to the Board on a quarterly basis, but more frequently if required.
20.11 Stronger corporate and clinical governance has been a key element of the Improvement Plan. Consequently, the Trust received two detailed papers – these were referred to as the ‘Board Governance Manual Part One’ and the ‘Board Governance Manual Part Two’ and they form part of the overall Improvement Plan. The first was received by the Board at its meeting on the 16 December 2014 and the latter at the Board meeting on the 24 February 2015. Both documents we found to be fairly comprehensive in their coverage of the key issues and gaps and embraced both the corporate and clinical governance agendas.

20.12 The “Board Governance Manual Part One” was very much focused around the twin aims of implementing a robust and flexible clinical and corporate governance system that can be implemented into a locality model whereby clinical leadership and clinical strategy are devolved to the new localities and secondly to ensure the current governance system is safe, fit for purpose and responsive.

20.13 The “Board Governance Manual Part Two” made a series of recommendations around the corporate governance architecture of the Trust in terms of Board Committees and the sub-committee level as well as proposing a corporate governance structure for locality working.

20.14 Board meetings have a clearer quality focus than was the case prior to the arrival of the new leadership team and the Integrated Performance and Quality Report has been rightly organised around the five key Care Quality Commission domains of safe, responsive, caring, effective and well-led.

20.15 There is also greater openness and transparency than was the case prior to the arrival of the new leadership team, with most of the business of the Board now being conducted in the public part of the meeting, as opposed to in private.
20.16 There is also stronger evidence in recent Board minutes of greater scrutiny and challenge and in particular by the Non-Executive Directors. This is important, particularly in light of the comments we made in Part One of our review. A number of people we spoke to referred to points they had made at either the Board or at a Committee level but which we subsequently could not evidence in the minutes of those meetings. The minutes of a meeting are the official record of its proceedings and hence should be sufficiently explicit to allow others to understand what was discussed and how decisions were reached, recording in particular, key areas of scrutiny and challenge.

20.17 There are however a number of areas where we do have concerns. Recent Board papers that we have reviewed (June, July, September and October 2015) are very lengthy (for example, the papers for the June 2015 totalled 423 pages whilst those for October 2015 were 345 pages in length) and greater attention needs to be applied to writing board papers that are sharper, more focused and draw out clearly for the Board the key issues. This will enable Board conversations to be better focused and enhance the level of scrutiny, challenge and oversight. If this fails to be addressed going forward, we would be concerned that Board meetings become more of a feat of endurance rather than an exercise in ensuring scrutiny and effective oversight.

20.18 Alongside this, we feel that greater attention needs to be given to the compiling of Board agendas. Recent ones we have looked at are substantive – for example, the 27 October 2015 agenda contained twenty major agenda items - and this in our view makes it difficult for the Board to do each agenda item justice in the time allotted.

20.19 The Trust has made progress in terms of revisiting the committee structure and this now comprises a Human Resources and Organisational Development Committee, Quality Committee, Strategy and Performance Committee and a Health and Safety Committee (as well as an Audit Committee and Remuneration Committee) and each has an accompanying work programme, which was presented to the 27 October 2015 Board meeting. This in our view reflects the key priorities of the Trust today.
20.20 Each Board Committee has a supporting work programme, though given what we have said around the size of Board agendas in Section 20.18 there would be merit in looking at these to see what more can be delegated to Board Committees with a clear reporting line then back into the Board.

20.21 We note that the arrangements in the Trust around the membership of Board Committees differs from practice across many other parts of the NHS and is not consistent with good governance guidance, such as the *Healthy NHS Board 2013: Principles for Good Governance* (NHS Leadership Academy, 2013). For example, we note that there are just two Non-Executive Directors who are members of the Audit Committee, Human Resources and Organisational Development Committee, the Quality Committee and the Health and Safety Committee, whilst four Non-Executive Directors are members of the Strategy and Performance Committee.

20.22 Just having two Non-Executive Directors as members of any Board Committee, of which one is the Chair of that Committee, can limit its ability to scrutinise what is a significant agenda. The Board may wish to give consideration to adding a third Non-Executive Director to each Committee to reflect the size of the agenda that sits within the remit of the Committee, enable greater scrutiny to be applied and would be consistent with good practice. It would also create a better balance on Board Committees between Executive and Non-Executive Director attendees. These points about the Trust committee structure were made over a year ago in the letter from Monitor which we referred to in Section 19.3.

20.23 At the same time, whilst we can see why given the importance of the agenda, the Health and Safety Committee is being chaired by the Trust Chairman, in terms of good governance we would not expect the Trust Chairman to be a member of or Chair a Board level committee (other than the Remuneration Committee). We accept however the reason why this has been approached in this way and expect these arrangements to be reviewed as more substantive progress is made.
20.24 During the course of our review it was suggested to us that whilst the Board does have development days, the content for these was too operational in focus. This partly reflects the scale of the operational challenges that the new leadership team have had to get to grips with. We feel that the role of the newly appointed Chairman will be critical in helping to move these agendas forward and ensure that development sessions are genuinely strategic in nature.

20.25 There was a view expressed to us during the course of some of our interviews that Board relationships at the time particularly between Executive and Non-Executive Directors had been impacted by the commissioning of this review. The Board as we have observed in Section 20.4 has changed significantly since we undertook those interviews but ensuring that there is a unitary Board, with trust and candour at its heart, is nevertheless an area that will need to be the focus of the newly appointed Chairman.

20.26 An area of concern that we covered in Part One of our review was Board visibility. We heard during the course of our review about how there has been much time spent by the new leadership team meeting front line staff since they have been appointed. We feel that the Trust Board needs to ensure as a whole it connects effectively with staff at all levels and creates ways in which staff can gain access to Non-Executive Directors and vice versa. These need to be focused around ensuring genuine engagement so that Board members can understand those areas where things are going well, as well as those where that might not be the case.

20.27 There are a range of examples of how this has been done successfully across many other parts of the NHS, including unannounced visits to front line areas (something which we were informed the new Chairman has already started to do), back to the floor initiatives, clinical presentations at the Board, and drop in sessions for staff to meet with the Board on Board meeting days over lunch, as well as attempts to get the Chair and Interim Chief Executive to connect with staff across the Trust at different bandings, locations and levels of seniority.
20.28 The possible transient nature of the new leadership team was raised in numerous interviews from the perspective that if a member of the team leaves, then a new arrival may wish to radically alter what their predecessor has done, and which may then impact on progress of that particular agenda. For example since the appointment of the new leadership team the Trust now has its third interim Director of Nursing. Whilst everything would suggest that in each case the new Interim Director of Nursing has very much sought to build on, rather than radically alter what their predecessor has done, and that they have been clearly guided by the Improvement Plan, it is something the Trust needs to be mindful of as it moves forward.

20.29 Through the course of the review the Trust has found it difficult on occasions to identify key historical documentation and provide this to us in a timely manner. This reflects in part the difficulties the interim senior team have had in bringing key historical documentation together into a single place. Hopefully the process of undertaking this review has enabled that to happen but it reinforces the need to ensure that the Trust has clear systems for archiving key corporate material today.

20.30 Corporate governance support in the Trust remains for the review team a source of concern. We note that the Trust recently appointed a new Trust Secretary but who has unfortunately decided to move on after only a short period of time. This follows on from the departure of the previous Interim Trust Secretary. The Trust currently has sourced consultancy support in this area and shares our view that this is a key post that needs to be recruited to as quickly as possible.

20.31 We would encourage the Trust to ensure that when the post is recruited to, it puts into place the necessary infrastructure to support that post holder if it is to ultimately succeed. We make this point as we heard during the course of a small number of interviews that there is a sizeable workload in this area and that historically, this position has lacked that necessary support infrastructure.

20.32 We note that the Trust approved a new Risk Management Strategy on the 29 June 2015 and that the new Board Assurance Framework was received at the 27 October 2015 Board meeting.
20.33 Prior to the new Board Assurance Framework being presented to the October 2015 Board, there is evidence that the previous Board Assurance Framework was reviewed at the Board on a quarterly basis, which is in line with good practice and there is evidence it is updated to reflect current issues and the new Risk Management Strategy makes clear how risks are escalated from local risk registers to the Corporate Risk Register.

20.34 The new Board Assurance Framework which was presented to the 27 October 2015 Board contains seventeen strategic risks (this is not significantly out of kilter with good practice which is for a Board Assurance Framework to contain between eight and fifteen key strategic risks) and the overall length of the document is manageable. There is alignment of each risk to a Board committee and an Executive Director sponsor and that too is consistent with good practice.

20.35 Critically, though the Board Assurance Framework that was presented to the 27 October 2015 Board does not score each risk, nor does it set out how risks have moved since they were previously reviewed. The narrative in the Board report on the Board Assurance Framework states “Principal risks are purposely not scored or prioritised as the Board Assurance Framework sits separately from the Corporate Risk Register which operates in accordance with the Risk Management Strategy.”

20.36 We have found it difficult as a review team to understand the rationale for this. It is correct that the Board Assurance Framework should sit separately from the Corporate Risk Register as it is a very specific assessment of risks against the corporate objectives but there should be a connection with the Corporate Risk Register and the Board Assurance Framework as they are both part of the overall Trust Risk Management Strategy. Furthermore, by not scoring any of the risks on the Board Assurance Framework the Board can take no assurance that the controls and mitigations that have been put in place to reduce risks are actually working.
20.37 The Corporate Risk Register was also presented and considered at the 27 October 2015 Board meeting. The covering paper contains statements and proposals for managing the Trust Risk Register that the review team consider potentially flawed. In the opinion of the review team there seems to be a possible misunderstanding of what a trust risk register should be – i.e. an integrated register that pulls together the Board Assurance Framework, corporate risks and local (operational) risks into a single register that can be reported as a whole, separately, by risk or by department etc. The Board Assurance Framework, the corporate risks and the local risks are therefore all sub-sets of the Trust Risk Register. This should be a dynamic document and risks can escalate from local to corporate, (and if presenting a risk to delivery of corporate objectives) the Board Assurance Framework, with appropriate assessment and agreement by the relevant oversight committees(s). The Corporate Risk Register presented to the Board in October 2015 seems to suggest the Trust Risk Register will simply be a register of those risks designated as corporate with no clarity as to how local (operational) risks can be escalated to the corporate element of the overarching Trust Risk Register.

20.38 The review team feels that the Trust needs to reconsider the thinking and approach to both the Board Assurance Framework and Corporate Risk Register. It is also worrying that concerns around the Trust approach to risk management were already flagged to the new leadership team in the letter from Monitor to the Trust which we refer to in Section 19.3.

20.39 We would also suggest that it would be good practice for the Audit Committee to undertake deep dives into the risk associated with two strategic aims included on the Board Assurance Framework at each meeting. We feel this will enable a deeper level of scrutiny to be achieved complement the oversight of the Board Assurance Framework at the Board.
A final area we would express some concern around is the pace of change and the time it is taking to move agendas forward as well as the ability to track progress of agreed actions. Indeed during the course of 2014/15, the lack of evidence to demonstrate that appropriate controls are in place, an accumulation of outstanding actions from internal audit reviews and a failure to close outstanding actions in a timely manner led to the Trust receiving from the Head of Internal Audit “limited assurance” for 2014/15.

On pace of change, the Monitor letter to the Trust dated 4 July 2014 made clear the need for the Trust to revise its approach to risks. A key element of that is the Board Assurance Framework and whilst there has been some progress in the months since the 4 July 2014 Monitor letter, it is only at the 27 October 2015 Board meeting that a revised Board Assurance Framework was presented. Furthermore, as we have already noted in Sections 20.35 to 20.37, we have concerns not only about the new Board Assurance Framework but also the Corporate Risk Register.

Whilst on the ability to track progress, the Governance Manual, Part One and Two which we referred to earlier, made a series of recommendations, which have been incorporated into the overall Improvement Plan. However it has been hard to track progress on this as governance was labelled as “under development” in the Improvement Plan update that was received by the 22 September 2015 Board meeting. The update to the Board at the 27 October 2015 failed to cover this and leaves open the question of what progress the Trust has made against the key recommendations within the Governance Manual, Part One and Two to date.

In conclusion, we welcome the progress that has been made by the new leadership team since spring 2014, but there is considerable further work to do in this area as we have highlighted. We would again emphasise our point that the pace of progress is for us a cause for concern.
21 The Framework and Structure for Clinical Governance Today

21.1 We next want to turn to some of the wider issues for the Trust around its current clinical governance arrangements, which have emerged through the review of documentation and through the course of our interviews. We initially focus in this section on the remainder of the 2014 calendar year, following the appointment in April 2014 of the new leadership team.

21.2 The clinical governance framework of the Trust was not changed significantly for the rest of the 2014 by the new leadership team. The review team believe that this was understandable given the ongoing quality and safety challenges within the organisation which needed to be the focus of attention. The Trust also took the time to set out a clear vision to move the organisation forward through the overall Trust Improvement Plan which we referred to in Section 20 and this included a detailed work stream to review and make recommendations around its corporate and clinical governance arrangements.

21.3 However, this did mean that some of the weaknesses within the clinical governance framework that could have improved Board assurance during the rest of 2014 remained.

21.4 The Patient Safety Group continued in our view to flounder over the remainder of the 2014 period as there was still no clarity on the Chair, it met infrequently and provided little or no information or assurance on patient safety issues, incidents or learning. In fact at the December 2014 IGQC meeting it was reported by Craig Gradden, Medical Director that “The Patient Safety Group remains a risk.” It was not only the Patient Safety Group though where problems continued to exist during the period from spring 2014 onwards.

21.5 For instance, the IGQC meeting of the 3 June 2014 noted that in relation to the HGSC sub-committee - the Emergency Planning Group - that it had not met for the past three months.
21.6 There were also concerns around the Patient Experience Group not meeting regularly and this was “causing problems with processes.” Indeed, the HGSC were informed at its meeting on the 10 June 2014 that the most recent scheduled meeting of the Patient Experience Group “had not taken place; that papers had not gone out; and the meeting was cancelled on the day.”

21.7 Whilst at the IGQC meeting on the 7 October 2014, when the key points were fed back from the most recent meeting of the HGSC, “the IGQC Chair [Deborah Morton, Non-Executive Director] raised concerns around the lack of attendance by staff at this meeting as it impacts on this Committee. The Committee asked for an email to go from CG [Craig Gradden, Medical Director] to all members of the HGSC informing them that attendance is not as it should be and how important it is to ensure attendance and when unable to attend to ensure a suitable and fully briefed representative attends on their behalf. Staff should be attending at least 75% of these meetings.”

21.8 In relation to the Care Quality Commission inspections and action plans, we found little or no evidence that the action plans and related reports/investigations had been received and approved by the full IGQC during the remainder of 2014. We would expect this to have happened and for the Quality Action Plan Sub-Committee as a sub-committee of the IGQC to have been given delegated responsibility to monitor the action plans. There was seemingly no discussion on the work of the Quality Action Plan Sub-Committee, its action plan and any blockages to the delivery of those actions. There is no report or comment on whether the actions were resulting in identifiable improvements in care. We make further comment about this later in Section 21.24, as it has been more positively addressed in 2015.

21.9 During this period from spring 2014 to the end of 2014, we did though observe that the annual report (April 2013 – March 2014) of the IGQC was reported to the July 2014 meeting – this in itself is good practice. On one level it reads well but in our view shows a complete lack of insight into the challenges that had occurred in the Trust in the previous 12-18 months and the role the IGQC (and HGSC) should have had in identifying them and providing assurance to the Board. It states “it spent a considerable amount of time focussing on the Care Quality Commission inspection reports and warning notices.”
21.10 We would suggest the evidence (minutes of the meetings) does not verify that but even if they did, there is no reflection on how they occurred and why the IGQC were not cognisant of the issues earlier. It appears to the review team that the IGQC Chair thought they and the HGSC had fulfilled their remit successfully when in our view the reality was considerably at variance with that. There appears to be no challenge to this view by the new leadership team or Non-Executive Directors to this assertion in the minutes of the IGQC meeting.

21.11 We have drawn out below further over-arching comments around the IGQC during the period between spring 2014 and the end of calendar year:

- It should be noted that there are some positives around the IGQC – they did in this period, and before, look at the bigger strategic governance issues in some detail such as the Board Assurance Framework, Compliance Frameworks and policy approvals. They also put considerable emphasis on Quality Impact Assessments, in particular on getting the system right and getting the reporting of these correct and more robust. Reporting of Quality Impact Assessments improved in this period and there was a strong paper to the Board on this and to the IGQC in this period;

- Clinical Audit is discussed at most meetings and in some detail, and we would consider this to be a strength in terms of gauging the effectiveness of services. However, we have looked at the 2014/15 Quality Account and of the six national audits the Trust were eligible to participate in, the Trust did so in just two or as stated in the Quality Account 33%. In both of these data collection was still in progress and they were unable to provide the number of cases submitted to each audit. We would suggest this is poor and saw little evidence of this being reported as part of the regular report on Clinical Audit to the IGQC;
The Quality Account reported that in 2013/14 there were 37 Serious Untoward Incident’s including one Never Event – in 2014/15 this went up to 102 including four Never Events. From reading the IGQC papers and minutes up to December 2014 we would not have known this, or the reasons why the numbers increased. We understand the numbers increased because of a ‘look-back’ exercise carried out by the new Executive Team. Whilst this is to be commended we believe this further highlights our concern around patient safety, the Patient Safety Group and the “Weekly Meeting of Harm” – and the lack of reporting to, and oversight by, the HGSC and IGQC in 2014.

21.12 We now turn to some wider observations around the clinical governance arrangements in the Trust today.

21.13 As we have stated in Section 20, as part of the Improvement Plan, the Trust received two detailed papers – these were referred to as the “Board Governance Manual Part One” and the “Board Governance Manual Part Two.”

21.14 The “Board Governance Manual Part One” was very much focused around the twin aims of implementing a robust and flexible governance system that can be implemented into a locality model whereby clinical leadership and a clinical strategy are devolved to the new localities and secondly to ensure the current clinical governance system is safe, fit for purpose and responsive until the move to the new locality model. The “Board Governance Manual Part Two” made a series of recommendations around the governance architecture in terms of Board Committees and the sub-committee level and proposed a corporate governance structure for locality working.

21.15 As the Trust continues to implement the “Board Governance Manual Part One and Two”, we would encourage the Trust to ensure there is greater visibility of the progress being made to implement the recommendations contained within them. We would anticipate this would happen through the Improvement Plan updates to the Board. That said, the most recent update on the Improvement Plan to the September 2015 Board meeting worryingly listed this as an area “under development.”
Progress nevertheless has been made across a number of notable areas.

Everything that we saw and heard signalled significant recent improvement in the reporting and investigation of serious incidents and learning from what has gone wrong, but we must stress that this has been from a very low starting position.

In particular, there have been undoubted improvements in root cause analysis. The Board for example received a detailed paper from the Interim Director of Nursing on the 23 June 2015 setting out the current position with regards to serious incidents in the Trust, and how the governance arrangements around these are being enhanced, and in particular learning the lessons. The “lessons learnt” initiative is to be particularly welcomed and the paper to the Board on the 28 July 2015 drew out the specific learning from a serious incident in phlebotomy services. It starts to show a degree of openness and more crucially to learning.

These are the latest in a series of serious incidents reports to the Board – each show continuous progress in getting to grips with a sizeable and complex agenda but also each demonstrates a degree of openness and transparency and a desire to learn lessons and disseminate actions.

The Trust has recently established the Health & Safety Committee, a Board level committee to provide focus in this area. Given the scale of the agenda in this area as set out in a paper to the private Board on the 24 February 2015, we would endorse this position though over time this should operate as either a sub-committee of the Quality Committee or have an assurance route into the new leadership team meetings and will not require it to be chaired by the Trust Chairman.

There has also been significant progress around ensuring clear systems and structures are in place for ensuring Patient Safety Alerts are implemented across the Trust. This was a particular area of weakness that the new leadership team inherited when it was appointed in spring 2014 and where it was discovered that Patient Safety Alerts had been classed as completed without any of the necessary underpinning action being taken to support their closure.
By way of background, Patient Safety Alerts are a crucial part of the work of NHS England to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. These incidents are identified using a reporting system to spot emerging patterns at a national level, so that appropriate guidance can be developed and issued to protect patients from harm.

Patient Safety Alerts are issued via the Central Alerting System, a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care. The position in the Trust as at October 2015 is that 79% of Patient Safety Alerts have been closed within the designated timescales set nationally.

The Board has also set out clearly progress against the Care Quality Commission action plan in a document we have seen, dated 23 October 2015. This not only helpfully sets outs progress but also includes a “Care Quality Commission Action Plan Status” report which identifies the Care Quality Commission recommendation, updated narrative, future actions, evidence, a rating showing overall progress and a revised completion date.

The HGSC, now chaired by the Interim Director of Nursing, Director of Infection Prevention & Control is now in our view working better.

The Quality Committee now meets monthly which is consistent with practice across most of the NHS and also enables the Committee to effectively address the size and scale of the quality and safety agenda.
21.27 Attendance however at the IGQC from spring 2014 until the end of 2014 and at the Quality Committee from 2015 onwards is a cause for concern. Indeed as part of the Salmon process three of the Non-Executive Directors who were in post for some or all of this period noted “The Quality Agenda has been made more difficult by the rapid turnover of the senior executives. There have been 4 different Directors of Nursing in the last 19 months. In addition, there have also been 4 different incumbents in the role of Trust Secretary in the same period. The repository for all Governance and Quality documentation has been adversely impacted by these rapid changes in key personal and has placed substantial pressures on Non-Executive Directors, and Executive PAs, to ensure that meetings proceed on schedule with all necessary reports and analysis available. Further, attendance at these meetings by key executives has been sporadic and again the Chair of the committee has had to seek assurance that all members of staff required to attend these meetings do so. This has caused real concern about the ownership or lack of ownership of this area and has required direct intervention.”

21.28 The length of meetings and agendas remains for the review team a cause for concern and as one senior member of staff we interviewed stated: “They are unmanageable and it’s almost they want too much detail at the Committee and for me it’s around them just having, well it needs to be exceptional reporting and then it needs to have a proper work...I mean it does have a work plan but the work plan needs to be very much around what needs to be redone at that level. I think for me I’m probably...there are things that appear more often than they should so policies is a good one....It’s been on every one.” More frequent Quality Committee meetings and a closer look at the sub-committee structure and their remits will help to address this issue.
21.29 It is the view of the review team that the Trust needs to ensure that there is a consistent level of understanding across the Trust of the multiple groups and meetings that connect with each other to create the assurance pathway. During all too many of our interviews we observed a lack of a coherent and consistent understanding of escalation of risks and concerns within the Trust. We make this point particularly because many of the problems the Trust experienced in the past related to the poor, inconsistent or non-existent application or implementation of the systems and processes that were in place to ensure good clinical governance and the Trust needs to ensure this does not happen again.

21.30 It is also important that the Trust ensures that there is a clear and consistent understanding at the new locality and sub-locality level of the systems and structures for clinical and corporate governance, and in particular around how concerns, risks and incidents are routed into the leadership teams at locality level and then escalated upwards. Equally, there needs to be a clear feedback and learning loop from concerns, risks and incidents as that will help to create a climate of confidence in the systems and processes that are in place to ensure good clinical governance. Again, during the course of our interviews we felt that there was either an inconsistent or incomplete level of understanding of the systems and structures for clinical and corporate governance within the Trust. This creates the potential climate, if not addressed, for risks to not be properly escalated upwards or concerns to be missed.

21.31 In terms of Executive Directors, at first glance the portfolios are broadly what you would expect to see the various Executive Directors accountable for. However, we believe what they also show is that the accountabilities for, and the management of, quality and quality governance is disjointed, unclear and quite possibly un-coordinated. Our specific observations are set out below.

21.32 Patient Safety is one of the three key quality elements (Patient Safety, Patient Experience and Clinical Effectiveness) and yet other than patient experience which is listed as the responsibility of the newly appointed Director of Nursing, Director of Infection, Prevention & Control, the other two are not listed anywhere.
21.33 This feels symptomatic of the profile that Patient Safety appears to have within the Trust. For example, whilst there is a Patient Safety Group, the effectiveness of this Group was and is open to question (see our comments on the Patient Safety Group in Section 17 and 21.4). There is no Patient Safety Manager (though there is a 0.6WTE Safer Care Support Manager which is currently vacant). Management, monitoring and learning from patient safety incidents appears low-key and low profile as evidenced from the report (or lack of) to the two principal clinical governance assurance committees, the IGQC and the HGSC. This maybe an issue of language. In other words, patient safety may be part of the risk function which now sits under the Director of Nursing, Director of Infection, Prevention & Control, but it is not clear and we would suggest it does need to be clearer and Patient Safety should be seen much more transparently as a fundamental part of quality and as part of a quality function across the Trust.

21.34 The new Director of Nursing, Director of Infection, and Prevention & Control is accountable for the quality structure. This structure includes Patient Experience and also Quality Standards and Quality Improvement. It is not clear however if this function includes Patient Safety but we are aware it does not include effectiveness which sits under the Medical Director, presumably within the Clinical Audit function. It raises the question of which Executive Director holds the overall accountability for quality at Board level and who is the Trust’s Chief Quality Officer.

21.35 It is not unusual to have different elements of quality under different Board members, but if an organisation is adopting that model then the Board must have absolute clarity on who is accountable for what. This model also normally means that the management of the three key quality functions (Patient Safety, Patient Experience and Clinical Effectiveness) is split and an integrated quality governance function is not achieved. It is imperative therefore that these functions do work in an integrated manner and that there is synergy, learning, and co-ordination across all functions. It is probable that if quality systems and processes are not managed, monitored and reported effectively at corporate level then they also will not be at a local level and the Trust will not get good “Ward to Board” quality governance. We have seen only limited evidence that these various functions work well in an integrated and co-ordinated manner thus far.
21.36 It is perhaps helpful to consider Board accountability for quality in two ways:

- The Board accountability for the standards, systems and processes for managing, monitoring and delivering quality – to include those departments and staff with defined quality functions (safety, effectiveness and experience). In our view for clarity, this is best placed with one individual – but where it is not, the Board need to be absolutely clear who has accountability for what;

- The Board accountability for the quality outcomes of care – this has to reside with the most appropriate Board member; i.e. nursing and allied health professional care outcomes with the Director of Nursing, Director of Infection, Prevention & Control; medical outcomes with the Medical Director. It must also be recognised that the delivery of quality care is not simply a clinical issue and other Board members must also be held accountable for the delivery of quality within the areas they are accountable for where they impact on the delivery of clinical care e.g. the Chief Operating Officer and Director of Human Resources & Organisational Development.

21.37 The review team also does not believe that the Trust has the number and level of people needed to support the overall delivery of the clinical governance agenda. The structure charts we have looked at include within them some vacancies which are due to be filled but even if they were filled, it does not appear to have beneath the Risk and Governance Manager, which is the most senior post in that team, the necessary supporting infrastructure to be able to address the clinical governance workload within the Trust. Indeed as one person we interviewed stated: “Light both in terms of capacity and capability if I may say so. So apart from the Risk and Governance Manager...there would be no-one in my opinion in his team that would be able to step up and know the breadth of knowledge that he held.”

21.38 A further area for the Trust to consider is the presentation of the report from the “Weekly Meeting of Harm” into the private Board meeting. We commented on this when we discussed clinical governance arrangements in the period before spring 2014, specifically in Section 17.11 – 17.13. These concerns still apply today and we would suggest that the report has no value in its current form.
A final point relates to Information Governance. We note the Senior Information Risk Owner or SIRO function and Caldicott Guardian roles are split which is good practice but that Information Governance is the accountability of the Medical Director who is the Caldicott Guardian. The Information Governance Toolkit (Requirement 13.101) states; “The IG lead and the SIRO may be the same individual but the Caldicott Guardian should be distinct from both of the others and advisory rather than accountable.” Therefore as Caldicott Guardian, the Medical Director should not hold the Board accountability for Information Governance and the Trust may wish to consider moving this to the SIRO.

As the Trust is in the early stages of implementing its new locality based structures, we have set out in Appendix 7 a concise framework of questions or challenges that the Trust themselves can use to self-assess and/or sense check their new structures, systems and processes. These questions are based primarily on findings from the review but also on established best practice from the quality governance framework and the emerging learning from recent national reviews. The reviewers hope this approach will aid the Trust in ensuring the lessons from previous clinical governance failings have been learnt, and also in gauging if their revised structures, systems and processes are robust and meet their needs moving forward.

Creating a Cohesive Trust Culture

The organisational culture that operated within the Trust until spring 2014 left an indelible mark on many people. Many staff we spoke to feel bruised and many had lost confidence in the management of the Trust. Many went as far as to say they felt betrayed and that no one listened to them and that things were allowed to go unchallenged for so long. This lack of trust and indeed anger was very evident in many of our interviews. Such attitudes among members of staff demonstrate how corrosive the erosion of trust can be and this cannot be turned around within a short period of time. Staff within the Trust we spoke to will need to be convinced by both words, but more fundamentally by actions that the culture in the Trust has changed to one that is inclusive, that values staff and their views and which seeks to learn from when things go wrong, which in complex health care systems they inevitably do, from time to time.
22.2 We consistently heard that the Trust has made progress across a number of areas since the appointment of the new leadership team.

22.3 We noted a visible confidence amongst the majority of clinical staff we spoke to, who felt they were now being listened to by the new leadership team.

22.4 Staff we spoke with as part of our review were also positive about the over-riding focus in the Trust today around quality and safety. That is also something that is evidenced in Board meetings, where quality and safety is now the first substantive item on the Board agenda.

22.5 The Trust has also just implemented as part of the Improvement Plan a new locality structure which at its core has two key elements: devolved decision making to localities and empowering clinical leadership. These developments are very much in their infancy.

22.6 In our view, key to delivering a culture of improvement is leadership, both clinical and managerial at all levels of the organisation. We would suggest that the new locality structure creates an ideal climate in which to develop this group of individuals as leaders of the future. We feel that this will be critical in order that the new leadership team can continue to operate at a strategic level and not become too operational. We heard from a number of individuals who felt that the new leadership team were at times too operational in their focus.

22.7 There are three areas we particularly wanted to draw out as they have come up consistently during the course of our interviews with Trust staff.

22.8 The first has been the open and visible management style of the Interim Chief Executive and indeed of the wider new leadership team. Almost without exception this has felt to us to be a key departure from the previous management team, though this is an ongoing process and not everyone we spoke to was as positive and we cover that later in Section 22.15 to 22.21.
22.9 The second has been the desire of the new leadership team to value the voice of clinicians at all levels in the Trust and make the investment in frontline clinical staff.

22.10 The third has been the open and transparent way in which the Trust gripped the issues around HMP Liverpool. We could equally extend this comment to the approach taken by the new leadership team to Intermediate Care Bed Based Service, both of which we have covered in Section 19, and in relation to the assault on a clinical member of staff which we extensively discussed in Section 10. This desire to ensure that the Board is kept fully abreast of such key matters is to be commended and entirely in keeping with the principles of good governance.

22.11 During the course of our interviews it became quite clear that there are many people in the Trust who have been left damaged as a result of their experiences in the Trust prior to spring 2014. On occasions it was difficult for us to hear their accounts but hopefully the opportunity to take part in our review and to share their experiences with us has been a key catalyst in helping them to start to move on and rebuild their careers and lives.

22.12 That said the Trust will wish to consider in the light of our review offering those staff the opportunity to receive further support and development to enable them to move on.

22.13 We also feel that the Board today recognises that what happens in its facilities begins in the Boardroom. The Board sets the tone, by what it does and, importantly by what it does not. There was a strong recognition of this in our interviews with the new leadership team and starts to come through in recent Board papers we have looked at.

22.14 Having set out an overall picture that is positive, we nevertheless heard during a few of our interviews concerns which we feel is important to reflect back.
Non-Executive Directors who have now left the Board but who fulfilled this role after the appointment of the new leadership team in April 2014 stated in their interviews with us that the found the new leadership team difficult to work with, felt marginalised by them and that this was not conducive to the creation of a unitary Board.

We spoke with one member of staff who stated “There was lots of incidences of I suppose hypocrisy is probably a better word where they came in and they said they were going to do all these things and they were championing and being open and inclusive and everybody was involved and then that you know, very short time later it wasn’t that...So lots of hypocrisy.”

Whilst another member of staff we spoke to stated “I don’t in any way think it’s improved, I think it’s got worse in terms of the current interim arrangements. I think in the past the organisation was very process driven. I think now there is very little process and actually there is very little application of fair process and policy. So I think it’s swung to the complete opposite extreme. So I think there are decisions made now based on very little fact and there is a lot of implementation based on, without being based on process and fair, sorry developing based on policy and fair process. So I think it’s gone completely to the opposite end of the extreme and not for the better.”

We have attempted to triangulate the above comments with the NHS Staff Survey 2014 given that two thirds of that year was when the new leadership team had been in situ and to see what staff are saying.

The NHS Staff Survey 2014 for the Trust was sent to a total of 2,808 employees of which 1,077 were completed; a response rate of 38.4%. This compared to an average response rate of 48.3% for other community NHS trusts nationally.

The response rate itself feels worrying to us and is significantly less than the community NHS trust average nationally and a marked reduction on the number of staff completing the NHS Staff Survey compared to previous years. This may in part reflect a deeper weariness amongst Trust staff about the value of such surveys, given the lack of follow through from previous NHS Staff Surveys in the Trust.
We have drawn out below those areas which in our view are a cause for concern though we recognise there have been other areas in the survey where there has been more positive progress. A particularly worrying position is that over a quarter of staff in the NHS Staff Survey 2014 are saying that they have experienced “harassment, bullying or abuse from manager/team leader or other colleagues.” This is the marginally higher than in the NHS Staff Survey 2013 results, when the figure was 24% and is in fact at 26% at the highest it has been since the establishment of the Trust in late 2010. This needs to be better understood and a clear programme of action developed.
### NHS Staff Survey Theme and Questions

<table>
<thead>
<tr>
<th>Theme</th>
<th>Trust</th>
<th>Community Trust</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Personal Development</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No appraisal/KSF review in last 12 months</td>
<td>14</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Clear work objectives not agreed during appraisal</td>
<td>26</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Appraisal/performance review: left feeling work not valued</td>
<td>46</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td><strong>Your Job</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not have clear, planned goals and objectives</td>
<td>15</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Do not always know what work responsibilities are</td>
<td>13</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Not involved in deciding changes that affect work</td>
<td>26</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied with recognition for good work</td>
<td>28</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied with extent organisation values my work</td>
<td>35</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td><strong>Your Managers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate manager does not give clear feedback</td>
<td>20</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Immediate manager does not ask for my opinion</td>
<td>24</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Communication between senior management and staff is not effective</td>
<td>36</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Senior managers do not try to involve staff in important decisions</td>
<td>41</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Senior managers do not act on staff feedback</td>
<td>32</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td><strong>Your Organisation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of patients/service users is not organisation's top priority</td>
<td>14</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Would not recommend organisation as place to work</td>
<td>28</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Do not receive regular updates on patient/service user feedback in my directorate/department</td>
<td>30</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td><strong>Your Health, Well-Being and Safety at Work</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In last 3 months, have come to work despite not feeling well enough to perform duties</td>
<td>74</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Felt unwell due to work related stress in last 12 months</td>
<td>45</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Organisation does not treat fairly staff involved in errors</td>
<td>13</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Organisation blames/punishes people involved in errors/near misses or incidents</td>
<td>16</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Organisation does not take action to ensure errors not repeated</td>
<td>8</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Staff not informed about errors in organisation</td>
<td>30</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Staff not given feedback about changes made in response to reported errors</td>
<td>29</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Harassment, bullying or abuse from patients/service users, their relatives or members of the public</td>
<td>25</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Harassment, bullying or abuse from manager/team leader or other colleagues</td>
<td>26</td>
<td>19</td>
<td></td>
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</tbody>
</table>
In comparison with previous years, the number of verbatim comments provided by Trust staff also number very few. In fact in total just eleven such comments were provided. We have set out below those which we feel are of cause for concern.

“New CEO made initial effort to visit teams, this has diminished. Insufficient resources in place to move forward locality mobilisation. Managers feel undervalued across the organisation, especially non-clinical as we have been told and it is evident, that clinical staff are the priority and the rest of us aren’t needed. Morale is low, I feel more devalued than ever before. New sickness policy just lets the repeat offenders get away with more.”

“I have not been bullied myself but have witnessed this in the workplace. Concerns have been raised to senior managers by other staff members but the situation was never dealt with and the person concerned is still experiencing bullying.”

These results and verbatim comments were presented back to the Board at their 24 February 2015 meeting, alongside the results of the ‘pulse check’ survey which comprises 15 questions that staff across the Trust are asked to complete. The first ‘pulse check’ survey in February 2014 was completed by 1,130 staff; whilst in January 2015 770 staff took part. This again is a noticeable drop, in a way mirroring the drop in the staff completing the NHS Staff Survey from 2013 to 2014. The January 2015 results showed an improved score across all fifteen questions (average 7% increase) with the greatest improvement (15%) in the number of staff who felt that the quality and safety of patient care is the organisation’s top priority. The pulse survey results are shown below:
### Pulse Survey Question

<table>
<thead>
<tr>
<th>Pulse Survey Question</th>
<th>February 2014</th>
<th>January 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: I feel happy and supported working in my team/department/service</td>
<td>39</td>
<td>50</td>
</tr>
<tr>
<td>2: Our organisational culture encourages me to contribute to changes that affect my</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>team/department/service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3: Managers and leaders seek my views about how we can improve our services</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>4: Day-to-day issues and frustrations that get in our way are quickly identified and</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>resolved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5: I feel that our organisation communicates clearly with staff about its priorities</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>and goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6: I believe we are providing high quality services to our patients/service users</td>
<td>57</td>
<td>65</td>
</tr>
<tr>
<td>7: I feel valued for the contribution I make and the work I do</td>
<td>31</td>
<td>35</td>
</tr>
<tr>
<td>8: I would recommend our Trust to my family and friends</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>9: I understand how my role contributes to the wider organisational vision</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>10: Communication between senior management and staff is effective</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>11: I feel that the quality and safety of patient care is our organisation's top</td>
<td>43</td>
<td>57</td>
</tr>
<tr>
<td>priority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12: I feel able to prioritise patient care over other work</td>
<td>36</td>
<td>45</td>
</tr>
<tr>
<td>13: Our organisational structures and processes support and enable me to do my job</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14: Our work environment, facilities and systems enable me to do my job well</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>15: This organisation supports me to develop and grow in my role</td>
<td>25</td>
<td>31</td>
</tr>
</tbody>
</table>

The minutes of the 24 February 2015 meeting state the following: “Listening Into Action and NHS Staff Survey results (2014/15): Therese Harvey, Interim Director of Human Resources & Organisational Development advised the Board that the results of the Listening into Action show improvements in all areas. The staff survey results indicate some positive responses and some negative ones. Action Plans will be developed to address areas where improvements are required.” There is little evidence in the minutes of Board discussion though there was more discussion on this issue at the subsequent Human Resources and Organisational Development Committee meeting on the 24 March 2015.
In conclusion, we certainly feel that much progress has been made in creating a more positive Trust culture and the conversations we had with a number of Trust staff drew that out very well. However a small number of our conversations and the results of the 2014 NHS Staff Survey show that there is much more that needs to be done and some indicators within this, remaining very worrying indeed. The review team feel that it would be beneficial for the Trust to run a small number of targeted focus groups to understand better staff perceptions, recognising surveys may not be yielding the participation the Trust is seeking.

The Trust Whistleblowing Policy

The Trust has shared with the review team, its Whistleblowing Policy which was approved in February 2014. The Trust is currently working with Public Concern at Work and the Royal College of Nursing to review and develop its whistleblowing procedures and guidance. We welcome this approach and therefore have not commented on the Whistleblowing Policy as it is currently being re-written.

The Trust Board at its meeting on the 28 July 2015 received a detailed paper from the Interim Director of Human Resources & Organisational Development setting out the key findings and conclusions of Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS (Sir Robert Francis, February 2015). This looked at the raising concerns culture in the NHS and the report makes a number of key recommendations under five overarching themes and which includes actions for NHS organisations to help foster a culture of safety and learning in which all staff feel safe to raise a concern.

The July 2015 Trust Board paper helpfully highlighted that the Trust has identified the need to have a clear and comprehensive process for raising concerns as a key priority. The paper set out the procedure that has been designed to achieve this objective and we felt that this was clear and well-articulated.

We also note that this has been publicised in the Trust’s weekly bulletin, to all staff via their payslip and a copy of the process is available via the Trust’s intranet. All of which we would commend as good practice.
We felt that the narrative on the Trust intranet site was clear and well set out. We also felt that it was accessible and written in a language that genuinely attempts to explain to all Trust staff the spirit and intent behind the Trust approach.

In his speech to Parliament on the 11 February 2015, Jeremy Hunt, the Secretary of State for Health, stated that he accepted all of the actions highlighted in Sir Robert Francis’s report.

The Secretary of State for Health also subsequently wrote to every NHS trust chair to reinforce the importance of staff being able to discuss concerns openly in teams, and for appropriate actions to be taken. He specifically stated that each organisation should act now to appoint a local guardian who has a direct reporting line to the chief executive, who staff can approach to raise concerns.

Finally, we also note that on the procedure that the Trust has identified that a member of staff can speak to a Non-Executive Director if they wish to, as part of this process. We would encourage the Trust to ensure that the Non-Executive Director who fulfils this role is one of the newly appointed Non-Executive Directors as we feel that will instil greater confidence in the process and signal a clear and decisive break from what happened in the past.

Duty of Candour

Candour is important to maintain trust in health services, properly involve patients in their own care and identify concerns early. It helps to facilitate patient choice and to ensure that remedies are available and lessons learnt from mistakes. NHS staff must understand the Duty of Candour as well as the existing framework of obligations.
24.2 The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Sir Robert Francis QC proposed a statutory Duty of Candour. This would require that where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or their representative has asked for this information.

24.3 The new statutory Duty of Candour was introduced for NHS bodies in England (trusts, foundation trusts and special health authorities) from 27 November 2014, and applies to all other care providers registered with Care Quality Commission from 1 April 2015. The obligations associated with the statutory Duty of Candour are contained in Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles are:

- Care organisations have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout an organisation. The statutory duty applies to organisations, not individuals, though it is clear from Care Quality Commission guidance that it is expected that an organisation’s staff cooperate with it to ensure the obligation is met;

- As soon as is reasonably practicable after a notifiable patient safety incident occurs, the organisation must tell the patient (or their representative) about it in person. The organisation has to give the patient a full explanation of what is known at the time, including what further enquiries will be carried out. Organisations must also provide an apology and keep a written record of the notification to the patient;
A notifiable patient safety incident has a specific statutory meaning: it applies to incidents where a patient suffered (or could have suffered) unintended harm that results in death, severe harm, moderate harm or prolonged psychological harm. Severe and moderate harm definitions are derived from the National Patient Safety Agency’s Seven Steps to Patient Safety. Prolonged psychological harm means that it must be experienced continuously for 28 days or more;

There is a statutory duty to provide reasonable support to the patient. Reasonable support could be providing an interpreter to ensure discussions are understood, or giving emotional support to the patient following a notifiable patient safety incident;

Once the patient has been told in person about the notifiable patient safety incident, the organisation must provide the patient with a written note of the discussion, and copies of correspondence must be kept.

Clinicians, who are used to having candid discussions with their patients, are most likely to be the organisation’s representative under the statutory duty. It is important that they co-operate with the Trust policies and procedures, including the requirement to alert the organisation when a notifiable patient safety incident occurs.

An area of difficulty may be deciding whether an incident reaches the threshold for notification under the statutory duty. This may be confusing, as the threshold is low for the doctor's ethical duty (any harm or distress caused to the patient) while the thresholds for the contractual and statutory duties are higher and slightly different (with the inclusion of prolonged psychological harm in the statutory duty).
24.6 Closely aligned to the Duty of Candour is the recommended prohibition in the Francis Report on Mid Staffordshire NHS Foundation Trust on so-called “gagging clauses” which seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care. This has already resulted in the Secretary of State for Health writing to all NHS chairs reminding them of the need to ensure that contracts of employment and compromise agreements with departing staff do not prevent them from raising such concerns.

24.7 The challenge for employers is to achieve the right balance between permitting and fostering a culture of openness and transparency and protecting their legitimate business interests, particularly when employees leave their organisation.

24.8 The Public Interest Disclosure Act 1998 sets out various types of disclosure that may qualify for protection under the Act. The categories that are most relevant to healthcare bodies are failure to comply with a legal obligation or endangering health and safety. The Public Interest Disclosure Act expressly forbids any attempt by employers in contracts or other agreements to prevent employees from making protected disclosures provisions in a compromise or other agreement. The Government acknowledges that the use of confidentiality clauses within compromise agreements can help both parties end the employment with a clean break. However, it emphasises that such clauses should never go further than is necessary to protect matters such as patient confidentiality and commercial interest. It makes clear that gagging clauses are strictly prohibited and unenforceable in law.

24.9 The Trust will need to ensure its policies, training and induction programmes fully reflect the new legal requirements.

24.10 Alongside the above, there are in addition a number of actions the Trust may wish to consider in this area as detailed at Appendix 8.
Conclusion

25.1 Our report into Liverpool Community Health NHS Trust sets out a series of events that began with a sustained drive towards achieving NHS foundation trust status by the Board from almost its inception as a statutory body. What followed was an accompanying drive to reduce cost which resulted in pressures on front line services and the presence of a culture of bullying and harassment of staff at various levels within the organisation. Despite a programme that ensured Board visibility using a structured approach, the Board did not detect the culture of bullying and harassment that was evident in the findings of NHS Staff Survey results in 2011 and 2012 and the Staff Side survey results and which was then most powerfully highlighted by the Care Quality Commission after its inspection in late 2013.

25.2 The Board’s primary responsibility is to ensure that the Trust provides safe services and promotes the welfare of staff. In this respect, all Board members, Executive Directors and Non-Executive Directors have the same legal duties, despite a distinction in their respective levels of time commitment and depth of knowledge of the business concerned. In this case, the Board failed to recognise the nature and severity of the problems within the Trust and as far as we can ascertain Quality Impact Assessments of Cost Improvement Programmes largely did not happen in the way they should have, despite assurances provided to the Board and its Committees. For its part the Board should have more proactively been seeking evidence as opposed to accepting re-assurance on this point. In the few areas where Quality Impact Assessments were undertaken, they were not consistent with national guidance and fell well short of the standard expected. Equally the Board failed to analyse properly the worrying comments of its own staff coming out of the annual NHS Staff Surveys and to properly understand deaths in custody and the factors that contributed in part to those deaths, and the concerns that had been present for some time within the Intermediate Care Bed Based Service. They collectively represented a series of missed opportunities to intervene. Had any of these opportunities been taken, the subsequent sequence of failures could have been broken.
25.3 In our view there was a lack of effective scrutiny and challenge at the Board. The Non-Executive Directors told us they did provide challenge and oversight but that this was subsequently not reflected in the minutes which ultimately are the contemporaneous records. Even if the minutes do not record all the challenge that was made, it is clear that a number of key issues were not identified and followed up appropriately as they would have been, had sufficient scrutiny taken place.

25.4 Our review shows that on paper from 2011 onward the Trust had in place some reasonable, appropriate and well developed systems and processes to ensure a strong clinical governance framework and to a point they worked. Clinical governance meetings took place at directorate level. They discussed the range of issues we would have expected them to. Staff did report incidents on Datix and risks were escalated upwards in the Trust. What did not work though was that when risks were escalated upwards, they were either ignored or watered down by those in more senior positions to make them look less significant than they were.

25.5 On the journey towards achieving NHS foundation trust status, a number of external reviews were commissioned. Indeed five were undertaken within a six month period in the second half of 2012. These reports drew a number of positive conclusions, and understandably the Board will have taken a degree of assurance from those reports. However our view is that these pieces of work were not all positive and did not negate the need for the Board to look more widely at other sources of information, to triangulate and perhaps most importantly to proactively seek assurance not re-assurance.

25.6 In saying the above, we are acutely mindful that it is easier with the benefit of hindsight and all the information in front of us to make these linkages but our view is that a great deal of this was known and available at the time. What it required was for the Board to provide greater scrutiny, challenge and oversight. Our report also details a worrying series of concerns in individual clinical areas and the subsequent actions of an Executive Team inexperienced at this level. In some of these it is clear that they were not shared by the Executive Team with the wider Board. This failure to present a complete picture to the Board is inexcusable and represented a serious breakdown in the governance of the Trust.
For many of these concerns, it is hard to come to any other conclusion than that they were managed in the way they were in order to ensure the Trust application for NHS foundation trust remained on track.

It is also a cause for concern that many of the organisations that had a supervisory or regulatory function for the Trust failed to identify these issues.

The work of the new leadership team in actively seeking to support staff and to create a culture of openness and transparency is to be welcomed and was commented on by many of the staff we spoke with as part of our review. However not everyone we spoke to was of the same view and the NHS Staff Survey 2014 results continue to identify areas of concern around the culture of the Trust.

The new leadership team has made much progress since spring 2014, guided by a clear and well thought through Improvement Plan and we strongly believe that the Trust now has the capability to recover. However we do have concerns about pace and there are some key governance areas, clinical and corporate, which need to be addressed. Once addressed, they will strengthen governance at both the corporate and locality level.

The appointment of a new Chairman and new Non-Executive Directors provides further encouragement and a marked change in approach, which has been particularly visible in the focus of the Board on quality and safety.

We also welcome the development of a new locality structure which at its core enables decision making to be made closer to the patient and fundamentally values clinical leadership. The Trust needs to ensure that there is a clear and consistent understanding at locality and sub-locality level of the systems and structures for clinical and corporate governance, and in particular around how concerns, risks and incidents are routed into the leadership teams at locality level and then escalated upwards. Equally, there needs to be a clear feedback and learning loop from concerns, risks and incidents as that will help to create a climate of confidence in the systems and processes that are in place to ensure good clinical governance. During all too many of our interviews we observed a lack of a coherent and consistent understanding of escalation of risks and concerns within the Trust.
25.13 More resources are also required to support the current clinical governance agenda in the Trust and the Trust needs to appoint a substantive Trust Secretary to help take forward the range of corporate governance issues we have identified, including but not limited to lengthy agendas, the size and quality of Board papers, the membership of Board Committees, and risks and assurance.

25.14 The value of setting out a catalogue of failures in this way will inevitably be questioned by some and challenged by others. Our response to this is clear; that there is a need to learn from what went wrong in the past to avoid it happening again in the future and equally for all the progress that has been made, they are at a formative stage.

25.15 Many of the staff who agreed to take part in this review told us frankly and respectfully about some of their experiences. They deserve a huge credit for not giving up when it would have been so easy to do so and the Trust owes it to them to learn the lessons from the issues we have set out in our report and to take forward its findings in a timely and effective manner.

25.16 There is a great deal of research which confirms that the operating environment in any organisation is created from the very top. A lot of management is about turning the stones. That sense of challenge and continuous enquiry is vital, not just for improving performance but also for uncovering problems.

25.17 We are convinced that the current Board and indeed the staff that we interviewed are committed to a patient safety culture and providing high standards of care and one in which staff are valued.

25.18 We would urge the Trust to take steps to implement our recommendations in a timely manner.
## 26 Recommendations

26.1 Our recommendation to the Trust are set out below. Much of these are of course directed at the Board of the Trust. We suggest that the Board considers the findings outlined in the report and subsequently develops an action plan to take the recommendations forward. The action plan should clearly outline how the Board proposes to implement our recommendations in a timely manner and set out how the Board will monitor progress.

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<th>Ref</th>
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<tr>
<td>1</td>
<td>Further Action</td>
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<tr>
<td>1.1</td>
<td><strong>Recommendation 1:</strong> We recommend that the Board gives consideration to whether some professional staff are referred to their regulatory bodies in the light of our findings in Part One of this review.</td>
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<td>1.2</td>
<td><strong>Recommendation 2:</strong> We recommend that the Board gives consideration to making contact with new employers, whether they remain in the NHS or not, where individuals have left the Trust, to make them aware of the findings in Part One of this review and whether if in relation to any individuals who have left the Trust whether under the Fit and Proper Persons Test referrals need to be made to the Care Quality Commission.</td>
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<td>2</td>
<td>Staff Development</td>
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<td>2.1</td>
<td><strong>Recommendation 3:</strong> We recommend that the Board gives consideration to a programme of development for all managers across the new locality structure and at a corporate level, with a specific focus around learning from serious incidents, how to respond to concerns and around culture, vision and values.</td>
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<td>2.2</td>
<td><strong>Recommendation 4:</strong> We recommend that the Board should give consideration to identify opportunities to broaden staff experience in other NHS trusts, through buddy ing and shadowing arrangements.</td>
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Staff Support

| 3.1 | **Recommendation 5:** We recommend that the Board gives consideration to establishing a programme of reflective learning and closure to repair the emotional damage experienced by numerous staff across the Trust. |

Executive Director Portfolios

| 4.1 | **Recommendation 6:** We recommend that the Board gives consideration to ensuring director portfolios are clarified, especially around quality and safety in the light of the findings we have set out in Part Two of our review. |
| 4.2 | **Recommendation 7:** We recommend that there is a review of the SIRO role in the light of our review. |

Clinical Leadership

| 5.1 | **Recommendation 8:** We recommend that the Board gives consideration to reviewing arrangements for clinical leadership across the Trust, to ensure that the right people are in place with appropriate skills and support and to establish a programme of development to support them in their new roles. |

Clinical Governance Structures

| 6.1 | **Recommendation 9:** We recommend that the Board gives consideration to further strengthening the current clinical governance infrastructure across the Trust, to ensure that they are appropriately resourced to provide the necessary support to the new locality structure. |
| 6.2 | **Recommendation 10:** We recommend that the Board gives consideration to commissioning a short focused review to understand the overall effectiveness of the IGQC and its underpinning sub-committee structure. |
6.3 Recommendation 11: We recommend that the Board reviews the systems and processes that form the basis of the incident reporting system and ensure that the importance of the system is well understood across the organisation and that reporting is actively encouraged by all staff. As part of this review, we would encourage the Trust to give consideration to adopting the proactive use of the incident reporting system across the Trust.

6.4 Recommendation 12: We recommend that the Board reviews its current serious incident investigation policy to ensure it is fit for purpose. We recommend that the Trust establishes a clear policy for investigating serious incidents in line with the National Patient Safety Agency Root Cause Analysis guidance and NHS England guidance, whilst retaining the flexibility to investigate serious concerns relating to individuals under the relevant Trust workforce policies.

6.5 Recommendation 13: We recommend that the Board gives consideration to using Root Cause Analysis meetings more consistently and frequently to investigate serious incidents. This will not only in our view improve the standard of serious incident reports but will also mean more staff are involved in investigations and thus lead to better understanding and appreciation by staff that incident reports are taken seriously, investigated and acted upon.

6.6 Recommendation 14: We recommend that a serious incident group should initially meet weekly to consider all serious incidents and that they are graded in terms of severity and ensure that investigations are progressed in accordance with the Trust policy and delivered to time and accompanied by a clear action plan. The group would also have a key role around learning lessons from each serious incident investigation and ensuring common themes and issues are picked up and addressed and fed back to staff. This group should also provide a report to the Patient Safety Group and Quality Committee and a SUI Report provided to the public Board.
**6.7** **Recommendation 15:** We recommend that clinical governance meetings across all parts of the Trust should take place to a prescribed frequency and agenda and that these are reviewed from time to time.

**6.8** **Recommendation 16:** We recommend that the Board commissions work to ensure there is a consistent understanding across the Trust of the governance assurance framework across the Trust and the escalation routes within that.

**6.9** **Recommendation 17:** We recommend that the Board gives consideration to the framework of questions at Appendix 7 to self-assess and/or sense check their new structures, systems and processes and specifically look at the points we have raised in Part Two of our report as part of its on-going journey to improve and enhance clinical governance arrangements across the Trust.

**6.10** **Recommendation 18:** We recommend that the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, should go to the Board promptly and be notified to bodies such as the Care Quality Commission and the NHS Trust Development Authority.

**6.11** **Recommendation 19:** We recommend that the Board gives consideration to reviewing the reporting upwards into the Trust from the “Weekly Meeting of Harm” in the light of our review.

**7** **Corporate Governance**

**7.1** **Recommendation 20:** We recommend that the Board gives consideration to appointing a Trust Secretary as soon as possible and ensuring there is the appropriate level of support in place for the newly appointed Trust Secretary.

**7.2** **Recommendation 21:** We recommend that the Board ensures that there is robust document archiving process in place across the Trust.

**7.3** **Recommendation 22:** We recommend that the Board ensures that minutes for all key Board and sub-committees are written to the highest standards and that a programme of training is undertaken, where required.
| 7.4 | **Recommendation 23:** We recommend that the Board gives consideration to having in place a clear board development programme. |
| 7.5 | **Recommendation 24:** We recommend that the Board ensures that the Improvement Plan provides coverage of progress against 4 July 2014 Monitor letter. |
| 7.6 | **Recommendation 25:** We recommend that the Board ensures that the Improvement Plan provides details of progress against all areas within its coverage. |
| 7.7 | **Recommendation 26:** We recommend that the Trust Secretary works with the new leadership team to ensure Board reporting is streamlined. |
| 7.8 | **Recommendation 27:** We recommend that the Board considers how it streamlines Board and committee agendas to ensure that they remain manageable. |
| 7.9 | **Recommendation 28:** We recommend that the Board considers the membership of Board Committees in the light of our report. |
| 7.10 | **Recommendation 29:** We recommend that the Board reviews the Board Assurance Framework and Corporate Risk Register in the light of our review findings. |
| 7.11 | **Recommendation 30:** We recommend that the Audit Committee considers deep dive sessions on directorate level emerging risk in the light of our report. |

### 8 Board Visibility

<p>| 8.1 | <strong>Recommendation 31:</strong> We recommend that the Board gives consideration to a range of approaches to connect effectively with staff at all levels in the Trust. This could include such initiatives as “Back to the Floor” and clinical presentations at the Board. |
| 8.2 | <strong>Recommendation 32:</strong> We recommend that the Board ensures it establishes a clear programme of Board visits across front line services and that the outputs from these are then fed back into the Board. |</p>
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<th>9</th>
<th>Creating a Cohesive Trust Wide Culture</th>
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<td>9.1</td>
<td><strong>Recommendation 33:</strong> We recommend that the Board gives consideration to create an environment in which staff feel free to raise matters of concern. This requires a cultural shift and clear direction from the Board that emphasises a just culture. In particular, staff should be thanked for reporting incidents; given feedback on what has happened as a result of their reporting an incident; and receive regular feedback about the type of incidents being reported and what has changed as a result.</td>
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<th>Staff Perceptions</th>
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<td>10.1</td>
<td><strong>Recommendation 34:</strong> We recommend that the Board undertakes a series of focus groups to understand currently the views and perceptions of staff. The findings of which should be openly reported back into the Trust and accompanied by a clear action plan that is signed off by the Board in public.</td>
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<th>Duty of Candour</th>
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<td>11.1</td>
<td><strong>Recommendation 35:</strong> We recommend that the Board reviews its arrangements regarding the Duty of Candour in the light of our comments in Appendix 8.</td>
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<th>Whistleblowing Policy</th>
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<td>12.1</td>
<td><strong>Recommendation 36:</strong> We recommend that the Board gives consideration to the areas we have drawn attention to in Part Two of the report as part of its current review of its Whistleblowing Policy.</td>
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**Key**

- **Red** To be implemented within two months of the acceptance of this report by the Board.
- **Amber** To be implemented within four months of the acceptance of this report by the Board.
Appendix 1
Schedule of Documents Reviewed
Appendix 1

Corporate Governance Documents

Liverpool Community Health NHS Trust Public Board Papers

November 2010

December 2010

February 2011

March 2011

April 2011

May 2011

June 2011

July 2011

September 2011

October 2011

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Liverpool Community Health NHS Trust Integrated Governance and Quality Committee Papers

February 2011

April 2011

June 2011

August 2011

October 2011

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Liverpool Community Health NHS Trust HR and OD Committee

December 2010

January 2011

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October 2011
December 2011

January 2012

April 2012

Liverpool Community Health NHS Trust Audit Committee

Audit Committee Pack 8.3.11

Audit Committee Pack 7.6.11

Audit Committee Pack 19.9.11

Audit Committee Pack 20.12.11

Audit Committee Pack 6.3.12

Audit Committee Pack 06.06.12

Audit Committee Pack 10.09.12

Audit Committee Pack 04.12.12

Audit Committee Pack 12.3.13

Audit Committee Pack 05.06.13

Audit Committee Pack 23.09.13

Audit Committee Pack 25.11.13

Audit Committee Pack 10.3.14

Audit Committee Pack 3.6.14

Audit Committee Pack 15.9.14
Audit Committee Pack 15.12.14

Audit Committee Pack 16.3.15

Audit Committee Pack 19.5.15

Audit Committee Pack 2.6.15

Audit Committee Pack 8.9.15

Audit Committee Pack 8.12.15

**Other Key Governance Documents**

Liverpool PCT Provider Services Remuneration Committee Draft Terms of Reference, March 2008

Liverpool PCT Provider Services Integrated Governance Committee Draft Terms of Reference, March 2008

Liverpool PCT Provider Services Audit Committee Draft Terms of Reference, March 2008

Liverpool PCT Provider Services Health Care Governance Sub-Committee Draft Terms of Reference, March 2008

Liverpool Community Health NHS Trust Governance Committee Structure, November 2010

Liverpool Community Health NHS Trust Audit Committee Terms of Reference, November 2010

Liverpool Community Health NHS Trust Integrated Governance and Quality Committee Terms of Reference, November 2010

Liverpool Community Health NHS Trust Health Care Governance Sub-Committee, Terms of Reference, November 2010
Liverpool Community Health NHS Trust Board and Committee Meeting Guidance, November 2010

Healthcare Governance Sub Committee Meeting and Reporting Cycle, November 2010

Liverpool Community Health NHS Trust Committee and Assurance Structure as at August 2015

Liverpool Community Health NHS Trust Remuneration Committee papers 2010/11 to 2014/15

Liverpool Provider Services Board, Draft Terms of Reference, March 2005

Liverpool Community Health NHS Trust Annual Report 2010/11

Liverpool Community Health NHS Trust Annual Report 2011/12

Liverpool Community Health NHS Trust Annual Report 2012/13

Liverpool Community Health NHS Trust Annual Report 2013/14

Liverpool Community Health NHS Trust Annual Report 2014/15

Liverpool Community Health NHS Trust HR and OD Committee Meeting Minutes 24 February 2015

Liverpool Community Health NHS Trust HR and OD Committee Meeting Minutes 24 March 2015

Liverpool Community Health NHS Trust HR and OD Committee Meeting Minutes 28 April 2015

Liverpool Community Health NHS Trust HR and OD Committee Meeting Minutes 26 May 2015

Liverpool Community Health NHS Trust HR and OD Committee Meeting Minutes 27 July 2015

14 | P a g e
Liverpool Community Health NHS Trust Executive Team Organisation Structure and Portfolios, June 2015


Liverpool Community Health NHS Trust Governance Manual Part Two, 24 February 2015

Liverpool Community Health NHS Trust Draft Notes Board Time Out 18 March 2014

Liverpool Community Health NHS Trust Draft Notes Board Time Out, 21 January 2014

Liverpool Community Health NHS Trust Draft Notes Board Time Out, 10 December 2013

Liverpool Community Health NHS Trust Approved Notes Board Time Out, 19 November 2013

Liverpool Community Health NHS Trust Approved Notes Board Time Out 15 October 2013

Liverpool Community Health NHS Trust Draft Notes Board Time Out 12 April 2011

Liverpool Community Health NHS Trust Draft Notes Board Time Out 8 February 2011

Liverpool Community Health NHS Trust Draft Notes Board Time Out 24 December 2010

Liverpool Community Health NHS Trust Draft Notes Board Time Out 21 December 2010

Liverpool Community Health NHS Trust Draft Notes Board Time Out 23 November 2010

Liverpool Community Health NHS Trust Draft Notes Board Time Out 19 October 2010

Liverpool Community Health NHS Trust Draft Notes Board Time Out 21 September 2010

Liverpool Community Health NHS Trust Approved Notes Board Time Out 15 June 2010

Liverpool Community Health NHS Trust Approved Notes Board Time Out 18 May 2010
Liverpool Community Health NHS Trust Corporate Structures Phase 2, Internal Information. Version 2, September 2015

Liverpool Community Health NHS Trust Assurance Framework, October 2015

Liverpool Community Health NHS Trust Phase 3 Improvement Plan May 2015 Board Paper

Liverpool Community Health NHS Trust Improvement Plan Q1 2015/16 Progress Report, September 2014

Liverpool Community Health NHS Trust Improvement Plan Progress Report, November 2014

Liverpool Community Health NHS Trust Changes to Operational Management, September 2015 Locality Structures Presentation July 2015

Liverpool Community Health NHS Trust Locality Structures September 2015

Liverpool Community Health NHS Trust Governance Review of Committees, February 2012

Liverpool Community Health NHS Trust Annual Governance Review of Board Committees, April 2013

Liverpool Community Health NHS Trust Board Committee and Sub Committee Structure 2015

**Risk Management**

Liverpool Community Health NHS Trust Risk Management Strategy 2010-2012

Liverpool Community Health NHS Trust risk management strategy and policy, 2015 – 2017, June 2015
Offender Health Services

Peer review into clinical risk, quality and governance of the integrated primary healthcare delivered by Liverpool Community Health NHS Trust to HMP Liverpool, Spectrum Health CIC, January 2015

Liverpool Community Health NHS Trust prison healthcare complaints 1 March 2013 to 31 May 2015

HMP Liverpool and HMP Kennet STEIS reported RCA (which includes 17 individual RCA reports)

HM Chief Inspector of Prisons report of an unannounced inspection of HMP Liverpool, 8-16 December 2011, May 2012


Prison Incident Data as at July 2015

All prison data 2012-2014

Deaths in custody database Liverpool Community Health NHS Trust

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in January 2014

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in September 2013

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in September 2013

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in April 2013
Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in December 2012

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in August 2012

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in August 2012

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in April 2012

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in March 2012

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in January 2012

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in October 2011

Prison and Probation Ombudsman HMP Liverpool Investigation into the death of a man at HMP Liverpool in May 2011

CQC Inspection Report HMP Liverpool 7 May 2014

CQC Inspection Report HMP Liverpool December 2014

Liverpool Community Health NHS Trust Deaths in Custody Study (2011 – Present) Understanding the effectiveness of the current policy – Dr Tony Ryan and Dr Elaine Church, November 2014

Liverpool Community Health NHS Trust Staff Briefing – Liverpool Community Health NHS Trust Weekly – Issue 224, 24 October 2014

Liverpool Community Health NHS Trust Offender Health Lookback Timeline 31 December 2014
Liverpool Community Health NHS Trust HMP Liverpool Pharmacy Provision, January 2014

**NHS Staff Survey and Staff Side Survey/Staff Side Engagement**

Liverpool Community Health NHS Trust NHS staff survey results 2011

Liverpool Community Health NHS Trust NHS staff survey verbatim comments 2011

Liverpool Community Health NHS Trust NHS staff survey results 2012

Liverpool Community Health NHS Trust NHS staff survey verbatim comments 2012

Liverpool Community Health NHS Trust NHS staff survey results 2013

NHS staff survey verbatim comments 2013

Liverpool Community Health NHS Trust NHS staff survey results 2014

Liverpool Community Health NHS Trust NHS staff survey verbatim comments 2014

Liverpool Community Health NHS Trust NHS staff survey results 2015

Liverpool Community Health NHS Trust Staff side survey results January/February 2013

Staff side survey report January/February 2013

Staff Side Letter to Liverpool Community Health NHS Trust Interim Chief Executive 14 April 2015

North West RCN Letter to Liverpool Community Health NHS Trust Interim Chief Executive 3 July 2015
Reviews

Independent desktop review of the management and board response to serious incidents at Liverpool Community Health NHS Trust, Liz Craig and June Goodson-Moore, November 2014

ACAS review of Liverpool Community Health NHS Trust, July 2014

CQC inspection report, walk in centres, 15 August 2014

CQC inspection report, end of life care, 15 August 2014

CQC inspection report, services for children, 15 August 2014

CQC inspection report, health services for adults, 15 August 2014

CQC inspection report, inpatient services, 15 August 2014

CQC inspection report Liverpool Community Health NHS Trust, 15 August 2014

CQC inspection report Liverpool Community Health NHS Trust, January 2014

Liverpool Community Health NHS Trust CQC Action Plan Progress Letter – 17/2/14

Liverpool Community Health NHS Trust CQC Action Plan Progress Report

NHS Trust Development Authority governance review Liverpool Community Health NHS Trust, 25 April 2014

Letter to Trust Chair and Chief Executive from the NHS TDA Chief Executive, 23 December 2014

All Documentation (53 documents in total) Reviewed by June Goodson Moore and Liz Craig
Clinical Governance Documents


Liverpool Community Health NHS Trust Board Assurance Framework 2015, Version 4 as at 28 October 2015

Liverpool Community Health NHS Trust Clinical Investigation Report RCA: 2014 32966

Liverpool Community Health NHS Trust Clinical Investigation Report Level 1 RCA STEIS REF: 2014/38368

Risk Board assurance and escalation framework, Liverpool Community Health NHS Trust, October 2014

Liverpool Community Health NHS Trust Risk Scoring Matrix, November 2010

Liverpool Community Health NHS Trust HGSC – Reporting Structure to the Clinical and Patient Quality Safety Group

Liverpool Community Health NHS Trust Quality accounts 2010/11

Liverpool Community Health NHS Trust Quality accounts 2011/12

Liverpool Community Health NHS Trust Quality accounts 2012/13

Liverpool Community Health NHS Trust Quality accounts 2013/14

Liverpool Community Health NHS Trust Quality accounts 2014/15

Liverpool Community Health NHS Trust Investigation Report SDES Ref 2014 23310

Integrated Governance and Quality Committee, October 2014 – Quality Impact Assessment Update

Agenda and Supporting Papers for Meeting with CQC, 23 October 2015

QIA Documentation between 2013 and 2014 (54 documents in total)

**Intermediate Care Bed Based Services**

Liverpool Community Health NHS Trust district nursing complaints 1 March 2013 to 31 May 2015

Liverpool Community Health NHS Trust District nursing complaints and incident report, Liverpool Community Health NHS Trust Neighbourhood Delivery Manager, October 2011

Liverpool Community Health NHS Trust District Nursing Incident Data as at July 2015

Liverpool Community Health NHS Trust All District Nursing Data 2012-2014


**Appendix 1-42** of Above Review

Ann Ryan Investigation Report Bed Based Services 27.10.13

**Human Resources**

Medical Director Job Description

Job Description of Person Specification for Director of Operations and Executive Nurse, July 2010

Bullying and harassment allegation fact finding report, Nikki McFarlane, Independent Investigating Officer, February 2014

Chief Executive Objectives 2015/16
Director of Finance Objectives 2015/16

Medical Director Objectives 2015/16

Nurse Director Objectives 2015/16

Human Resources Director Objectives 2015/16

Chief Operating Officer Objectives 2015/16

Director of Performance Objectives 2015/16

**Review Process**

Interview transcripts *(44 documents in total)*

Selection of additional and supplementary documentation including emails, reports and letters provided by 7 interviewees

Salmon process responses and supporting documentation provided

**Medicines Management**

Business case to Liverpool Community Health NHS Trust: provision of medicines management audit support to all clinical areas throughout Liverpool Community Health NHS Trust, September 2012

Liverpool Community Health NHS Trust Medicines management risks update, HGSC, February 2013

Liverpool Community Health NHS Trust Offender Health Service Improvement Plan – Medicines Management, November 2014

Liverpool Community Health NHS Trust Medicines management clinical risk board paper, March 2014
Health and Safety

Liverpool Community Health NHS Trust Agenda Operational Health and Safety Working Group, 30 April 2015

Liverpool Community Health NHS Trust Minutes Operational Health and Safety Working Group, 30 April 2015

Liverpool Community Health NHS Trust Agenda Operational Health and Safety Working Group, 28 May 2015

Liverpool Community Health NHS Trust Minutes Operational Health and Safety Working Group, 28 May 2015

Liverpool Community Health NHS Trust Health and Safety Work Programme 2015/2016

Liverpool Community Health NHS Trust Operational Health and Safety Working Group Critical Fix List

Liverpool Community Health NHS Trust Chair of Operational Health and Safety Working Group Assurance Report to the Health and Safety Committee, 30 April 2015

Liverpool Community Health NHS Trust Health and Safety Annual Report 2014/2015

Liverpool Community Health NHS Trust Needle Stick Injuries Report 2014/2015


Liverpool Community Health NHS Trust Health and Safety Pro-forma Asbestos, May 2015
Liverpool Community Health NHS Trust Health and Safety Pro-forma Buildings, May 2015

Liverpool Community Health NHS Trust Health and Safety Pro-forma Management of Contracts, May 2015

Liverpool Community Health NHS Trust Health and Safety Pro-forma Water (Legionella), May 2015


Liverpool Community Health NHS Trust Agenda Health and Safety Committee, 21 May 2015

Liverpool Community Health NHS Trust Minutes Health and Safety Committee, 21 May 2015


**Community Dental Health Services**

Dental Directorate POD Clarification Requests

Primary Care and Public Health Sign Off Sheet Dental

DCDH Directorate of Community Dental Health Service Redesign Proposals January 2013

Dental Meeting Notes, 9 May 2013

Email from Dental Clinical Director to Divisional Manager, Primary Care and Public Health re Clinical Dental Director Job Description, 12 October 2012

Dental Health Promotion Report, January 2014, Amended April 2014

Directorate of Community Dental Health, Service Re-Design Proposals – The Case for Change – January 2013
B2 as is Organisation Appendix – Dental Change Request No 3. January 2013

B1 to be organisation Appendix – Dental CR3 – January 2013

Claimant QIA details Appendix – Dental Change Request – 3 January 2013

Defendant CIP Detail Appendix – Dental Change Request 3 January 2013

Dental Change Request No 3 v.1.1. Objects Removed Dental Service Re-Design CIP Change January 2013

Dental Quality Impact Assessment October 2013

Letter from Divisional Manager, Primary Care and Public Health to Dental Clinical Director, 3 October 2012

Letter from Dental Council Director to Divisional Manager, Primary Care and Public Health, 14 September 2012

Email from Medical Director to Dental Clinical Director, 17 January 2013

Email exchange re “A Matter of Principle for Part Time Workers”, September 2013

QIA Tool Dental Prot, 17 October 2013

QIA Dental Service Re-Design 25 February 2013

QIA Details Appendix Dental Change Request 3 17 October 2013

Community Dental Services Management Meeting Minutes 8 May 2015

Community Dental Services Management Meeting Minutes 13 March 2015

NICE Guidelines Review Community Dental Services June 2015

Community Dental Services Management Review June 2014
Community Dental Services Management Review June 2015 ISO Audit Summary

Community Dental Services Radiography QA 1 April 2014 – 31 March 2015

Community Dental Services Management Review NOC1/Clinical Review March 2014

Community Dental Services Wrong Tooth Extraction Management Review Update 12 June 2015

Community Dental Services Management Review June 2015 Quality Improvement Plan Review March 2014

Directorate of Community Dental Health Services Management Review No 34 Agenda, 12 June 2015

**Raising Concerns at Work**

Raising Concerns at Work. RCN Guide March 2013

Liverpool Community Health NHS Trust Whistleblowing Policy, February 2014

Liverpool Community Health NHS Trust Whistleblowing Procedure

Liverpool Community Health NHS Trust Help and Advice about Raising a Concern

Liverpool Community Health NHS Trust Intranet Pages

**Foundation Trust Status**


Liverpool Community Health NHS Trust Independent report on the governance of quality, 11 September 2012 (re-issued 5 November 2012) Deloitte LLP

Independent review of performance against the Board Governance Assurance Framework, Liverpool Community Health NHS Trust, 26 October 2012, KPMG

Liverpool Community Health NHS Trust Stage Two: Historic Due Diligence and Financial Reporting Procedures Update Report, Final Draft, 3 December 2012, PricewaterhouseCoopers LLP

Follow up of the independent review of performance against the Board Governance Assurance Framework, Liverpool Community Health NHS Trust, November 2013, KPMG

Quality Visit Outcome letter - TDA - July 2013

PWC Stage 2 Interviews

PWC Review Team

PWC Appendix 2 Stage 2 Information Deliverables

Historic Due Diligence / F.T Assessment

LTPS Scheme Rules

Report publication timetable

Executive Team FT Assessment Report 11 April 2013

Finance - FT Assessments Action List April 2013

FT Assessments Action List April 2013

FT Assessments Action List June 2013

FT Assessments Action List June 2013
FT Assessments Quality Governance Action List June 2013

FT Assessments Action List March 2013
Finance - FT Assessments Action List March 2013

FT Assessments Action List November 2012 – 4

FT Assessments Action List November 2012 - 4 HL


Finance - FT Assessments Action List December 2012 MC

FT Assessments Action List December 2012 ARW

Finance - FT Assessments Action List December 2012 ARW

FT Assessments Action List November 2012 - 4 ARW

FT Assessments Action List November 2012 - 4 HL

FT Assessments Action List November 2012 – 2

FT Assessments Action List November 2012 – 3

FT Assessments Action List November 2012 – 4

FT Assessments Action List November 2012

FT Assessments Action Plan November 2012

FT Assessments Action List December 2012 UPDATED

FT Assessments Action List December 2012

Finance - FT Assessments Action List November 2012 – 4
Finance - FT Assessments Action List December 2012 UPDATED

Finance - FT Assessments Action List December 2012

Board Governance Assurance Framework Action Plan

BGAF action plan

BGAF action plan September 2012

BGAF action plan August 2012

BGAF re-assessment follow up 2013 - Liverpool Community Health November 2013

QGAF action plan October 1

QGAF action plan September 2012 FINAL

QGAF Closure Report v1.1

QGAF action plan October 2012 final

Letter to Sue Page, Interim Chief Executive from Monitor re: Monitor Quality Governance Pilot, 4 July 2014

**NED Service Feedback Reports**

Completed by EQ Board Members Service Visit feedback - HMP Kennett

NED service visits - 2011/12 x 9

NED service visits - 2012/13 x 11

NED service visits 2013/14 x 8

NED service visits 2014/15 x 4
National Reference Documents

Quality Governance: How Does a Board Know that its Organisation is Working Effectively to Improve Patient Care? Monitor, April 2013

A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, National Advisory Group of Patients in England, August 2013

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, HC 947, 6 February 2013

Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, Professor Sir Bruce Keogh, 19 July 2013

Freedom to Speak Up: An Independent Review into Creating an Open and Honest Reporting Culture in the NHS, Sir Robert Francis QC, February 2015


The Healthy NHS Board: Principles for Good Governance, NHS National Leadership Council, 2010

The Healthy NHS Board 2013: Principles for Good Governance, NHS Leadership Academy, 2013

Guidance Document on Minutes, the Institute of Chartered Secretaries and Administrators 2015


The Report of the Morecambe Bay Investigation, Dr Bill Kirkup CBE, March 2015

Miscellaneous

Trust emails dated 6 March 2013

A selection of emails between the NHS Trust Development Authority and Trust Chairman up to May 2014

Good Medical Practice: Working with Doctors Working for Patients, General Medical Council, 25 March 2013

The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives, Nursing and Midwifery Council, 1 May 2008

The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council, March 2015

Liverpool Echo, 29 January 2014

Liverpool Echo, 6 March 2015

Liverpool Echo, 5 February 2014


Hansard 5 February 2014, Column 290 Q10 [902407]
Appendix 2
Timeline of Key Events
## Appendix 2

### 2010/11

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2010</td>
<td>Liverpool Community Health NHS Trust formed. Frances Molloy is appointed Chair of the new organisation, Bernie Cuthel Chief Executive, and Gary Andrews, Director of Finance</td>
</tr>
<tr>
<td>March 2011</td>
<td>Helen Lockett appointed as Director of Operations &amp; Executive Nurse</td>
</tr>
</tbody>
</table>

### 2011/12

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2011</td>
<td>Trust acquired the majority of community services for Sefton</td>
</tr>
<tr>
<td>April 2011</td>
<td>Intermediate Care Bed Based Service expanded to include Ward 25 at Aintree University Hospital</td>
</tr>
<tr>
<td>November 2011</td>
<td>Senior Manager for Adult Community Nursing produced report entitled “District Nursing Complaints and Incidents” but which failed to elicit any evidential action or escalation to the Board</td>
</tr>
<tr>
<td>February 2012</td>
<td>Michelle Porteus appointed Director of Human Resources and Organisational Development</td>
</tr>
<tr>
<td>February 2012</td>
<td>Trust received NHS Staff Survey results for 2011</td>
</tr>
<tr>
<td>March 2012</td>
<td>Dr Craig Gradden appointed Medical Director</td>
</tr>
<tr>
<td>2011/12</td>
<td>Trust made savings of £7,096K or 5.0% of turnover</td>
</tr>
</tbody>
</table>

### 2012/13

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2012</td>
<td>HM Chief Inspector of Prisons published report of an unannounced visit to HMP Liverpool that took place from 8-16 December 2012</td>
</tr>
<tr>
<td>June 2012</td>
<td>National Quality Board published guidance for the NHS on how to undertake quality impact assessments as part of a programme of cost improvement</td>
</tr>
<tr>
<td>September 2012</td>
<td>External review questioned quality governance aspects of the Director of Finance’s role and breadth of remit of the Director of Operations &amp; Executive Nurse</td>
</tr>
<tr>
<td>Date/Period</td>
<td>Event Description</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>November 2012</td>
<td>Trust abolished Human Resources &amp; Organisational Development Committee and subsumed its work into the Finance and Commercial Committee and with some of its work going into the Integrated Governance &amp; Quality Committee</td>
</tr>
<tr>
<td>Late 2012</td>
<td>Staff Side survey commissioned</td>
</tr>
<tr>
<td>December 2012</td>
<td>Integrated Governance &amp; Quality Committee received NHS Staff Survey results for 2011; ten months after being received by the Trust</td>
</tr>
<tr>
<td>January 2013</td>
<td>Director of Operations &amp; Executive Nurse disagreed with high risk rating applied by the Adult Services Division to the Intermediate Care Bed Based Service because of staffing issues and concerns</td>
</tr>
<tr>
<td>Jan/February 2013</td>
<td>Staff Side survey concluded amongst other things that 96% of respondents identified bullying and harassment as a problem within the Trust</td>
</tr>
<tr>
<td>February 2013</td>
<td>Trust received NHS Staff Survey results for 2012</td>
</tr>
<tr>
<td>February 2013</td>
<td>Integrated Governance &amp; Quality Committee received NHS Staff Survey results for 2012</td>
</tr>
<tr>
<td>February 2013</td>
<td>Healthcare Governance Sub Committee noted high risks issues in Intermediate Care Bed Based Service and Integrated Governance &amp; Quality Committee commissioned an internal review into Intermediate Care Bed Based Service</td>
</tr>
<tr>
<td>February 2013</td>
<td>Internal review commissioned into Intermediate Care Bed Based Service by the Integrated Governance &amp; Quality Committee concluded</td>
</tr>
<tr>
<td>March 2013</td>
<td>Healthcare Governance Sub Committee agreed to escalate to Integrated Governance &amp; Quality Committee high risks issues within the Integrated Care Bed Based Service workforce</td>
</tr>
<tr>
<td>March 2013</td>
<td>Staff Side survey results sent to the Chief Executive and Director of Human Resources and Organisational Development. It failed to elicit any significant actions and is not shared with the Board</td>
</tr>
<tr>
<td>Spring 2013</td>
<td>Assault on health care professional</td>
</tr>
<tr>
<td>Spring 2013</td>
<td>Assault on health care professional made aware to all the Executive Directors and discussed at the Weekly Meeting of Harm but not escalated upwards to the Board</td>
</tr>
<tr>
<td>2012/13</td>
<td>Trust made savings of £6,450K or 4.4% of turnover</td>
</tr>
</tbody>
</table>
## Appendix 2

### 2013/14

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2013</td>
<td>IGQC failed to discuss the high risk issues within the Intermediate Care Bed Based Service despite concerns raised at the Healthcare Governance Sub Committee in March 2013</td>
</tr>
<tr>
<td>April 2013</td>
<td>Board failed to receive intended report on NHS Staff Survey results for 2012. A decision agreed at the February 2013 Integrated Governance &amp; Quality Committee meeting</td>
</tr>
<tr>
<td>April 2013</td>
<td>Board appointed first Non-Executive Director with a clinical background. Recommendation to address this was made to the Trust in June 2012</td>
</tr>
<tr>
<td>May 2013</td>
<td>Care Quality Commission report into Ward 25 at Aintree University Hospital which formed part of the Intermediate Care Bed Based Service confirmed that the Service was meeting all five key standards</td>
</tr>
<tr>
<td>July 2013</td>
<td>Clinical leadership team for Intermediate Care Bed Based Service suspended on the 9(^{th}) July 2013; then changed to redeployed to project duties and suspended from clinical leadership role on the 12(^{th}) July 2013</td>
</tr>
<tr>
<td>July 2013</td>
<td>Board received detailed report into concerns around the clinical leadership team within the Intermediate Care Bed Based Service</td>
</tr>
<tr>
<td>October 2013</td>
<td>Internal review into Intermediate Care Bed Based Service commissioned</td>
</tr>
<tr>
<td>November 2013</td>
<td>Care Quality Commission report into the Health Suite at HMP Liverpool noted that the service was meeting three of the seven standards and identified that action was needed for the other four</td>
</tr>
<tr>
<td>January 2014</td>
<td>Care Quality Commission report into the Trust highlights a culture within the Trust they found “unsupportive and oppressive” and subsequently issued two warning notices</td>
</tr>
<tr>
<td>January 2014</td>
<td>ACAS review commissioned by the Trust</td>
</tr>
<tr>
<td>February 2014</td>
<td>NHS Staff Survey results 2013 published and which showed Trust results were in the worst performing quartile in the country</td>
</tr>
<tr>
<td>February 2014</td>
<td>Independent review commissioned into the Intermediate Care Bed Based Service</td>
</tr>
<tr>
<td>March 2014</td>
<td>Care Quality Commission follow up report into the Health Suite at HMP Liverpool noted a much improved position</td>
</tr>
</tbody>
</table>
## Appendix 2

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2014</td>
<td>HM Chief Inspector of Prisons published report of an unannounced visit to HMP Liverpool that took place from 14-25 October 2013</td>
</tr>
<tr>
<td>2013/14</td>
<td>Trust made savings of £6,951K or 5.1% of turnover</td>
</tr>
<tr>
<td><strong>2014/15</strong></td>
<td></td>
</tr>
<tr>
<td>April 2014</td>
<td>Chief Executive, Director of Operations &amp; Executive Nurse and Director of Human Resources &amp; Organisational Development leave the Trust</td>
</tr>
<tr>
<td>April 2014</td>
<td>Independent review into the Intermediate Care Bed Based Service reported</td>
</tr>
<tr>
<td>April 2014</td>
<td>The Health &amp; Safety Executive commence investigation into assault on healthcare professional that occurred in spring 2013</td>
</tr>
<tr>
<td>April 2014</td>
<td>Independent review commissioned by the NHS Trust Development Authority undertaken by Sir Ian Carruthers into governance at the Trust</td>
</tr>
<tr>
<td>May 2014</td>
<td>Interim Chief Executive appointed</td>
</tr>
<tr>
<td>June 2014</td>
<td>Care Quality Commission report into the Health Suite at HMP Liverpool noted a range of concerns</td>
</tr>
<tr>
<td>Summer 2014</td>
<td>Independent desktop review into serious incidents at the Trust commissioned</td>
</tr>
<tr>
<td>July 2014</td>
<td>Trust received letter from Monitor regarding “Pilot Review of Quality Governance”</td>
</tr>
<tr>
<td>July 2014</td>
<td>Trust escalated offender health services on to Trust Risk Register following visit and subsequent findings by Interim Chief Executive and Interim Director of Nursing</td>
</tr>
<tr>
<td>July 2014</td>
<td>Board received extensive paper on concerns within offender health services at HMP Liverpool</td>
</tr>
<tr>
<td>July 2014</td>
<td>Trust Improvement Plan first presented to the Board</td>
</tr>
<tr>
<td>August 2014</td>
<td>Following risk summit, Spectrum Review of offender health services commissioned</td>
</tr>
<tr>
<td>September 2014</td>
<td>Board received report following internal review into actions taken by the Trust following assault on healthcare professional that occurred in spring 2013</td>
</tr>
</tbody>
</table>
## Appendix 2

<table>
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<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>November 2014</td>
<td>Independent desktop review into serious incidents at the Trust published</td>
</tr>
<tr>
<td>December 2014</td>
<td>Review of ten SUIs in the Health Suite at HMP Liverpool undertaken</td>
</tr>
<tr>
<td>December 2014</td>
<td>Trust received outcome of the Sir Ian Carruthers review into governance at the Trust</td>
</tr>
<tr>
<td>January 2015</td>
<td>Trust received Spectrum Review report</td>
</tr>
<tr>
<td>January 2015</td>
<td>Trust stops providing health services at HMP Liverpool</td>
</tr>
<tr>
<td>January 2015</td>
<td>Trust formally made decision to leave NHS foundation trust pipeline</td>
</tr>
<tr>
<td>February 2015</td>
<td>NHS Staff Survey results 2014 published and presented to the Board. They show that 26% of Trust staff experienced harassment, bullying or abuse from their manager or team leader. The highest since the establishment of the Trust in 2010</td>
</tr>
</tbody>
</table>

### 2015/16

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>Capsticks Governance Consultancy commissioned by Trust to undertake quality, safety and management assurance review</td>
</tr>
<tr>
<td>May 2015</td>
<td>Trust Chairman stepped down</td>
</tr>
<tr>
<td>May 2015</td>
<td>New Trust Chairman appointed</td>
</tr>
<tr>
<td>February 2016</td>
<td>NHS Staff Survey results 2015 published and presented to the Board. They show the first annual decline in staff reporting bullying concerns (25%) through the NHS Staff Survey since 2011.</td>
</tr>
</tbody>
</table>
Appendix 3

Board Composition 2010/11 Onwards
### 2010/11

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frances Molloy</td>
<td>Chair</td>
<td>1 October 2006 to 21 May 2015</td>
</tr>
<tr>
<td>Wally Brown</td>
<td>Non-Executive Director</td>
<td>12 October 2006 to 30 September 2014</td>
</tr>
<tr>
<td>Sue Ryrie</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 30 September 2014</td>
</tr>
<tr>
<td>Eileen Quinn</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 31 March 2015</td>
</tr>
<tr>
<td>Paul Patterson</td>
<td>Non-Executive Director</td>
<td>1 February 2011 to 31 October 2015</td>
</tr>
<tr>
<td>Jack Stopforth</td>
<td>Non-Executive Director</td>
<td>1 February 2011 to 23 July 2012</td>
</tr>
<tr>
<td>Bernie Cuthel</td>
<td>Chief Executive</td>
<td>1 April 2002 to 3 August 2014</td>
</tr>
<tr>
<td>Gary Andrews</td>
<td>Director of Finance</td>
<td>7 September 2009 to 23 July 2015</td>
</tr>
<tr>
<td>Sylvia Carney</td>
<td>Interim Director of Nursing and Therapies</td>
<td>1 April 2002 to 10 April 2011</td>
</tr>
<tr>
<td>Nicola Bunce</td>
<td>Director of Organisational Development and Strategy</td>
<td>4 February 2008 to 31 October 2013</td>
</tr>
<tr>
<td>Dr Jim O Conner</td>
<td>Medical Director</td>
<td>14 June 2007 to August 2012</td>
</tr>
<tr>
<td>Jeanette Pilsbury</td>
<td>Director of Operations</td>
<td>1 November 2002 to March 2011</td>
</tr>
<tr>
<td>Helen Lockett</td>
<td>Director of Operations &amp; Executive Nurse</td>
<td>7 March 2011 to 2 May 2014</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Period</td>
</tr>
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</tr>
<tr>
<td>Gary Andrews</td>
<td>Director of Finance</td>
<td>7 September 2009 to 23 July 2015</td>
</tr>
<tr>
<td>Nicola Bunce</td>
<td>Director of Organisational Development and Strategy</td>
<td>Until January 2012</td>
</tr>
<tr>
<td>Dr Jim O Conner</td>
<td>Medical Director</td>
<td>14 June 2007 to August 2012</td>
</tr>
<tr>
<td>Helen Lockett</td>
<td>Director of Operations &amp; Executive Nurse</td>
<td>7 March 2011 to 2 May 2014</td>
</tr>
<tr>
<td>Michelle Porteus</td>
<td>Director of Human Resources and Organisational Development</td>
<td>From January 2012 to May 2014</td>
</tr>
</tbody>
</table>
### 2012/13

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<th>Date</th>
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<tr>
<td>Sue Ryrie</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 30 September 2014</td>
</tr>
<tr>
<td>Eileen Quinn</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 31 March 2015</td>
</tr>
<tr>
<td>Paul Patterson</td>
<td>Non-Executive Director</td>
<td>1 February 2011 to 31 October 2015</td>
</tr>
<tr>
<td>Jack Stopforth</td>
<td>Non-Executive Director</td>
<td>Until August 2012</td>
</tr>
<tr>
<td>Bernie Cuthel</td>
<td>Chief Executive</td>
<td>1 April 2002 to 3 August 2014</td>
</tr>
<tr>
<td>Gary Andrews</td>
<td>Director of Finance</td>
<td>7 September 2009 to 23 July 2015</td>
</tr>
<tr>
<td>Dr Craig Gradden</td>
<td>Medical Director</td>
<td>From August 2012</td>
</tr>
<tr>
<td>Dr Jim O Conner</td>
<td>Medical Director</td>
<td>Until August 2012</td>
</tr>
<tr>
<td>Helen Lockett</td>
<td>Director of Operations &amp; Executive Nurse</td>
<td>7 March 2011 to 2 May 2014</td>
</tr>
<tr>
<td>Michelle Porteus</td>
<td>Director of Human Resources and Organisational Development</td>
<td>From January 2012 to May 2014</td>
</tr>
</tbody>
</table>
## Appendix 3

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Date of Appointment/Leaving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frances Molloy</td>
<td>Chair</td>
<td>1 October 2006 to 21 May 2015</td>
</tr>
<tr>
<td>Wally Brown</td>
<td>Non-Executive Director</td>
<td>12 October 2006 to 30 September 2014</td>
</tr>
<tr>
<td>Sue Ryrie</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 30 September 2014</td>
</tr>
<tr>
<td>Eileen Quinn</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 31 March 2015</td>
</tr>
<tr>
<td>Paul Patterson</td>
<td>Non-Executive Director</td>
<td>1 February 2011 to 31 October 2015</td>
</tr>
<tr>
<td>Debbie Morton</td>
<td>Non-Executive Director</td>
<td>1 April 2013 to current</td>
</tr>
<tr>
<td>Matt Wilson</td>
<td>Associate Non-Executive Director</td>
<td>17 June 2013 to 31 August 2015</td>
</tr>
<tr>
<td>Bernie Cuthel</td>
<td>Chief Executive</td>
<td>1 April 2002 to 3 August 2014</td>
</tr>
<tr>
<td>Gary Andrews</td>
<td>Director of Finance</td>
<td>7 September 2009 to 23 July 2015</td>
</tr>
<tr>
<td>Dr Craig Gradden</td>
<td>Medical Director</td>
<td>1 July 2012 to 20 March 2013</td>
</tr>
<tr>
<td>Helen Lockett</td>
<td>Director of Operations &amp; Executive Nurse</td>
<td>7 March 2011 to 2 May 2014</td>
</tr>
<tr>
<td>Michelle Porteus</td>
<td>Director of Human Resources and Organisational Development</td>
<td>From January 2012 to May 2014</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Date</td>
</tr>
<tr>
<td>---------------------------</td>
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<tr>
<td>Frances Molloy</td>
<td>Chair</td>
<td>1 October 2006 to 21 May 2015</td>
</tr>
<tr>
<td>Bernie Cuthel</td>
<td>Chief Executive</td>
<td>1 April 2002 to 3 August 2014</td>
</tr>
<tr>
<td>Wally Brown</td>
<td>Non-Executive Director</td>
<td>12 October 2006 to 30 September 2014</td>
</tr>
<tr>
<td>Sue Ryrie</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 30 September 2014</td>
</tr>
<tr>
<td>Eileen Quinn</td>
<td>Non-Executive Director</td>
<td>1 August 2008 to 31 March 2015</td>
</tr>
<tr>
<td>Paul Patterson</td>
<td>Non-Executive Director</td>
<td>1 February 2011 to 31 October 2015</td>
</tr>
<tr>
<td>Debbie Morton</td>
<td>Non-Executive Director</td>
<td>1 April 2013 to current</td>
</tr>
<tr>
<td>Sally-Anne Watkiss</td>
<td>Non-Executive Director</td>
<td>1 May 2014 to current</td>
</tr>
<tr>
<td>Matt Wilson</td>
<td>Associate Non-Executive Director</td>
<td>17 June 2013 to 31 August 2015</td>
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<td>Sue Page</td>
<td>Interim Chief Executive</td>
<td>1 April 2014 to current</td>
</tr>
<tr>
<td>Gary Andrews</td>
<td>Director of Finance</td>
<td>7 September 2009 to 23 July 2015</td>
</tr>
<tr>
<td>Helen Lockett</td>
<td>Director of Operations &amp; Executive Nurse</td>
<td>7 March 2011 to 2 May 2014</td>
</tr>
<tr>
<td>Jo Reilly</td>
<td>Interim Director of Operations</td>
<td>5 May 2014 to current</td>
</tr>
<tr>
<td>Dr Craig Gradden</td>
<td>Medical Director</td>
<td>1 July 2012 to current</td>
</tr>
<tr>
<td>Marie Crofts</td>
<td>Acting Director of Operations/Executive Nurse</td>
<td>1 September 2013 to 29 March 2015</td>
</tr>
<tr>
<td>Jill Byrne</td>
<td>Interim Director of Nursing</td>
<td>May 2014 to 24 October 2014</td>
</tr>
<tr>
<td>Amanda Pye</td>
<td>Interim Director of Nursing</td>
<td>3 November 14 to 24 October 2015</td>
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<tr>
<td>Michelle Porteus</td>
<td>Director of Human Resources &amp; OD</td>
<td>3 January 2012 to 11 May 2014</td>
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<tr>
<td>Ros Fallon</td>
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<td>22 April 2014 to 31 December 2015</td>
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<td>12 May 2014 to 30 September 2014</td>
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<td>Interim Director of HR/OD</td>
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</tr>
<tr>
<td>Mark Graham</td>
<td>Director of Communications, Engagement and Marketing</td>
<td>August 2014 to current</td>
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### Appendix 3

#### 2015/16

<table>
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<tr>
<td>Frances Molloy</td>
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<tr>
<td>Trevor Lake</td>
<td>Chair</td>
<td>21 May 2015 to current</td>
</tr>
<tr>
<td>Mike Roach</td>
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<td>28 August 2015 to current</td>
</tr>
<tr>
<td>Paul Patterson</td>
<td>Non-Executive Director</td>
<td>1 February 2011 to 31 October 2015</td>
</tr>
<tr>
<td>Debbie Morton</td>
<td>Non-Executive Director</td>
<td>1 April 2013 to current</td>
</tr>
<tr>
<td>Sally-Anne Watkiss</td>
<td>Non-Executive Director</td>
<td>1 May 2014 to current</td>
</tr>
<tr>
<td>Matt Wilson</td>
<td>Associate Non-Executive Director</td>
<td>17 June 2013 to 31 August 2015</td>
</tr>
<tr>
<td>Karen Fielding</td>
<td>Non-Executive Director</td>
<td>9 September 2015 to current</td>
</tr>
<tr>
<td>Julie Goulden</td>
<td>Non-Executive Director</td>
<td>28 August 2015 to current</td>
</tr>
<tr>
<td>Greg Gottig</td>
<td>Non-Executive Director</td>
<td>9 September 2015 to 30 September 2015</td>
</tr>
<tr>
<td>Sue Page</td>
<td>Interim Chief Executive</td>
<td>April 2014 to current</td>
</tr>
<tr>
<td>Amanda Pye</td>
<td>Interim Director of Nursing</td>
<td>3 November 2014 to 24 October 2015</td>
</tr>
<tr>
<td>Carole Panteli</td>
<td>Interim Director of Nursing, Director of Infection Prevention &amp; Control</td>
<td>17 August 2015 to current</td>
</tr>
<tr>
<td>Gary Andrews</td>
<td>Director of Finance</td>
<td>7 September 2009 to 23 July 2015</td>
</tr>
<tr>
<td>Jo Reilly</td>
<td>Interim Director of Operations</td>
<td>5 May 2014 to current</td>
</tr>
<tr>
<td>Dr Craig Gradden</td>
<td>Medical Director</td>
<td>1 July 2012 to current</td>
</tr>
<tr>
<td>Therese Harvey</td>
<td>Interim Director of HR/OD</td>
<td>1 October 2014 to current</td>
</tr>
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<td>Nora Ann Heery</td>
<td>Interim Director of Finance</td>
<td>1 October 2015 to current</td>
</tr>
<tr>
<td>Ros Fallon</td>
<td>Interim Director of Performance</td>
<td>22 April 2014 to 31 December 2015</td>
</tr>
<tr>
<td>Mark Graham</td>
<td>Director of Communications, Engagement and Marketing</td>
<td>August 2014 to current</td>
</tr>
</tbody>
</table>
Appendix 4

Over the two year period of 1st April 2012 to 31st March 2014 District Nursing services reported a total of 4340 incidents. Over the same period of time there were 11,575 reported incidents, meaning that approximately 37.50% of incidents were reported by the District Nurse Service.

<table>
<thead>
<tr>
<th>Year</th>
<th>District Nursing Reported Incidents</th>
<th>All other Services / Team Reported Incidents</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>2201</td>
<td>3625</td>
<td>5826</td>
</tr>
<tr>
<td>2013/2014</td>
<td>2139</td>
<td>3610</td>
<td>5749</td>
</tr>
<tr>
<td>Total</td>
<td>4340</td>
<td>7235</td>
<td>11575</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Incidents</th>
<th>Number of District Nursing Contacts</th>
<th>District Nursing Incidents per contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>2201</td>
<td>418,949</td>
<td>0.0052536</td>
</tr>
<tr>
<td>2013/14</td>
<td>2139</td>
<td>405,172</td>
<td>0.0052792</td>
</tr>
<tr>
<td>Total</td>
<td>4340</td>
<td>824,121</td>
<td>0.0052662</td>
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</table>
### Breakdown of Major and Catastrophic Incidents

<table>
<thead>
<tr>
<th>Category</th>
<th>Team</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Central</td>
<td>Night Service</td>
</tr>
<tr>
<td>Admission/Discharge/Referral</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Breach of security</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Community Equipment</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Environmental Issues</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Equipment (Non Medical)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Information Governance</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Occupational Stress</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Personal Accident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure care relief</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Staffing issues</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Treatment problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Unwell/illness/Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence/Abuse/Harassment</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>25</td>
<td>3</td>
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### Reported Incident by Type

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Financial Year</th>
<th>Grand Total</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>2012 / 2013</td>
<td>2013 / 2014</td>
</tr>
<tr>
<td>Admission/Discharge/Referral</td>
<td>165</td>
<td>153</td>
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<tr>
<td>Breach of security</td>
<td>15</td>
<td>10</td>
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<tr>
<td>Child Protection</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Clinical Medical Devices</td>
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<td>15</td>
</tr>
<tr>
<td>Community Equipment</td>
<td>81</td>
<td>47</td>
</tr>
<tr>
<td>Environmental Issues</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Equipment (Non Medical)</td>
<td>46</td>
<td>16</td>
</tr>
<tr>
<td>ESR/E-Learning/Smartcard Issues</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Exposure to harmful agent</td>
<td></td>
<td>2</td>
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<tr>
<td>Fire</td>
<td>4</td>
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<td>Infection Control</td>
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<td>3</td>
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<tr>
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<td>39</td>
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<td>IV Incident</td>
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<td>2</td>
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<tr>
<td>Lifting/handling injury</td>
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<td>6</td>
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<td>179</td>
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<tr>
<td>Needle sticks</td>
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<tr>
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<td>45</td>
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<td>29</td>
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<td>Pressure care relief</td>
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<td>1173</td>
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<tr>
<td>Safeguarding Adults</td>
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<td>71</td>
</tr>
<tr>
<td>Self Harm</td>
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<td>5</td>
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<tr>
<td>Slips, trips and falls</td>
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<td>17</td>
</tr>
<tr>
<td>Staffing issues</td>
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<td>132</td>
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<tr>
<td>Treatment problems</td>
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<td>106</td>
</tr>
<tr>
<td>Unwell/illness/Injury</td>
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<td>14</td>
</tr>
<tr>
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<td>1</td>
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<tr>
<td>Violence/Abuse/Harassment</td>
<td>53</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>2201</strong></td>
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### Top 10 Incidents by year

<table>
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<tr>
<th>Incident Type</th>
<th>20012/2013 Number</th>
<th>20013/2014 Incident Type</th>
<th>Number</th>
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<tr>
<td>1 Pressure care relief</td>
<td>1101</td>
<td>1 Pressure care relief</td>
<td>1173</td>
</tr>
<tr>
<td>2 Medication</td>
<td>170</td>
<td>2 Medication</td>
<td>179</td>
</tr>
<tr>
<td>3 Staffing issues</td>
<td>170</td>
<td>3 Admission/Discharge/Referral</td>
<td>153</td>
</tr>
<tr>
<td>4 Admission/Discharge/Referral</td>
<td>165</td>
<td>4 Staffing issues</td>
<td>132</td>
</tr>
<tr>
<td>5 Treatment problems</td>
<td>133</td>
<td>5 Treatment problems</td>
<td>106</td>
</tr>
<tr>
<td>6 Safeguarding Adults</td>
<td>96</td>
<td>6 Safeguarding Adults</td>
<td>71</td>
</tr>
<tr>
<td>7 Community Equipment</td>
<td>81</td>
<td>7 Community Equipment</td>
<td>47</td>
</tr>
<tr>
<td>8 Violence/Abuse/Harassment</td>
<td>53</td>
<td>8 Occupational Stress</td>
<td>45</td>
</tr>
<tr>
<td>9 Equipment (Non Medical)</td>
<td>46</td>
<td>9 Violence/Abuse/Harassment</td>
<td>42</td>
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<tr>
<td>10 Information Governance</td>
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<td>10 Information Governance</td>
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</table>
Overview of Reported Pressure Ulcer Data

<table>
<thead>
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<th>Year 2012</th>
<th>Year 2013</th>
<th>Year 2014</th>
<th>Grand Total</th>
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<tr>
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<td>13</td>
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<td>Grade 2</td>
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<td>756</td>
<td></td>
<td>1502</td>
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<td>Grade 4</td>
<td>87</td>
<td>98</td>
<td></td>
<td>185</td>
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<tr>
<td>Inappropriate treatment/procedure</td>
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<td>7</td>
<td></td>
<td>15</td>
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<tr>
<td>Insufficient information - referral</td>
<td>4</td>
<td>5</td>
<td></td>
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<tr>
<td>Lack of pressure relieving equipment in nursing homes</td>
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<td>1</td>
<td></td>
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<tr>
<td>Not Pressure Ulcer</td>
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<td></td>
<td>14</td>
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<tr>
<td>NOTPU</td>
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<tr>
<td>Staff concerns raised</td>
<td>53</td>
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<td>Traumatic Wound</td>
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<td>Wrong treatment decision/given</td>
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<tr>
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<td><strong>1101</strong></td>
<td><strong>1173</strong></td>
<td><strong>2274</strong></td>
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</tbody>
</table>

From the table above, the majority of Pressure Care Relief incidents are attributed to pressure ulcers graded from a one to a four (92% of incidents). Please note that these are reported occurrences and NOT all are attributed to LCH services.

All Occurrences

<table>
<thead>
<tr>
<th>Team</th>
<th>Year 2012</th>
<th>Year 2013</th>
<th>Year 2014</th>
<th>Grand Total</th>
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<tr>
<td></td>
<td>2012 2013</td>
<td>2013 2014</td>
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<td></td>
</tr>
<tr>
<td>Central</td>
<td>318</td>
<td>296</td>
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<td>614</td>
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<tr>
<td>Night Service</td>
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<td>North</td>
<td>277</td>
<td>251</td>
<td></td>
<td>528</td>
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<tr>
<td>Sefton</td>
<td>172</td>
<td>226</td>
<td></td>
<td>398</td>
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<tr>
<td>South</td>
<td>240</td>
<td>308</td>
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<td><strong>1011</strong></td>
<td><strong>1081</strong></td>
<td></td>
<td><strong>2092</strong></td>
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</table>
2012 / 13
LCH Acquired Pressure Avoidable Ulcers

Grade 2: 3%
Grade 3: 14%
Grade 4: 83%

Total 2012/13 LCH Acquired Avoidable Pressure Ulcers = 157
Grade 2 = 131
Grade 3 = 22
Grade 4 = 4

2013/14
LCH Acquired Pressure Avoidable Ulcers

Grade 1: 1%
Grade 2: 30%
Grade 3: 15%
Grade 4: 54%

Total 2013/14 LCH Acquired Avoidable Pressure Ulcers = 85
Grade 1 = 1
Grade 2 = 13
Grade 3 = 46
Grade 4 = 25
Pressure Ulcer Type by Team

<table>
<thead>
<tr>
<th>Team</th>
<th>Pressure Ulcer Type</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td></td>
<td>470</td>
<td>93</td>
<td>51</td>
<td></td>
<td>614</td>
</tr>
<tr>
<td>Night Service</td>
<td></td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>North</td>
<td></td>
<td>1</td>
<td>358</td>
<td>101</td>
<td>68</td>
<td>528</td>
</tr>
<tr>
<td>Sefton</td>
<td></td>
<td>2</td>
<td>276</td>
<td>88</td>
<td>32</td>
<td>398</td>
</tr>
<tr>
<td>South</td>
<td></td>
<td>2</td>
<td>395</td>
<td>117</td>
<td>34</td>
<td>548</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>5</td>
<td>1502</td>
<td>400</td>
<td>185</td>
<td>2092</td>
</tr>
</tbody>
</table>

Overview of Staffing Issues

There were 302 incidents categorised as ‘Staffing Issues’

**Staffing Issues sub categories**

- 68% of incidents relate to staff shortages:
  - 61% of these occurred in 2012/13
  - 39% occurred in 2013/14
  - Of the 202 incidents relating to staff shortages, 24 were reported to have a caused ‘Major’ Harm (see below). Of the Major Harm 9 were reported in 12/13 and 15 in 13/14
Sample Staff Datix Entries

No band 6 on Saturday 22/12/12. 1 full day band 5 and 1 band 5 doing split. 2 HCA’s and 1 band 5 doing extra hours 1/2 day only, instead of 1 band 6 and 4 band 5s. This will leave a band 5 and a HCA in the afternoon.

No other staff are able to do extra hours. In fact all the staff in this team are ready to all go off with stress due to the overwhelming workload. We are not providing a quality care service. All part time staff are working extra hours and are exhausted due to the number and complexity of the patients we see on a daily basis.

For many months the reduced number of staff has meant an increase in workload, this has resulted in reduced quality of care to clients, as most shifts the number of patients and complexity of patients are not manageable. Staff are becoming stressed and demotivated, we are working in breach of our NMC guidelines and this needs highlighting.

Following meeting with XXX, Aintree neighbourhood DN’s and Deputy Area Managers following issues were highlighted:

- High weighting allocated to all grades on a daily basis, average 24-26 (are scoring these lower than guidelines on weighting tool)
- Working longer than contracted hours (all staff except XXX starting at 07:45-08:00hrs to commence morning insulin’s as if starting at 08:30hrs not able to fit in all daily visits. Regularly finishing later than contracted hours. Most staff not recording on SVLs.
- Lunch breaks not taken or only taking 20-30 minutes (this is on a regular basis). This is not being recorded on SVLs.
- Rushing visits to ensure all visits are completed. All staff fear they will make a mistake as workload unmanageable
- Documentation- minimum amount being completed e.g. Care plans being update but not being read properly to check if all aspects are still appropriate to patient needs, wound tools not being updated frequently enough. Staff are risk assessing what documentation is absolutely necessary and ensuring this is completed. They feel they are leaving themselves at risk in relation to NMC/LCH guidelines. Complexity tool not being updated in a timely manner. This has an impact on the duration of visits being inputted onto EMIS Web data as visits should be taking longer but they are being completed in a rushed manner.
- Not getting back to office from early morning calls until late afternoon, leaving little time for referrals, phone calls etc.
- Formal patient handovers not taking place
- Mandatory training not taking place
- PDRs overdue
- Newly seconded Band 6 (XXX aware she needs to cleanse her caseload however she requires support doing this and all staff too busy to support.
- Established Band 6 (XXX) aware her caseload requires cleansing but too busy carrying out visits to complete.
EMIS Web- staff are managing to input however this is not in a timely manner and is often 3 days overdue. Staff feel they are inputting minimal data and are not capturing all information they should be (reviews and accurate times of visits)

SPC – Nurse who has SPC phone allocated same amount of calls as other staff due to demand and capacity issues, when she should have less to enable her to deal with enquiries, extra visits etc. SPC staff not triaging appropriately or requesting correct/adequate information e.g. Requests for injections not being sent with prescription sheet. New patient visits often have no commence date and DN's have to phone referrer to obtain more information.

Lack of continuity of care due to staff vacancies (x3 Band 5s)

All staff advise they are experiencing sleep disturbance worrying about work e.g. whether they have completed all documentation, EMIS, referrals, have they missed of forward planning any visits, have they handed over patient information?

All staff advise they have no time to read emails

Not forward planning for TWP, therefore correct dressing not always being taken to patients in a timely manner

Postponing visits such as palliative observations (trying to carry out telephone obs but not always able to due to work demands), Doppler postponed unless required urgently

X3 Band 5 vacancies, x2 sickness (will be long term), x1 staff pregnant and now on restricted duties

HCA requesting trained staff reviews for patients however reviews being delayed as trained staff needing to triage more urgent cases to be seen sooner (average reviews every 6 weeks when they should be every four weeks)"

Over the past few months the reduced level of staff has meant an increased workload is such that it is not possible to give high quality care.

Staff are becoming stressed and demotivated, although staff are doing their level best to maintain quality care, are becoming increasingly concerned that we are in breach of our NMC guidelines.

For many months the reduced level of staff has meant an increase in work load. Although we are doing our best this has resulted in staff becoming stressed and has the potential to reduce standards. We are starting early going without breaks and finishing late. As a registered nurse I have an obligation to keep myself safe, patients safe and the organisation safe I believe this is being compromised.

For many months the reduced level of staff has meant and increase in current workload in order to meet the generated patient contacts from emis. This has the potential of a reduced quality of care being delivered to our patients. Staff are becoming stressed and demotivated and although staff are doing their best to meet patient needs, whilst also completing their office duties. It is felt that we are in breach of our NMC guidelines.

For many months the reduced level of staff has meant an increase in the work load in order to meet the generated contacts. This is resulting in dangerous level of daily work therefore staff are becoming stressed, demotivated and exhausted. Although staff are working as best as possible NMC registration guidelines are not being met. I am also six months pregnant and feel that my health and my babies are being affected as my colleagues and line manager are unable to support
me as we are all working to maximum capacity. I am still continuing on normal duties, everyday tasks despite the fact I am pregnant. I feel stressed and coming to work on a daily basis is so exhausting and it is beginning to affect my mental health, I am concerned that this will have an implication on my pregnancy if this continues. My risk assessment has not yet been completed by my manager as she has been unable to provide me with the time required to complete this.

AS A BAND 7 TEAM LEADER I HAVE FELT TODAY THAT I AM NOT ABLE TO DO THE ROLE OF MY JOB AS SET OUT IN MY JOB DESCRIPTION. THIS HAS BEEN COMPROMISED BY THE HIGH LEVEL OF SICKNESS IN THE TEAM AND THAT I AM TEAM LEADER TODAY OVERSSING THREE TEAMS. I AM NOT ABLE TO PERFORMANCE MANAGE THE TEAM IN THE WAY I SHOULD BE DOING, I AM DAILY HAVING TO ENSURE THAT THE STAFFING LEVELS ARE SAFE TO PREVENT RISK TO PATIENTS STAFF AND LCH. I AM NOT ABLE TO ATTEND GSF MEETINGS AND COMMUNICATE WITH THE GP'S ATTACHED TO THE TEAM WHICH IS NINE IN TOTAL DUE TO THE DEMAND OF OTHER ASPECTS THE ROLE HAS TAKEN ON. I AM CONCERNED THAT THE LEVEL OF DOCUMENTATION IS NOT UP TO A LEVEL I WOULD EXPECT IT TO BE AND IT IS PROVING DIFFICULT FOR ME TO OVERVIEW THIS AS MUCH AS POSSIBLE BECAUSE OF THE LACK AND ABSENCE OF CLH IN THE TEAM.

On 06/08/13 there was myself, XXX (HCA) and 2 bank nurses to cover the whole Anfield team.

Workload was un-manageable.

Patients’ notes are out of date and there is no time to complete them, water low, must, complexity etc.

I never had a lunch break.

A palliative patient’s condition deteriorated and due to the staffing levels there was no staff or time to take on the unplanned care properly, resulting in me not having a lunch and then worrying that everything had been done properly.

We are so short staffed we are only task orientated in patients homes.

Staff stress is high.

There is no continuity of care.

There is no time to update Emis so potentially visits will be missed.

We are a serious incident waiting to happen.

Unsafe staffing levels. weighting yesterday 34 travelling to Waterloo Crosby Blundellsands and Hightown worked through lunch (my choice) did not get back to DN base at all therefore unable to emis or refer. Today weighting 32 again worked through lunch but office based this time still 6 calls to do and will answer phones before leaving office. We have prioritised our visits.
Poor/unsafe staffing levels. Nurses on a weight of 28-34 which equates to 8.5 hours of work (weight of 4=1 hour) I’m employed to work for 7.5 hours per day including 1 hour lunch break. This is not possible as the weight does not allow for travelling time. We are constantly working through our lunch break, staying late and coming into work early. No time to input information onto emis, referral, handovers. Paperwork. We have prioritised but these patients need to be seen by our service.

I arrived into work after completing my early visits to obtain my work for the day. My weighting for the day is 34 (8.5 hours not including travelling time) which I feel is completely unachievable for a very experienced district nurse never mind myself who has only been in post for 6 months. I feel that these unrealistic visits are causing extreme amounts of stress on myself and all the staff and I cannot see how we can maintain working as safe practitioners under these extremely challenging conditions which are becoming a regular occurrence. We have no time for computer work or completing referrals which is also significantly impacting on the service which our patients receive.

Even after raising concerns on Friday 13/09/13 regarding dangerous staffing levels. Today we have been given a weight of 30 due to there only being four band 5’s on duty. I feel this is unacceptable as it has increased stress levels and staff morale is low. It is only a matter of time until mistakes are made causing harm to ourselves or patients.

Even after raising concerns on Friday 13.09.13 regarding dangerous staffing levels today we have been given a weight of 30 due to there only being 4 band 5 nurses on duty. Clearly this is unacceptable and has increased stress levels and staff morale is low also. It is only a matter of time until mistakes are made causing harm to ourselves or patients.

After raising concerns Friday 13/9/13 about staffing issues, workload and stress. Today our weights were 30 due to there only being 4x Band 5’s throughout our network. This is an unachievable expectation for one day. I was also asked to cancel my mandatory training course this morning due to staffing levels. I must reiterate the stress that we are feeling and it will be only a matter of time before mistakes are made.

Even after raising concerns about staffing issues staff are still going out with unachievable weights. I had a weight of 28 on 13/09/13 and 14/09/13. Also on 13/09/13 I was expected to accommodate a first year/first placement student. Having such high weights makes it impossible to follow up work generated by visits, input on emis, attend to telephone calls/messages. We are also running 2-3 clinics a week. I feel given this amount of work puts my stress levels dangerously high and at risk of making mistakes.

Over past few weeks workload weights increased leading to increased stress levels & anxiety in our job role.

I was given a list of patients which had a time weight of 31, which equates to a work load of eight hours and thirty minutes without calculating travelling time. I have recently returned to work having been off with work related stress. Each day the amount of patients and the weighting is increasing. I have flagged this up to my line manager and they are aware of this.
Given a weighting of 30 for the days visits. Resulting in stress and leaving no office time to deal with follow-ups, EMIS etc. Resulted in leaving work late and impacted on childcare arrangements.

Given a weight of 32 for a days visits. This already adds to stress before even leaving the office to attempt the volume of calls given. I have had no office time to deal with phone calls, follow ups, emis. One patient I attended today was not expecting me as she stated she had been discharged last week. I’m sure the person discharging her had not had time to amend this due to own volume of calls. I am behind on emis myself and am regularly not getting my full lunch hour.

I feel that even though I have reported through the datix process before regarding staffing issues things are actually getting worse. On Friday 27th September I had a weight of 37 equalling over 9 hours work for a 7 hour day, with weighting not much better this week. I feel this is extremely dangerous as stress levels are extremely high and I feel mistakes are going to be made. I understand that as part of my job role is to prioritise my workload but I feel this is unrealistic with such a high weighting.

Once again, I have been given an unachievable amount of work to get through the working day. I feel that mistakes will be made as my stress levels are becoming dangerously high. I realise that it is part of my job role to prioritise calls, however it is very difficult to do this at present as things have not improved over the last few weeks and I cannot see any signs of improvement in the foreseeable future.

Very low staffing levels with no capacity to cover sickness impacting on patient care and staff morale. Staff stressed due to workload and not being able to complete documentation. No opportunity to have lunch breaks and working over hours. No opportunity to caseload cleanse.

Please note that there are some spelling mistakes in the above Datix entries but we have not amended these as they reflect what was recorded at the time.
Overview of Medication Incidents

<table>
<thead>
<tr>
<th>Sub Category</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration Error</td>
<td>65</td>
<td>69</td>
<td></td>
<td>134</td>
</tr>
<tr>
<td>Controlled drugs incident</td>
<td>21</td>
<td>20</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Dispensing Error</td>
<td>14</td>
<td>9</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>End of Life - No Pain Relief</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Incorrect storage</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Non-adherence to medication procedure</td>
<td>24</td>
<td>23</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Out of date medication (administered or received)</td>
<td>6</td>
<td>7</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Patient Non- Compliance</td>
<td>9</td>
<td>8</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Prescribed Medication not given</td>
<td></td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Prescribing Error</td>
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<td>15</td>
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<tr>
<td>Stocks</td>
<td>7</td>
<td>14</td>
<td>21</td>
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</tr>
<tr>
<td>Syringe Driver Issue</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td></td>
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<tr>
<td>Vac &amp; Imms (Up to 31/03/2015)</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td>170</td>
<td>179</td>
<td>349</td>
<td></td>
</tr>
</tbody>
</table>

Of the 349 Medication incidents only 12 reported as Major Harm (see below), with 4 of these being controlled drug issues.

Sample Staff Datix Entries

After Joint Visit with Specialist Nurse (SN) 1/2/13. Rang surgery to ask for increase in pain relief medication to 25mg/BD Oxycodone tablets and to inform that she need more Oxycodone liquid for the weekend. As she had been advised by SN to take 25mg/BD and hourly oxycodone liquid. Patient only had half of a small bottle left. Joint visit again 4/2/13 with SN Patient had not had no liquid oxycodone left from Saturday. Had only been delivered 5mgs of oxycodone tablets (dated 1/2/13 on box).

Additionally, I had requested other medication in blister packs. Which was delivered 1/2/13. Patient informed us that it had Ramipil 5mg in pack, which had been discontinued by the hospital and replaced with 1.25mgs. I had included discharge summary of medication on the 30/2/13, with letter.

Contacted GP surgery to request supply of insulin syringes, as previous requests had not resulted in syringes being prescribed / delivered for use.

Discrepancy in controlled drugs, following death of pt- drugs checked for destruction- lorazepam4mg/ml 3 vials and oxycodone10mg/ml 3 vials unaccounted for. Full search in house made with help of family. Both drugs last used 8/01/2013 for symptom control at 21.25- Nurse was not on duty at the time of discovery of discrepancy to ask. All other drugs in house have been accounted for and destroyed as per policy.
My colleague and I visited a patient to assess her in regard to administering symptom relief. The lady did require symptom relief. On checking/counting the patients prescribed drugs in the home the nursing staff found a drug error in that: Diamorphine 5mg x 2 amps; Midazolam 10mg/2ml x 4 amps; Levomepromazine 25mg x 6 amps where missing. Nursing staff with the permission of the patient's relatives searched the home but where unable to find the missing drugs. The lady's niece then informed us that the pt's son, who is resident in the home, was a known illegal drug user. I contacted the manager on call via the R.L.H., advise him of the situation. On return to base we also informed the Social Worker on call of the situation, the patients day D.N.'s, (having informed the G.P. on call while in the home as pt required further drugs). O.O.H.s manager, subsequently contacted the night-staff for details of the incident. The referral from the day D.N.s re information about this patient should she require a visit did not contain any information re known illegal drug user in the pts home. ? They had not been informed of situation by patients own G.P.

Patient on apomorhine pump that should run overnight, pump had been replenished but not switched on therefore patient received no medication overnight.

Patient was diagnosed with a PE in august and was prescribed warfarin but did not take it for 6 weeks, on admission to hospital recently patient's INR was 1. Hospital commenced patient on dalteparin 18000 units due to non compliance with warfarin. Patient was administered dalteparin 18000 units by a nurse yesterday at 16.00. The nurse advised that the injection would be given today at 14.00 and asked patient to stay in until or be back for 14.00. I knocked, patient's brother answered and stated patient had been out since this morning and did not know when he would return. Nobody else in the household could administer the injection. Patient lives with his brother and his girlfriend. I rang and spoke to patient's mother and advised that he was not in and asked her to speak to him but she could not as she had no credit. I rang patient and asked him to come home but he stated he would not be home until this evening. Team Leader spoke to patient and asked him to

Patient was not given insulin at prescribed time 17:00 on 19/6/2013 as no nurse arrived.

Patient's carer informed me that patient had been giving his prescription tablets of dihydrocodeine to his girlfriend. Asked the patient about this patient said he had been as his girlfriend couldn't get them off her GP. Informed patient he would have to stop doing this as they were prescribed for him only and that I would have to inform GP of this. Patient said he never needed the tablets for pain as he didn't have any pain anymore. He kept getting the tablets as a repeat prescription.

Patients was discharged from a nursing home with another patients drugs

Requested controlled drug from GP. Have not been done. Which has left the patient with no medication.
The night Service received a call from a qualified Nurse who was on overnight placement with an end of life patient in Southport, requesting permission to administer symptom control to the patient she was with, who was in pain. The Nurse stated this was a 'courtesy phone call' as advised by Queens Court Hospice who are her employers, and if we did not give our permission we would need to visit for symptom control ourselves.

Visited patient's to provide last offices, on counting the controlled medication to destroy, I was unable to locate two ampoules of Diamorphine that the stock control sheet indicated was present, the Diamorphine box was empty.

Please note that there are some spelling mistakes in the above Datix entries but we have not amended these as they reflect what was recorded at the time.
Appendix 5

Prison Health Incident Data 2012 – 2014
Appendix 5

A total of 299 incidents were reported on Datix during the period of 1st April 2012 and 31st March 2014.

During the 2 year period there was a small increase in reporting.
Overall Reported Levels of Harm

<table>
<thead>
<tr>
<th>Level</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>74</td>
<td>58</td>
</tr>
<tr>
<td>Minor</td>
<td>31</td>
<td>54</td>
</tr>
<tr>
<td>Moderate</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Major</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>23</td>
<td>0</td>
</tr>
</tbody>
</table>

HMP Liverpool - Reported Levels of Harm (n=270)

- No Harm: 45%
- Minor: 29%
- Moderate: 20%
- Major: 4%
- Catastrophic: 2%
<table>
<thead>
<tr>
<th>Category</th>
<th>2012-13</th>
<th>2013-14</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission/Discharge/Referral</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Breach of security</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Equipment (Non Medical)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>IV Incident</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Medication</td>
<td>7</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Needlesticks</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Personal Accident</td>
<td></td>
<td>1</td>
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</tr>
<tr>
<td>Staffing issues</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Treatment problems</td>
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<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Violence/Abuse/Harassment</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>12</strong></td>
<td><strong>17</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

**Reporting Trends 01/04/12 - 31/03/14**
Reported Incidents by Category

- Staffing issues: 18 (2012-13), 30 (2013-14)
- Slips, trips and falls: 11 (2012-13), 8 (2013-14)
- Self Harm: 2 (2012-13), 3 (2013-14)
- Safeguarding Adults: 4 (2012-13), 2 (2013-14)
- Personal Accident: 1 (2012-13), 1 (2013-14)
- Death: 1 (2012-13), 5 (2013-14)
- Clinical Medical Devices: 1 (2012-13), 1 (2013-14)
Sample Staff Datix Entries

This person informed Prison staff on the wing that he had been given the wrong medication, stated that he had only noted that the name on the bottle was not his after taking it.

Emergency call to I wing where inmate had been found hanging by Prison staff colleague.

A BOX OF IBUPROFEN WAS LEFT ON THE FRONT DESK OF THE HEALTHCARE INPATIENT DEPARTMENT. ONE OF THE PRISONERS LEANT OVER THE DESK WHILST IT WAS UNATTENDED AND TOOK SOME OF THE TABLETS. IT WAS RECORDED ON CCTV AND THE EMPTY PACKETS HAVE BEEN RECOVERED.

Healthcare staffs were unable to locate the keys for the medication trollies for both G and H wings. They were not in the key safe in the main nurse’s room in the Healthcare unit.

A prescription chart was put under the door of H2 surgery prescribing a patient 5 nights sleeping tablets.

The GP’s signature was not recognised and was not matched up to any of our current locum doctor’s. A tablet had been given 27/7/12 and the nurse’s signature was also not recognised as that of any of our current registered nurses.

Patient was discharged home yesterday. He was given meds to take home. He was given a supply of Depakote and Olanzapine in white boxes. Attached to the sealed bags were prescription sheets with his name and prescription on. Unfortunately it would appear that a box of gabapentin for a different patient was inside the bag. The discharged patient rang healthcare last night to report the incident. He did offer to bring the medication back to us today. He lives in Formby. I advised him this wasn’t necessary. I have informed XXX today of the situation.

Whilst administering medication on A3 surgery due to unavoidable distractions from numerous prisoners the affected individual was given 400mg Amitryptiline instead of 400mg Amisulpiride.

As I gave a patient his medication through the cell door hatch he took the medication with his left hand and threw a punch with his right hand that lightly connected with my face.

Centre surgery had sharps and other contaminated items in a sharps bin with no lid sat on a work surface.

A person came to the hatch requesting his px meds, was advised to get his I.D card which he did, on return he became verbally abusive.

There was no officer on the door, I then went to see the S.O on the wing and informed him that treatments would not be happening till an officer on the door.
Whilst giving out evening medication from G1 surgery a patient became irate as I refused his request to give him more medication than he was prescribed for that time. I attempted to re-inforce the prescribing and administration of medicines policy, however the patient threw his medication at me through the hatch and walked away. There was no officer present at the medication hatch at the time although there had been one at the start of treatments.

I WAS INFORMED FOR THE SECOND TIME THAT I WAS ON WEEKEND DUTY THAT THE DOOR TO THE DOCTOR’S OFFICE WAS UNLOCKED WHEN STAFF WENT DOWN TO RECEPTION AT LUNCHTIME.

Drug error prisoner given wrong medication patch had 2 prisoner cards in hand while working in centre surgery giving out morning treatments, at the time on that morning I had a prisoner come into centre surgery with a bite from a fight on the wing and I had been taking a telephone call also ...this person was given his depot injection on the 2nd of May, which was one week early, was actually due on the 9th May.

Weekend reception and GP booked from 10am - 2pm. 6 patients through reception with four of them being DDU patients requiring review by GP. GP was only able to review one of these patients and complete his methadone prescription before having to leave. 3 patients (two methadone, one requiring subutec) were not reviewed by GP.

DDU took over their care and arranged interim arrangements to ensure patient safety, however the GP cover for reception was inadequate.

When dispensing methadone, staff noted that this person had been px 5mls of Methadone for dates 12th and 13th April as per px chart. However on the methadone computer, it stated that he was dispensed only 4mls on both occasions. His px card had been signed by staff, on the 12th and 13th of April for giving 5mls of Methadone, but only 4mls had been dispensed according to methasoft computer

Two patients admitted from reception with self-harm risk warnings; one was for hourly observations and the other for five observations an hour. There were also eight other patients on self-harm plans on standard levels of observations. The unit is manned by two staff overnight. Five observations an hour would constitute a constant watch needing extra staff. The staff have a duty of care towards all the other patients on the unit. The nurse still has to fulfil the nursing duties like administration of medication, writing reports and attending to other patients as needed.

Patient attended the surgery for his medication which was dispensed by nursing staff. His medicine card showed that he had received no medicines, so all his medication was dispensed including his concerta. When going to sign out the concerta from CD book, the CD book showed that it had actually been dispensed at lunchtime. As the CD book was reconciled retrospectively he received a double dose for the day -i.e.: 144mgs instead of 72mgs.
It became apparent at 14.00hrs on Sat 2.6.12 that the Dr who should start at 12.30 for reception was not coming. I asked another nurse to contact the agency who was working over in the healthcare. After phoning two numbers for the agency with no reply our on call manager was contacted who managed to speak with someone. The agency did not have anyone booked in for this day or Monday.

I and the nurse from the drug dependency unit contacted UC24 and managed to obtain the prescriptions we needed over the telephone. The SO in reception would not keep the prisoners in reception until we had done this so we then had to go round the wings to dispense the medication we had had prescribed. We had finished by 15.20. The agency is now sending a Dr for 3 hours on Sunday and Monday as planned.

Please note that there are some spelling mistakes in the above Datix entries but we have not amended these as they reflect what was recorded at the time.
Appendix 6

Letter to Sue Page, Interim Chief Executive from Monitor dated 4 July 2014 re: Monitor Quality Governance Pilot
Dear Sue

Pilot review of Quality Governance - Liverpool Community Health NHS Trust ("you" or "the Trust")

Thank you and your team for attending the feedback and challenge session on 23 June. As agreed, I am writing to you to confirm material findings from our review which concluded in March 2014 and to set out the areas that the trust will need to focus on to address our quality governance findings.

Quality Governance Score

Section 5.3.2.4 of the Guide for Applicants requires that the Trust Board has appropriate quality governance arrangements in place. To be authorised, applicants must demonstrate a quality governance score of less than 4, with an overriding rule that none of the four categories in the Quality Governance Framework (Strategy, Capabilities and culture, Structures and processes, and Measurement) can be entirely Amber-Red rated.

Our pilot review process concluded that the Trust has an unauthorisable quality governance score of 7.0 and this score is supported by Monitor's Quality Governance Associate. Our principal concerns relate to Amber-Red scores for Questions 1A, 1B, 2B, 3A, 3B and 3C. The Trust therefore also scores entirely Amber-Red across domains 1 (Strategy) and 3 (Structures and processes). The Trust also scored Amber-Green on questions 2A and 4B. Further details are provided below. I would also highlight that, as discussed in our meeting, considering the seriousness of the issues highlighted in relation to question 3B, there was some debate as to whether this question would be scored Red; the Amber-Red score on 3B therefore represents a marginal decision.

1A - Does quality drive the trust’s strategy? [A/R]

Quality is a central part of the Trust's three high level, strategic themes of prevention, integration, and growth. The strategy does not however set out specific, measurable and time-bound goals or clear milestones through which these themes can be understood and interpreted. Although some specific quality targets are set out in reports and dashboards received by the Board, there is a lack of clarity between those metrics and the three...
strategic themes; it is often not evident how the metrics support and underpin the strategic themes. There is awareness of the three strategic themes of integration, prevention and growth across the Trust, but limited evidence of an understanding of what these mean for the divisions and services. This lack of understanding is reflected in the weak link between divisional objectives in the 2013/14 business plans and the Trust’s strategic themes, in particular, it is difficult to determine how divisions are required to support their delivery and how they will be held to account for the achievement of those themes.

Only elements of the integrated clinical and quality strategy (ICQS) have been described in a way that permits monitoring of progress and where monitoring is possible, the various reporting methods through which this is reported makes it difficult to establish how the Board can understand and be assured of progress against the achievement of strategic objectives. The Board have not yet received any formal progress reports on the Trust’s quality strategy, although it was agreed at the June 2013 Board meeting that there would be six monthly updates.

We understand that the Trust is currently undertaking a process to refresh the ICQS.

**IB - Is the Board aware of risks to quality? [A/R]**

**BAF and risk registers**

The Board were able to articulate current and future risks to quality and their views on risk are consistent with those highlighted in various recent external reviews. The Board reviews the board assurance framework (BAF) quarterly and there is evidence that it is kept up to date to reflect current issues. However, the lack of clarity in the Trust’s strategic objectives, as discussed above, makes it difficult to evaluate whether the strategic risk assessment set out in the BAF is adequate and complete.

Division and service level risk registers broadly reflect key quality risks, although there are some gaps. For example, risks relating to pressure ulcers have not been identified through, or reflected in, divisional risk registers. The Trust has nevertheless identified these as its ‘breakthrough aims’ which are recognised in the strategic dashboard as top clinical risks, however it does not appear that these risks are monitored and managed from the bottom up.

Divisional risk registers do not feed clearly into the ‘strategic’ risk register or the BAF, which are reviewed by the IGQC and there are significant concerns with the risk escalation process from divisions to the IGQC, via the healthcare governance sub-committee (HGSC): in January 2014, there was only one risk on the strategic risk register, in contrast to the 21 risks that had a risk score of 15 or above across the organisation. Therefore, under the current process, NED oversight of high scoring risks is greatly limited.

The basis for the decision on whether risks should be included on the strategic risk register was not clear to us and is not described in the risk management strategy. Furthermore, there are examples of high scoring risks that were clear candidates for being considered strategic and nevertheless remained only on divisional risk registers; these include a risk relating to staffing in district nursing and to problems with the recruitment process, which is outsourced to Capita. In addition, senior management interviewed could not articulate why a risk that is high scoring and considered to be strategic would not be escalated to the BAF.

More than half of divisional risks that are over six months old are at the same risk score as when they were originally logged. Of the current 15 risks scored at 16 of above, 13 have not reduced their risk score for over six months. This indicates that there may be an issue with effective management of divisional risks and also raises concerns over risk escalation processes, as noted above.

**CIPs and QIA**
The quality impact assessment (QIA) process is relatively new and the design is potentially robust. There are however concerns that it is in not yet being implemented robustly, with QIA documentation being unclear about the nature of the scheme being assessed, low risk scores being assigned where significant reductions to frontline staff are planned, and not being updated when significant changes to the scheme occur. In addition, there is evidence of significant delays (up to eight months) in receiving sign-off from the medical director and the nursing director from QIAs being completed and sign-off being obtained. There are also concerns about reporting QIAs to the IGQC and Board, as current reports mainly focus on providing assurance that the QIA process is occurring, rather than on providing clear information on high risk schemes, particularly the nature and level of risks and mitigations.

2B - Does the Board promote a quality-focused culture throughout the Trust? [A/R]

There are concerns with the culture at the Trust. The CQC recently issued a warning notice in relation to support to staff, and referred to an ‘unsupportive, oppressive culture’, in addition, the national staff survey (NSS) results for both 2012 and 2013 highlighted concerns regarding the number of staff experiencing bullying from colleagues in the last 12 months, with the Trust being in the worst performing quartile in 2013 and a local staff survey reported that 49% of respondents did not believe the Trust has a compassionate culture. A staff side survey, conducted in April 2013 in response to the 2012 NSS, reported that 75% of respondents believed bullying was a moderate or worse problem at the Trust.

There is also limited evidence of engagement with staff on the CIP programme. The Trust’s recently established PMO leads on the development of CIP plans with some involvement from services (primarily more senior clinical staff) and the completed plans are subsequently given to the services to deliver. It is difficult to establish how engagement of front line staff occurs during the CIP development process, until they become involved in delivery. Additionally, in our experience, effective PMOs typically co-ordinate CIP plans and reporting progress to the Board, whilst the development and ownership of individual plans rests with services/divisions, with appropriate support.

Following the outcome of the CQC report and the issues highlighted through staff surveys, the Trust has noted it does not yet have a clear understanding of whether cultural issues are isolated or widespread; however the Trust is planning to commission a further independent review from ACAS to explore the issue.

3A - Are there clear roles and accountabilities in relation to quality governance? [A/R]

The key line of accountability for quality governance is through the IGQC and the healthcare governance HGSC below that. There are concerns that the role and remit of the latter subcommittee is unclear, and that it is not fulfilling the purpose assigned to it, namely performing more detailed review into quality issues to allow the IGQC to focus on strategic issues. The role of the IGQC in relation to quality governance is consequently compromised due to the nature, level and quality of information it receives from the HGSC.

Specific concerns relating to the HGSC include: the lack of clarity of divisional reporting into this group, e.g. on incidents, complaints, clinical audits and risks rated below 15 (the latter being required by the HGSC terms of reference); reports from subgroups are of poor quality; there have been problems with attendance; there is evidence that subgroups are unclear as to their purpose; and subgroups, specifically the patient safety group, did not meet for a significant period of time.

In addition to the issues highlighted over the HGSC above, there are concerns that the membership, reporting processes and methods of the IGQC prevent it from functioning effectively. The committee comprises seven members - two NEDs and the five executive directors. A lack of balance in favour of executive attendees is compounded by the lack of divisional attendees presenting items (only two attendees in the last two years) and
the lack of deep dives or other methods of detailed review.

The committee is also responsible for a detailed review of the BAF but it is unclear how it fulfils this function. At the IGQC observed by Monitor, an updated BAF was presented, but no discussion took place. Minutes of past IGQC meetings provide limited evidence of discussion of specific risks, controls or assurances.

We understand that the Trust is planning to undertake a detailed review of its committee structure, including a review of committee membership.

**3B - Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? [A/R]**

There is a significant example of a major issue not being escalated to the Board appropriately in the past year. This relates to issues regarding Trust culture and specifically bullying within the organisation, whereby the Chair and NEDs were not informed of the outcomes of a critical staff side survey until after the CQC issued a warning notice referring to problems with the culture and after the start of the quality governance pilot, in February 2014 (the survey was completed in April 2013).

There are broader concerns regarding risk escalation. In particular, the process for escalating risk to the strategic risk register, which is reviewed by the IGQC, is not clearly defined in the Trust's policies and the distinction between this and the BAF did not appear well understood. As described above, there are examples of risks that have significant strategic implications which had not been escalated to the strategic risk register.

The CQC reported that a number of staff did not feel comfortable using the whistleblowing line because they feared the consequences. Subsequently the Trust has implemented a new independent confidential whistleblowing line. The cultural issues identified at the Trust indicate a risk that concerns and issues identified by staff potentially may not be reported and escalated appropriately.

The assessment team has concerns regarding the Trust's ability to establish clear action plans to resolve fundamental problems and to follow these up-for example, the action plans in relation to recent CQC reports. These plans are difficult to follow; for instance, they do not set out what issue the specific action is attempting to resolve and therefore it is difficult to determine whether the action is sufficient or appropriate and difficult to judge whether it is likely to be effective. In addition, it is not clear whether the fundamental problem is being addressed based on the actions outlined.

**3C - Does the Board actively engage patients, staff and other key stakeholders on quality? [A/R]**

Although the Board does have methods for obtaining soft intelligence, there is a lack of systematic collection of staff feedback through surveys. When this data is collected, it is not always reported to or discussed at the Board. This includes, for example, the 2012 annual staff survey.

Patient surveys are regularly performed, but we have not seen evidence of any results being reviewed and discussed at Board. The Board does receive and discuss in detail patient feedback in the form of patient stories, but does not consider the broader and more representative data from surveys. Additionally, there is limited evidence of patient involvement in governance or service redesign.

it is therefore unclear how the Board gains a systematic understanding of the views of both patients and staff and of the impact that changes to services potentially have on these groups.
Next steps

Given the quality governance score and issues raised in the CQC report, we would not expect the Trust to be referred to Monitor for assessment until these issues are addressed. In terms of addressing the quality governance concerns in this letter, as a minimum the Trust will need to:

1. Clearly articulate the link between the Trust’s high level strategic objectives and SMART outcome metrics, including where these are reported and monitored, and demonstrate they have been effectively reflected in divisional business plans.
2. Review the process for risk identification from the bottom up, including the subsequent escalation of risks to the strategic risk register, to assure the Board and its sub-committees that risks are being monitored and mitigated appropriately.
3. Embed the process to monitor C1P impact on quality, ensuring that all initiatives (both original and replacement schemes) have appropriately documented and approved QIAs, and demonstrating that it provides clear and appropriate information on high risk schemes.
4. Demonstrate that progress has been made against the area of Culture and staff engagement, as set out above, incorporating the findings highlighted through other internal and external reviews.
5. Demonstrate the effectiveness of the senior meetings structure, particularly the role of the IGQC in independently monitoring and seeking assurance on clinical and quality issues, and the role of the HGSC below it in performing more detailed review into quality issues.
6. Demonstrate the effectiveness of escalation processes and the ability to establish robust and effective action plans, including how these are used to act on and resolve fundamental issues.
7. Demonstrate a systematic understanding of the views of patients and staff across the Trust and how these are being acted upon.

We also understand that the Trust has recently been subject to a number of further external reviews:

- CQC unannounced follow-up visit to the November 2013 visits;
- CQC inspection in Q113/14;
- TDA leadership capability review by Sir Ian Carruthers;
- ACAS review into Trust culture;
- CCGs’ review of pressure ulcers; and
- any other reviews.

The Trust will also need to demonstrate that it has resolved any issues and implemented any recommendations and actions arising from those reviews.

We understand that the Trust is currently developing a three stage improvement programme that aims to address some of the key issues raised in the above reviews, as well as those highlighted through our quality governance review. We hope this letter is helpful in informing the improvement plans you are developing. Should you wish to discuss any of the matters set out in this letter, please do not hesitate to contact me.

Yours sincerely,

Miranda Carter
Executive Director of Provider Appraisal
cc: Maureen Choong, Clinical Quality Director (North), NHS TDA
    Lyn Simpson - Director of Delivery & Development (North), NHS Trust Development Authority Malcolm Bower-Brown - Regional Director (North), CQC
Appendix 7

Ward to Board Questions: Trust Quality Self-Assessment
Appendix 7

The Trust has recently implemented (and is still we understand, in the active process of implementing) a new assurance and operational management framework. The reviewers have not had the opportunity to review an organogram of this framework and therefore are unable to make either meaningful comment or an informed assessment of the new arrangements; however the reviewers would like at this early stage to offer a concise framework of questions or challenges that the Trust themselves can use to self-assess and/or sense check their new structures, systems and processes.

These questions will be based; primarily on findings from the review but also where relevant to this review, on established best practice from the quality governance framework and the emerging learning from recent national reviews. The reviewers hope this approach will aid the Trust in ensuring the lessons from previous clinical governance failings have been learnt, and also in gauging if their revised structures, systems and processes are robust and meet their needs moving forward.

This section will cover the following broad areas:

Strategy;

Structures and Processes;

Measurement
Has the Trust an approved Quality Strategy?
Does the strategy define the priorities for quality improvement and set measurable goals?
Has the strategy taken account of patient and staff feedback?

Do the Trust’s Quality Account priorities link to the strategy?
Has the Trust implemented a development programme for senior leaders and managers that ensures they understand the quality governance framework/systems and processes, the Trust’s strategy and allows them to set the quality agenda for their services?

Has the Trust a clearly identified Chief Quality Officer?
Do Board members regularly visit clinical areas across all sites to meet staff and patients to assess implementation of the strategy?

Do staff clearly understand the Trust’s vision and strategy for quality?
Do individual service strategies take account of the Quality Strategy and include service specific quality measures and objectives?
Are staff set personal objectives based on the Trust’s quality objectives and priorities?

Is any risk to delivering the strategy and related objectives taken into account when designing and delivering cost improvements?
Has the strategy been developed in conjunction with staff, patients and partners?
## STRUCTURES AND PROCESSES

### Board

- Is the quality governance framework coherent, complete, clear, well understood and functioning?
- Are there clear roles and responsibilities in relation to quality governance?
- Can these be clearly defined at each level of the organization, and across all services and sites of the organization?
- As part of the assurance framework of the Trust, does the Board have regular oversight of patient safety, clinical effectiveness and patient experience?
- Are voting ED’s/NED’s part of that framework and provide assurance to the full Board.
- Does the Trust have an integrated corporate function overseeing/facilitating quality (safety, effectiveness and experience)?
- How are safety, effectiveness and experience ‘outcomes’ integrated to form overall intelligence of quality delivery at all levels and sites of the Trust?
- Is this function appropriately and adequately resourced?
- Does this function provide the necessary support to the operational management function i.e. divisions and directorates, and if so, is this adequately and appropriately resourced?
- If the division/directorate provide their own resource, is this to an agreed specification?
- Does each division/directorate hold a regular management meeting and does quality (performance, outcomes, delivery against objectives, risk to quality) form part of that meeting?
- Does each specialty/directorate hold a regular multi-disciplinary quality meeting to consider each element of quality?
- Is this cross-site based where appropriate?
- Is that meeting lead by the clinical director or other senior clinical leader?
- Is it managed to a corporately agreed agenda and minuted?

### Ward

- Is the effectiveness of the meeting monitored and assessed by the corporate quality function?
- Are the policies for risk management clear and up to date?
- Is appropriate training carried out on risk and incident management?
- Is there alignment between risks on the risk register and what senior clinical and managerial say is “on their worry list”?
- Does the Board receive regular updates on complaints, including response times, number of follow-up (indicating unsatisfactory responses) and Ombudsman reviews?
- Do the relevant Executives, in particular the Chief Quality Officer, regularly see patient complaints?
- Does the Chief Executive sign off all complaints?
- Are serious incidents seen and assessed immediately by relevant executives and other senior clinical and managerial leaders?
- Is the type of investigation, and who should lead it, decided at this time?
- Is the default investigation a Root Cause Analysis?
STRUCTURES AND PROCESSES

Ward

- How is the investigation overseen to ensure compliance with the relevant time limits – either the Trust's own policy or external requirements?
- How is the final report checked for accuracy and quality?
- Who approves the final report and if the report is not approved how are delays kept to a minimum to ensure compliance with policy or external requirements?
- How are action plans agreed and followed up from serious investigations?
- Are the Board informed of outcomes of investigations?
- How is the Board assuring themselves that the Duty of Candour is being applied to patients (or their relatives) in respect of serious incidents?
- Does the Trust have a system for reviewing all deaths?
- If a mortality review identifies significant deficiencies in care, does that trigger a serious incident investigation?

Can staff clearly articulate the quality governance framework in the Trust and in their own specialty/department?
- Are staff in leadership roles clear on their roles and responsibilities in relation to quality governance?
- Do all staff understand their own responsibilities in respect of ensuring and delivering quality services, and do they know which leaders both locally and corporately are responsible and accountable?
- Do all staff know and understand the role and responsibilities of the corporate quality function?
- Do staff know who their local quality governance facilitator is, and what their role is?
- Do staff get feedback from their divisional/directorate management meeting on delivery of quality and safety in their own areas?
- Do staff get the opportunity to attend specialty/directorate cross-site (if appropriate) quality meetings?
- Do all staff in the specialty/directorate get feedback on the key issues and learning from the cross-site quality meeting?
- Are staff at all levels clear about raising concerns about risk and about the risks for which they have responsibility?

Board

- If staff are worried about a colleague or situation, do they know the systems available to them to escalate that worry?
- Are medical staff aware that unexpected outcomes should be reported via the Incident Reporting mechanisms?
- Are relevant staff asked to provide statements to complaint investigations?
- Are staff involved in complaints made aware of the final response?
- Are action plans developed for all relevant complaints and is that fed back to staff?
- Is it clear who has responsibility for implementing any actions as a result of complaints?
- How is the learning from complaints fed back across the organization in general and is it across all sites?
- Do clinical staff regularly meet with patients and relatives to discuss complaints and feedback on any actions taken?
- Do all staff understand the definition of a serious incident and of the reporting requirements for such incidents?
- Are all staff involved in a serious incident provided with the appropriate support?
- Are all staff involved in a serious incident invited to the root cause analysis meeting, or asked to provide a statement?
- How are the outcomes of serious incident investigations fed back to relevant staff, and more widely to staff across the organization including other sites?
- If staff attend a RCA meeting, are they given the opportunity to comment on the notes of the meeting and on the report prior to approval?
- Does the specialty/directorate quality and management meeting see and consider the outcomes of relevant serious incident investigations?
- Are staff aware of the Duty of Candour to patients (and possibly their relatives) involved in serious incidents and of the need to be open and at all times?
- How are the findings from mortality reviews discussed with relevant staff and required actions disseminated?
- Do consultant individual appraisals consider mortality rates?
MEASUREMENT

Does the Board use a strategic integrated performance dashboard?
Is the quality element of that dashboard aligned with the Trust quality strategy and objectives?
Does the dashboard expand to directorate/specialty/service/ward level?
Is the Board assured that the quality indicators provide a full picture of quality outcomes across the trust and all its services and sites?
Does it highlight and explain variances at corporate, site and service level?
Does the dashboard benchmark the Trust against comparable providers?
Are the hard facts of the dashboard consistent with the intelligence that Board members see and observe across the Trust?
How is the delivery of quality performance managed in divisions and directorates?
Are there any consequences of not delivering the level of quality required by the Trust Board?
How is the Board measuring patient experience?
Do Board members get regular (daily) feedback from real time monitoring of patient experience?

Does the divisional/directorate management meeting consider an integrated performance dashboard at each meeting?
Does the directorate/specialty have any specific quality measures over and above the corporate dashboard?
Does the specialty multi-disciplinary quality meeting consider quality data and benchmarking?
Does the specialty multi-disciplinary quality meeting consider qualitative information, including learning from safety, effectiveness and patient experience reports?
Do specialties across the Trust benchmark themselves against other specialties?
Are site differences in quality identified and reported?
Are all staff made aware of both the Trust’s performance against quality indicators and objectives and their own ward, department and specialty?
Do clinical leaders and management get regular (daily) feedback from real-time monitoring of patient experience?
Are staff aware of how patients rate their particular service and are positive and negative comments fed back to them?
Appendix 8

- As part of the review of the Whistleblowing Policy, ensure that staff at all levels have appropriate training in the Policy and that they know what to report and when.

- Ensure that the Whistleblowing Policy reflects the requirement of the Duty of Candour.

- Ensure that the Whistleblowing Policy clearly sets out the process by which all matters reported under the policy are clearly investigated and that there is an auditable investigation process that underpins this as well as a clear feedback loop.

- Ensure staff check with senior colleagues that documents they disclose do not breach confidentiality, that discussions and explanations are documented in patient records and internal paperwork is completed.

- Ensure the Trust has an established system for reporting incidents and collating data in line with the Trust’s contractual obligation.

- Ensure that incidents leading to serious harm or death can be identified and information passed to the Board or external regulator as necessary.

- Review all information from complaints to identify possible patterns of poor care.

- Review the handling of complaints, litigation and inquests. Ensure that staff working in these areas are clear about their legal obligations and process matters promptly and thoroughly, with sensitive, responsive and accurate communication.

- Ensure that staff preparing documents for the purpose of complaints, internal incident investigations and risk management are aware of the context in which their view is sought and that they provide clear and factual accounts. They should remember there is no legal privilege attaching to such documents.
• If a request is made to the Trust for disclosure of records in contemplation of litigation, consider the pre-action protocol; arguably all disclosable documents should be sent out rather than only the medical records.

• Review contracts of employment, codes of conduct and disciplinary procedures. These should make reference to the statutory Duty of Candour and include specific provisions requiring staff to be honest, open and truthful in all their dealings with patients and the public.

• Consider your response if members of staff do not meet the standards of candour expected of them, now or in the future under a possible statutory duty. Any decision to adopt a ‘zero tolerance’ approach by treating such instances as grounds for dismissal would demonstrate a commitment to the principles underlying the Francis Report but would work only if applied consistently to all staff, irrespective of their seniority or profession.

• Include in any new contracts of employment and compromise agreements, an express provision permitting disclosures that are in the public interest.

• Ensure you differentiate between confidentiality provisions which aim to protect the legitimate interests of the employer and those which seek to prevent a public interest disclosure. In determining whether a clause might be viewed to be a gagging clause, consider whether it appears to limit the scope of employees to make protected disclosures.