The Royal Wolverhampton
NHS Trust

Report of the Liverpool Community Health Independent Review January 2018 Initial Summary and details 4 June 2018

Agenda Item No: 11.5

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	4th June 2018
Title:	Report of the Liverpool Community Health Independent Review January 2018
Executive Summary:	The findings of an inspection of Liverpool Community Health NHS Trust (the Trust) carried out by the Care Quality Commission (CQC) in late November and early December 2013 identified a range of serious issues at the Trust that required an immediate response to systemic failings identified. In part, the inspection had been undertaken following a number of whistleblowing concerns raised directly with the CQC by staff at the Trust.
Action Requested:	**Receive and note,**
For the attention of the Board	This paper forms the first of a two-part review. This paper sets out in summary and detail the findings of the Independent Review for Board members to read, review and reflect upon. Part two at the following Board will provide an initial overview 'Gap analysis' between the findings and the current assessed RWT position and provide a point to decide any further action required.
Assure	• Reflection on aspects of the report when compared with RWT may provide assurance in relation to the issues highlighted in the report.
Advise	• Reflection on aspects of the report when compared with RWT may provide areas to seek further assurance or information in relation to the issues highlighted in the report.
Alert	• Reflection on aspects of the report when compared with RWT may provide the basis for action in relation to the issues highlighted in the report.
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	None at present
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	None at present
Risks: BAF/ TRR	None identified at present.
Public or Private:	Public
Other formal bodies involved:	As identified following Gap Analysis at June Board.
References	Report of the Liverpool Community Health Independent Review Dr Bill Kirkup CBE, January 2018
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Briefing Summary:

Report of the Liverpool Community Health Independent Review

Dr Bill Kirkup CBE, January 2018

Themes

The themes identified below are distilled from the main findings. They are not exclusive and often cut-across more than one Theme as can be seen from the detail in the report.

Board/Senior level culture

- An inexperienced Board and senior staff, and received inadequate scrutiny because it was regarded as low risk.
- Concern about the management culture of the Trust and practices demonstrated by senior managers.
- Commissioners demand to achieve a very significant cost saving offered little or no challenge to the feasibility of achieving this while sustaining existing service levels.
- Lack of clear senior input and accountability for aspects of risk assessment clinical and financial as part of the QIA process.
- Lack of senior attention to an increasingly demoralized workforce, increasing indicators e.g. staff sickness, incident prevalence, poor investigations, lack of robust actions taken.
- Culture of denial at Board level.
- Bullying and pressure down the organisation impacting on middle grade and junior staff adversely.
- A climate of fear and insecurity among Trust staff generally that made them understandably very reluctant to speak out about both service failures and working conditions.
- Taking on additional services to increase income whilst placing further stress on stretched staff and a failure to recognize the impact of this at a senior level.

Patient harm

- Unnecessary harm to patients over a period of several years, and unnecessary stress for staff who were, in some cases, bullied and harassed when they tried to raise concerns about deterioration in patient services.
- Setting infeasible financial targets that damaged patient services.

Impact on staff

- Unattended to Whistleblowing concern sin the media and from a local MP.
- Staff were overstretched, demoralised and, in some instances, bullied.
- Punitive acts against staff raising concerns including suspensions.

Failure in external scrutiny

- External NHS bodies failed to pick up the problems for four years.

Failure in systems and processes

- Grossly deficient quality impact assessment (QIA) that should have identified the adverse effects on services so that they could be mitigated and, if necessary, the proposal abandoned.
- Failure of processes to safeguard those raising concerns.

Briefing Report:

Report of the Liverpool Community Health Independent Review – Board/Well-led Themes

(report by Dr Bill Kirkup CBE, January 2018)

- an inexperienced Board and senior staff
- inadequate scrutiny because it was regarded as low risk
- unnecessary stress for staff who were, in some cases, bullied and harassed when they tried to raise concerns about deterioration in patient services

Background to the Review

The findings of an inspection of Liverpool Community Health NHS Trust (the Trust) carried out by the Care Quality Commission (CQC) in late November and early December 2013 identified a range of serious issues at the Trust that required an immediate response to systemic failings identified. In part, the inspection had been undertaken following a number of whistleblowing concerns raised directly with the CQC by staff at the Trust.

Whistleblowing concerns by staff at the Liverpool Community Health NHS Trust had also been raised with Rosie Cooper MP, whose father had recently been a patient in an intermediate care ward run by the Trust and she had witnessed staff under significant pressure trying to provide appropriate levels of patient care. In February 2014 she raised questions about the management of the Trust with the Prime Minister and the Secretary of State for Health.

Following publication of the CQC report and increased local media interest, NHS Improvement oversaw a number of changes to executive directors at the Trust, culminating in the appointment of an interim executive management team to turn the failing Trust around. The Trust Board sought to address issues raised in the CQC report by commissioning a quality, safety and management assurance review, carried out by Capsticks Solicitors LLP. Their report *Quality, safety and management assurance review at Liverpool Community Health NHS Trust* was published on 22 March 2016.

The publication of the Capsticks report generated a sustained level of concern about the management culture of the Trust and practices demonstrated by senior managers. It raised questions about the quality of the healthcare being provided by the Trust to patients in the community and in HMP Liverpool. As a result, NHS Improvement established this Independent Review of the Trust.

REVIEW FINDINGS – relating to Board function and Well-led KLOE

1.1. Liverpool Community Health NHS Trust (LCH) was a dysfunctional organisation setting infeasible financial targets that damaged patient services. The Trust managed services that it was ill-equipped to deal with. Senior leadership and the Board failed to realise that the Trust was out of its depth, and did not take heed of the effects. Staff were overstretched, demoralised and, in some instances, bullied. Significant unnecessary harm occurred to patients. External NHS bodies failed to pick up the problems for four years.

1.2. The Trust had a new and inexperienced management team. Their leadership was inadequate from the outset. The Chair and non-Executive Directors were also relatively inexperienced and offered insufficient challenge to the management team.

1.3. The Trust Board's principal objective was to become a FT, though frontline staff did not share this view. This objective dominated the time and attention of the management team, and they and the Board became blind to the real concerns that began to arise throughout the organisation.

1.4. The Trust had sufficient contract income at least to continue with its previous level of services when established. It was asked by its commissioners to achieve a very significant cost saving over the next four years, and appears to have offered little or no challenge to the feasibility of achieving this while sustaining existing service levels. This naivety on the part of the Trust tipped it into a position of major cost pressures.

1.5. In addition to their acceptance of an unsustainable revenue position, the Trust undertook to generate a significant cash surplus over the same period. This appears to have been generated by a desire to demonstrate a robust financial position in pursuit of their application to become a FT, but the cumulative impact of this with the revenue reduction was not adequately considered.

1.6. In order to address the external and self-imposed cost pressures, the management team embarked on a series of drastic cost-improvement measures. Unless there are exceptional circumstances, an annual cost improvement programme of 4% is generally regarded as the upper end of achievability; the Trust undertook to achieve 15% in a year. There is no evidence that the management team or the Trust Board recognised the substantial risk that this posed.

1.7. Proposed cost improvements mainly involved reducing staff numbers, as they were bound to, given the nature of community services. Proposals were subject to quality impact assessment (QIA), a process that should have identified the adverse effects on services so that they could be mitigated and, if necessary, the proposal abandoned. However, these assessments were grossly deficient in the Trust, and failed to identify the obvious adverse consequences of most of the proposals that were implemented. On the occasions that QIAs were undertaken, they were not actively managed nor robustly reviewed.

1.8. The Trust should have had clear and effective systems to manage risk, including the clinical risk arising from over-ambitious and ill-considered cost improvement measures, as well as clinical governance systems to monitor the quality of clinical services. Both should have informed the QIAs but, in practice, systems were unclear and ineffective. At one point, the Executive Director responsible for clinical quality was the Finance Director, who had set the cost improvement targets, and the Medical Director had no clear responsibility for clinical quality.

1.9. This placed significant responsibility for clinical quality on the Nurse Director, but she was, for at least part of the period, the Trust's Chief Operating Officer, and therefore also responsible for achieving the cost improvement programme.

1.10. The result of this confused and conflicted arrangement was that Trust management neither identified properly the serious risks inherent in the cost improvement programme nor picked up the significant adverse consequences for services as they began to emerge. They remained focused predominantly on becoming a FT.

1.11. The adverse consequences were significant. First, many staff soon became demoralised. They had not felt involved in planning for the impact of staff reductions, and when they reported difficulty in maintaining safe and effective services, they did not feel listened to; certainly there was no evident change in the approach taken. Sickness absence levels rose, worsening staffing levels further.

1.12. Second, although it is clear that most staff tried hard to compensate for staff reductions, it is equally clear that services began to suffer despite their efforts. The incidence of patient harm incidents subject to mandatory reporting nationally rose, including pressure ulcers and falls. Other incidents, some serious, should also have been reported and investigated, but we heard repeated accounts that reporting was discouraged, investigation was poor, incidents were regularly downgraded in importance, and action planning for improvement was absent or invisible.

1.13. Third, it is clear to us that the reaction of the Trust Board to this gathering crisis in services was based on denial. The management team was still focused predominantly on becoming a FT, and reports of service problems were not only a distraction, they would adversely affect the assessment of the Trust's capability of achieving their goal.

1.14. The initial impact fell predominantly on the middle managers, positioned between the Trust Board's insistence on pushing through the cost reductions regardless and the staff's difficulty in maintaining safe and effective care and their consequent unhappiness. Unfortunately, faced with this undoubtedly challenging position, it is clear that their response was inadequate and inappropriate and, in too many cases, included extreme action against more junior staff, amounting to bullying. Whatever its origin in the pressure they were under themselves, this behaviour was inexcusable.

1.15. When some staff attempted to raise concerns, or in some cases grievances as a result of being bullied, the response was seriously deficient. We heard repeated accounts that staff would be suspended without being told why, or what the next steps would be. In some cases, these suspensions lasted for many months without any apparent process for resolution. We heard specific examples of very poor practice in nursing management and human resources (HR). There were serious shortcomings in the leadership of both departments.

1.16. We heard that this caused significant distress to those so treated, and affected their long-term wellbeing. We have no doubt that the reports of these occurrences spread to other staff, and contributed significantly to a climate of fear and insecurity among Trust staff generally that made them understandably very reluctant to speak out about both service failures and working conditions.

1.17. There were additional problems. The Trust adopted an approach of expanding its provision. It took on responsibility for an additional geographical area – Sefton – while still struggling to manage an entirely different type of service – prison healthcare in HMP Liverpool. The acquisition of community services for Sefton caused immediate difficulties in integrating staff with a different organisational culture. Attempts to redeploy staff between localities caused friction, further worsening staff morale.

1.18. The management of prison health services proved even more problematic, with serious concerns about service delivery and some stark incidents that were not reported and investigated properly. The Trust should have recognised that it had neither the experience nor the capability to manage this service area. Their failure to realise that they were out of their depth caused significant harm to patients.

1.19. It is clear in light of all of these failings that the Trust was seriously dysfunctional. There was a lack of leadership at senior and middle levels. The Trust Board lacked the capability to see beyond its goal of becoming a FT, and failed to recognise the significant harm that its programme of cost reduction was inflicting. Demoralised staff were badly treated and sometimes bullied, and there was a failure of nursing management and HR procedures. Serious incidents causing patient harm were not reported, not investigated and lessons not learned. The result was unnecessary harm to patients.

1.20. Service commissioners did not take adequate steps to identify problems with the services delivered by the Trust. Initially, Primary Care Trust (PCT) commissioners assessed the Trust as low risk, based on their view of initial contract income. When commissioning transferred to CCGs, a reduction in contract income was proposed that was infeasible at the same level of service. When this was accepted, no concern was raised over the potential effects. The challenge of a very different service, healthcare in HMP Liverpool, also failed to generate concern among commissioners. When NHSE assumed responsibility, their monitoring was no more effective, and was marred by an undeclared potential personal conflict of interest.

1.21. External overview also failed to identify the service problems for at least four years. The Strategic Health Authority (SHA) regarded the Trust as low risk, despite its newness and the inexperience of its senior staff, and provided inadequate briefing when it was abolished and the responsibility transferred to the NHS Trust Development Authority (TDA). The NHS TDA did identify concerns but subsequently reversed its assessment for reasons we were unable to determine. The Care Quality Commission (CQC) failed to identify the extent and nature of the problems until they were alerted by Rosie Cooper MP. In part, these failures were because reconfigured organisations were coming to terms with new roles and did not communicate effectively, but this is insufficient alone to account for the missed opportunity.

1.22. Any of these external organisations could have identified the problems afflicting the Trust earlier had they looked critically at the information available to them. The primary responsibility, however, lay with the organisation statutorily accountable for the service, Liverpool Community Health NHS Trust. The Trust not only failed in its duty to provide safe and effective services, it concealed this from external bodies. Both patients and staff suffered harm for too long as a result.

PATIENT HARM

3.1. Prevention of patient harm is central to the quality of health services, including their safety, and depends on some essential elements. First, clinical care must be provided to evidence-based standards, by sufficiently competent and capable staff working together in effective teams. Second, there must be an organisational culture that promotes openness and learning, with effective professional and managerial leadership and supervision. Third, there must be effective clinical governance, to enable timely identification of any deviation from the necessary standards, so that the causes are identified and corrective measures implemented promptly. We examined how each of these areas operated in the Trust, and looked for direct evidence of the effects on patient outcomes.

3.2. At the outset, we wish to highlight that we heard many accounts of staff who, when faced with significant and often overwhelming difficulties from the circumstances they were working in, responded to the challenges by putting in additional time, not taking days off, and striving to manage excessive caseloads. Staff were doing what they could to maintain patient safety and ensure that patients were treated with compassion and dignity, regardless of the difficulties.

3.3. Despite these efforts, we found the care delivered during the period of the Review to be unsafe in significant areas, that staff should not have been placed in this position, and that avoidable harm resulted to patients. The services most affected were district nursing, intermediate care, community dentistry and healthcare in HMP Liverpool.

3.4. The following sections set out our detailed findings on clinical care capability, organisational culture, leadership and clinical governance.

Clinical care capability

3.5. Based on both the written evidence and what we heard from staff, we formed a clear view that clinical capability to deliver the patient care required was compromised by inadequate staffing levels, training, supervision and skills mix. We found that staff worked in a reactive environment, and prevention work was not introduced in a timely manner. Clinical competence and training were lacking in some staff; evidence- based standards were not uniformly applied; learning from incidents and serious incidents was not shared for wider learning; and staff had little time to undertake clinical and management supervision, preventing reflective practice and learning.

3.6. The Board's Serious Incident Report paper (January 2013) identified numerous safety concerns and some key themes. These were the same issues reported to the Trust Board two years later on 12 March 2015.

Themes included:

- documentation and record-keeping;
- lack of equipment;
- poor competency, training and expertise;
- effective communication; and
- supervision of staff.

3.7. These issues were common to numerous serious incidents that we reviewed. Over the period 2011 to 2014, there were 103 serious untoward incidents (SUIs) declared, and we believe that the real total should have been higher based on what we heard. There was some evidence that actions had been identified to improve these problems, but there was no evidence that effective action had actually taken place to improve practice. We found that action plans were significantly hampered through a combination of:

- lack of identification of actual root causes;
- lack of time-trend analysis and thematic analysis;
- plans based on process actions unrelated to patient outcome;
- failure to review whether actions had been undertaken and completed; and
- lack of evaluation to ascertain whether actions had been successful.

We consider how this affected patient outcomes in the specific areas of pressure damage and falls, as these were subject to mandatory reporting nationally, improving the reliability of information.

Pressure damage

3.8. In February 2013, the Director of Nursing, Helen Lockett, presented information to the Trust Board in a private session outlining the occurrence of 26 grade 3 pressure damage incidents over the year to date. She identified that record-keeping, documentation, assessment, wound care, supervision, equipment, training and communication had all been contributory factors and should be addressed. She also suggested that staffing problems within the District Nursing North Team had prevented senior review of a patient's care, leading to preventable pressure damage over the course of a whole year the patient had been receiving care.

3.9. These manifest failures of care and their underlying causes, including inadequate staffing levels and lack of senior review, should have been investigated as a matter of priority by the Trust and highlighted as a significant risk to the Board, but they were not. The same issues were identified again in the Board papers in November 2013, January 2014 and between March 2014 and March 2015, without prompting any definitive analysis or corrective action. It was not until March 2015 that a new, Interim Director of Nursing, Amanda Pye, produced some thematic and trend analysis that identified explicitly that the same problems had been recurring, uncorrected, for more than two years.

3.10. The number of significant and repeated identified root causes related to incidents alone should have alerted the management team, Director of Nursing and Trust Board to the serious failings that were taking place over this period. The underlying problems were not addressed in any of the actions. Instead, the word "reinforce" was regularly used in Trust Board papers, as in:

- reinforce the need to undertake assessment;
- reinforce the need to complete documentation;
- reinforce the need to undertake wound assessment;
- reinforce the importance of timely referrals;
- reinforce the need for staff to have Personal Development Plans; and
- reinforce the need for good communication.

All of these actions were to be disseminated to staff in front of colleagues at "share and learn" sessions.

3.11. It appears that at no point was it reported to the Board or to commissioners that there may be an underlying cause related to staffing levels, competency, training, supervision and skills mix. Appraisals and supervision had been highlighted as a shortcoming of staff undertaking them, but not in relation to the time allotted to do them. The information we received indicated that District Nursing teams had not been undertaking timely risk assessments nor using a preventative framework for pressure damage. As a result, pressure ulcers developed that could have been prevented, and had to be managed reactively.

Conclusion

3.12. On reviewing Serious Incident Reports in 2012/13, we found numerous additional concerns over the care of established pressure sores. These included a lack of follow-up risk assessments, delayed equipment deliveries resulting in patients waiting too long for pressure-relieving mattresses and cushions and a lack of timely visits by the skin specialist team as the service was struggling to meet demand. We also saw evidence of failure to recognise wound concerns such as hypergranulation (a relatively common phenomenon which can affect healing time), a serious lack of care plan record-keeping, lack of competence in wound care management resulting in moisture lesions deteriorating into pressure damage, and failure to escalate concerns promptly.

3.13. The cumulative impact of all of these factors caused further deterioration in pressure ulcers that was unnecessary and avoidable.

Falls

3.14. We found that, although significant work had been undertaken to reduce the numbers of falls, falls risk assessments were not being undertaken as often as they should, associated with poor care planning in bed-based services.

3.14. In December 2012, the results of a falls audit were presented to a meeting of the Integrated Governance and Quality Committee **(IG&QC, 18th December 2012),** a sub-committee of the Board chaired by Sue Ryrie, a non-Executive Director. This was reported as identifying:

- a lack of care planning – 37% of staff reported not writing a care plan after an assessment;
- a lack of knowledge within the workforce; and
- a lack of staff who had heard of required key elements after training.

3.15. The same themes were identified six months later **(IG&QC, 4th June 2013)** when high-risk incidents highlighted:

- poor record-keeping;
- lack of clinical records and content;
- staff not applying training on key themes; and
- failure to investigate incidents due to incomplete records.

3.16. The committee expressed its concern regarding this and Sue Ryrie (Chair/NED) commented on the failure to apply training in practice. The Director of Nursing, Helen Lockett, is recorded as responding that the Trust was due to commence peer review systems and that a peer review plan would be completed and submitted to the IG&QC in October 2013. We found no evidence that this report was ever presented.

3.17. A 'deep-dive' review into falls (April 2012 – March 2013) identified that 15% to 20% of patients who had fallen had no care plan in place to proactively manage their falls risk or improve their confidence and mobility status. It also identified four patients who had fractured their hips – incidents that had not been reported appropriately and categorised as a serious incident by the Intermediate Care Service. A lack of appropriate reporting as well as care planning are serious patient safety markers that should have prompted immediate action and a review of the reporting culture in the Trust. We found a note in the committee minutes that work was ongoing to ensure accurate reporting, but we failed to find any evidence that even this inadequate response was followed through. Improvement work to address falls was apparently under way though, as in April 2014, the Board received a report indicating that 98% of inpatients had falls care plans in place. The figure for community patients, however, remained at only 37%, calling into question the timeliness of intervention into question.

Other evidence of harm

3.18. We found additional evidence of harm in other areas, albeit less direct. Meeting records in June 2013 refer to "*the increase in complaints in relation to staff attitude and communication"*. Work on this was said to be "ongoing", but it is difficult to see what assurance the non-Executives were able to take from this statement. At the same meeting, Bernie Cuthel (Chief Executive) stated that: "*it is not an improving picture".*

3.19. Similar themes were highlighted in relation to other serious incidents, including medicines management, where there was a weakness in control, inappropriate storage, staff administration errors, staff awareness and failure of staff to comply with Trust policies.

3.20. In 2013/14 the records indicate that there had also been an increase in compensation claims against the Trust. The Trust identified that it was unable to defend these claims due to incomplete actions by managers, a lack of robust control and monitoring of action plans and a need to integrate governance and quality.

Conclusion

3.21. There was evidence of unnecessary patient harm, and overall levels of harm-free care within the organisation should have been higher. Although staff were attempting to implement strategies of improvement, they lacked the pace and effectiveness required.

Organisational culture and leadership

3.22. We found serious shortcomings in organisational culture and leadership, including failures of communication and teamworking, intolerance and a culture of blame. Poor leadership, combined with a Human Resources (HR) department that was not fit for purpose and a lack of management training resulted in staff working in a climate of fear, to their significant detriment.

3.23. During complex care management, clear goals should be in place and agreed with the patient, which all team members should be aware of and able to communicate. As part of a team, all staff should know the part they play in improving the outcome for the patient and for the optimum delivery of care. This requires regular assessments, reviews, handovers, briefing and feedback among team members to encourage strong professional relationships and trust, seamless care delivery and an environment of transparency, especially to prevent delays in care. Good communication requires active listening, comprehensive conveyance of all information required, good multi-disciplinary working and appropriate use of technology.

3.24. We found significant failures of multi-disciplinary teamworking, with poor communication leading to inconsistent and flawed handovers, both within teams, across different agencies and across management and leadership at all levels. Clinicians were not actively engaged in decision-making processes and opportunities for active treatment in a timely fashion were lost due to a lack of cohesive working.

3.25. We found that staff had insufficient expertise and time for adequate handovers, and lacked training and time to ensure good record-keeping and documentation. They also lacked time to reflect and learn and implement a sustainable system of individual performance review to allow clarity on both organisational targets and their own objectives and performance. Teams had inconsistent training, supervision and appraisal processes in place, and little time for senior clinical review of work and skills mix. The ability to put in place improvement plans was severely constrained by the lack of suitably trained staff and the imposition of cost improvement plans (CIPs) that had a direct impact on the quality of services provided.

3.26. A ‘just’ culture is one where openness and transparency is an essential ingredient to identify the root cause if care falls below standards, or when care doesn’t go according to plan. This requires staff to work in an open and transparent environment, where staff disclose incidents and are able to identify near-miss events to prevent adverse events on care. It also requires staff to pursue a duty of candour process with patients and relatives when a patient safety event occurs, and to instill public confidence.

3.27. We heard repeatedly that rather than a ‘just culture’, staff worked in a culture of intolerance, disbelief and fear, with a clear lack of care for the workforce. This hampered their ability to provide services to the standard required and impaired their willingness to declare incidents and learn from them.

3.28. We also heard repeatedly that the HR Department in the Trust was chaotic. HR managers failed to follow the Trust’s own procedures and were inadequate in communicating with those staff subject to apparently arbitrary disciplinary processes. As a result of this, we heard and saw documentary evidence of some appalling instances of staff treatment, including individuals who were suspended for prolonged periods with no apparent rationale or process for resolution.

3.29. The evidence we saw and heard confirmed that management of the organisation was excessively top-down, with a punitive and blame culture that spread throughout the organisation. Management and senior leaders in the organisation were aware of the poor training figures and appraisal rates and, in the Advisory, Conciliation and Arbitration Service (ACAS) Report of June 2014, staff reported *“They were just told to fix it”.*

3.30. This culture was reflected in the approach to the safety incidents that continued to occur. Staff were exhorted over and over that taking the correct action must be reinforced, regardless of the poor understanding of root causes and the constraining factors such as lack of adequate staff time, training and expertise.

3.31. A particular feature of the Trust’s approach to safety incidents was “scoping meetings”. These were described in numerous interviews as the meetings at which incidents were discussed and reviewed and actions agreed. This environment was described as “*an interrogation and a frightening experience, where staff felt blamed for incidents that occurred, leading to feelings of stress and anxiety”.* We heard of staff having sleepless nights prior to the meeting and feeling physically sick before attending the meeting. Middle managers told us that *“…you certainly approached the meeting with trepidation”.*

3.32. This was replicated elsewhere in the Trust’s management processes. One regular senior meeting, the Transformation Board, was described by one interviewee as *“an awful experience, hideous. I had to prepare for a week beforehand as I had the highest Cost Improvement Programme in my services at 20%, which was impossible to achieve, due to small teams and economies of scale”.* Addressing staff inappropriately by shouting or finger pointing had been the norm within the Trust, according to the experiences of many interviewees, and this kind of behaviour was replicated down the organisation.

3.33. The evidence that we heard and saw amply confirmed the existence of a bullying culture within the Trust, focused almost entirely on achieving Foundation Trust (FT) status. Inadequate staffing levels, poor staff morale and appalling HR practice went unheeded. This was the end result of inexperienced leadership that was not capable of rising to the challenges presented by the Trust.

3.34. At the same time, staff were struggling to cope with the effects of the draconian cost improvement programmes imposed by the Trust. In February 2013, the HR Director, Michelle Porteus, presented the workforce plans for the next two years to the Board in a closed session. Significant staff reductions were required in district nursing, dental services, medicines management and dietetics. Three of these areas were already being highlighted as a cause for concern, partly as a result of staffing shortfalls. There was no apparent recognition of the irony inherent in this being taken to the same Board meeting that had earlier considered the implications of the Francis Report into failings at Mid Staffordshire NHS Foundation Trust.

3.35. District Nursing posts were to reduce by 24.3 whole time equivalents (WTE) in 2013/14 and another 24.3 WTE in 2014/15. This was to be achieved by freezing all vacancy recruitment as well as introducing voluntary redundancy and retirement. Dental staffing was also to reduce by 21 WTE in 2013/14 and 15.5 in 2014/15. These were significant reductions, particularly in District Nursing, which was already overstretched, and had highlighted their difficulties in maintaining quality and safety due to vacancies.

3.36. The justification for these reductions was apparently a comparison with national workload figures. No heed was given, however, to whether a "like-for-like" comparison was being undertaken (for example, the Trust's use of a comparator based on high-street dentistry, despite community dental services dealing with a different patient group), and blanket reductions were imposed with no apparent clinician engagement in the planning.

3.37. Recruitment at the Trust had been outsourced to Capita, and we heard numerous accounts of delays in recruitment, sometimes more than three months for a single post. Clinicians were not involved in the vacancy review panel process that had been introduced and we heard of District Nurse Team Leaders having to repeat vacancy requests and, on occasions, waste valuable time "lobbying" senior managers to attend the vacancy review panel to plead their case for them. Service managers described merely receiving an email advising whether or not a vacancy had been approved for recruitment.

3.38. This process compounded the problems of short-staffing and increased the pressure on services. Although some concerns were voiced at Board meetings about the effect on patient services and staff morale, there was no discernible impact on the policy of staff reduction. We found no evidence that staffing levels or recruitment plans were being reviewed, or that the impact of staffing reductions on service quality was being evaluated or monitored.

3.39. The impact on staff was clear. In interviews we heard from staff who had worked long hours with insufficient breaks, and staff who had been actively told not to report incidents. We also heard that sickness absence from work-related stress was a regular occurrence, but that many staff had a "heads-down" mentality because of the blame culture they were in and their fear of recriminations.

3.40. According to Board minutes in 2013, a whistleblowing policy had been in place since 2010, allowing staff to raise concerns in an open and transparent way. This was not the reality on the ground for many staff. We heard consistent accounts that whistleblowing or raising concerns was discouraged and that staff who raised concerns were ostracised by their manager/leader and later let down by HR. Others were fearful of losing their job.

3.41. The difficulties for staff were compounded further by a HR function that was not fit for purpose. The effects were sometimes extremely serious in nature, with no proper investigative processes being put in place for staff suspended for prolonged periods.

As a result, a backlog built up of outstanding HR cases that the department was unable to cope with. In 2014 this amounted to 332 employee-related cases including *"… 26 grievances, 11 disciplinaries and 100 sickness-related cases… Many of these were not reported to the Board."* (Jill Byrne, Interim Director of Nursing, April – October 2014)

Conclusion

3.42. The combined effect of crudely applied workforce reductions, a heedless, bullying organisational culture, and a HR function not fit for purpose was devastating for staff and patients. We heard harrowing accounts from staff who clearly still bore emotional scars from the events, and the impact on patient care was evident from the nature of repeated safety incidents. We are in no doubt that the underlying cause behind all this was the inexperience and unsuitability of the senior leadership of the Trust, and their inability to recognise that they were unable to cope with the challenge.

Clinical governance

3.43. Effective clinical governance is a requirement of all NHS providers, to ensure that patient safety and clinical effectiveness are monitored and improved, and that any lapse in standards of care is identified and rectified promptly. It depends on good information, systems to monitor and analyse, and leadership to ensure that signals are not only identified but are also acted upon. Good clinical governance depends on proactive intervention, particularly to ensure that risks are identified and that learning from safety incidents leads to improvement.

3.44. We found clinical governance systems in the Trust to be poorly developed, with a lack of coherent communication from the frontline of service delivery through to the Trust Board. There was sufficient data on safety incidents to be able to identify and act on trends and recurrent themes, but analysis was poor. Important root causes were missed and staff were blamed instead. Action plans that were identified were not followed through and there was little knowledge of which actions had been completed and which had not. As a result, serious incidents recurred again and again, causing unnecessary harm to patients, when lessons should have been learned from the outset.

3.45. A 'never event' is described by the NHS Policy and Framework (October 2012) as a serious, largely preventable patient safety incident that has the potential to cause serious patient harm and should not occur. It is particularly important that never events that may occur are treated very seriously and investigated thoroughly to prevent recurrence. We were dismayed to find that six never events of a similar nature had occurred in the Trust, and that the Trust had failed in its duty to learn from the first occurrence to the last. We found a similar pattern of failure to find the underlying causes in the investigation of other patient safety incidents, and failure to implement improvements.

3.46. We found that risk assessments of clinical services were delayed or left incomplete, ostensibly because staff were under-resourced for the work required of them and, not surprisingly, chose to prioritise patient care. Staff training, clinical supervision and appraisal processes were inconsistently applied and oversight of the unregistered workforce was not as robust as it should have been, leading to delays in review of care or inappropriately applied care delivery.

3.47. Clinical leadership, particularly at a senior and executive level, was poorly developed and showed clear signs of inexperience at that level. At executive director level, clinical leadership was inconsistent and subject to change. The Medical Director, Craig Gradden, who took up the post in February 2012, lacked experience of the role and had only limited knowledge of community healthcare having practised previously in a specialist field. Both the Medical Director and the Director of Nursing, Helen Lockett presented papers to the Board that lacked assurance that clinical incidents were being dealt with appropriately. It appeared that the non-Executive Board members lacked the expertise to challenge or seek further assurance.

3.48. The Board's inexperience was replicated throughout the organisation, resulting in failure to get a grip on governance and quality improvement. It was clear from those interviewed that the main area of focus for the organisation was on achieving FT status, and quality and staffing levels were secondary to financial stability. This led, in our view, to clinical governance being significantly under-emphasised in the organisation, partly because it was seen as of lesser importance and partly because any messages concerning unsafe care and staffing levels would jeopardise the FT application.

3.49. Clinicians were not routinely party to discussions about quality of care and quality impact assessments (QIAs). Staff told us that they felt unheeded when raising concerns and were blamed when incidents occurred. This led to a lack of openness and transparency in working practice, breakdowns in multi-disciplinary working and an "us and them" attitude between clinicians and others. All of this prevented any constructive approach to learning from safety incidents and reducing risks.

3.50. We did see evidence that the Trust's corporate governance team did attempt to assess risk and develop plans for improvement – for example, to reduce the incidence of pressure damage and patient falls – but the information was not used effectively or routinely shared appropriately across the organisation, and action plans were not implemented or monitored. Consequently, learning was lost, adverse trends in services were not identified and the same type of incidents were allowed to happen repeatedly.

3.51. The Head of Clinical Quality at the time highlighted: *"Root cause analysis action plans were not signed off or reviewed to ensure action had taken place. A lack of scrutiny had been in place and it was felt that numerous layers between corporate and frontline teams may have added to the difficulty in communication".*

3.52. There had also been some attempt to benchmark data through the National Reporting and Learning System with other organisations, but information was not used effectively to make improvements. Examples of incidents highlighted that happened repeatedly included:

- falls with fracture in the intermediate care wards;
- deaths in custody at HMP Liverpool;
- pressure damage; and
- never events in dentistry.

3.53. We were told during an interview that, "*you don't know what you don't know".* This was certainly true of the Trust then, but there were ample opportunities for the Trust to have recognised their lack of knowledge at the time.

3.54. Prime responsibility lay with the IG&QC of the Board, but our Review revealed that the minutes of these Committee meetings were of poor quality, with confusion over issues raised and responsibilities for action. It was difficult to track progress on any matter without constant reference to previous minutes, and this must have created difficulty for those dealing with them. We could find no evidence of the monitoring of minutes and actions by the Committee Chair, and there was no action log within the papers.

3.55. The IG&QC records revealed numerous additional problems:

- lack of attendance at meetings, highlighted on numerous occasions, resulting in frequent absence of updates;
- meeting papers not produced;
- insufficient time available to discuss items, also highlighted numerous times by Committee members;
- concerns raised that the governance team downgraded some incidents without a clear rationale;
- lack of ownership of actions and lack of direction;
- concerns raised about continuing serious staffing issues not being addressed;
- updates not produced on continuing actions, despite service leads being asked repeatedly for them;
- risk registers remained incomplete and not updated;
- SUIs remained unresolved for months;
- unresolved training issues, including mandatory/SUI/customer care training;
- action plans not produced to time and not implemented; and
- a lack of communication concerning processes and governance.

3.56. We were very concerned to note from repeated minutes the poor attendance at this Committee by key personnel, particularly including the Nursing and Medical Directors. The two most senior clinicians in the Trust should have shown leadership in engaging visibly with these issues, however hard-pressed they may have been.

3.57. On those occasions that clinical quality (including patient safety) was discussed at the Trust Board, similar problems were evident. Patient safety incidents were reported in Part Two of Board Meetings, when the Board met in private session. Scrutiny of the papers did not demonstrate an open approach to learning nor any appreciation that there were important underlying causes in the pattern of repeated incidents. No link was made with repeated incidents and complaints or with staffing levels. The minutes indicate that there was little meaningful questioning over repeated incidents of the same type, and little challenge to suggested actions that were inadequate. In our view, this was due to the inexperience of the Board members.

3.58. On paper, a committee structure was in place that should have informed the Trust Board. A divisional, corporate and executive quality group and committee structure was designed and introduced to enable two-way communication of quality information. However, clear escalation between these groups did not always happen; the organisation used multiple names for the same committee, causing confusion; attendance was inconsistent; some agenda items were not escalated and those that were escalated were not always acted upon; and, again, actions were not undertaken or reviewed. In our view, the Committee structure was ineffective and failed to relay information from the frontline of service delivery.

3.59. We found no evidence that anyone was held to account for delivery of actions arising from safety incidents or risk assessments, and many remained incomplete.

3.60. A critical review of clinical audit was carried out by the Trust's internal auditors, and presented to the IG&QC in April 2013 by the Medical Director, Craig Gradden. The review identified two problems: failure to make improvements in practice identified from clinical audit; and failure to monitor plans to report on the state of implementation. The review recommended changes to improve both aspects, but these were not adopted, as they were argued not to be the responsibility of the management team, and because existing meeting agendas were already oversubscribed. This failure to respond to the findings of the internal auditors entirely misses the point that opportunities would not be taken to improve those services with significant problems, including, for example, pressure damage and falls.

Conclusion

3.61. It is clear to us that there were abundant warnings of the developing service problems, and these alarm bells should not have been ignored by the Trust Board. However, the Trust's clinical governance systems failed. This does not reflect well on those responsible for operating the systems, including clinical leaders, nor on the Trust Board that was responsible for ensuring that clinical governance was fit for purpose.

3.62. The lack of effective clinical governance was belatedly recognised by the former Chief Executive of the Trust, Bernie Cuthel, when we interviewed her. She said that *"governance systems were not strong enough, unions didn't come to me often enough, the formal governance structure didn't pull out themes and actions and the integrated governance and quality committee was not functioning as well as it could."* While this is all true, in our view, it overlooks the fact that the CEO, as Accountable Officer for the Trust, was responsible for ensuring effective clinical governance.

Patient outcomes

3.63. In setting out our findings on clinical care capability, organisational culture and leadership, we have already identified many examples of avoidable patient harm. We are in no doubt that, not only were patients harmed, the same type of incidents recurred unnecessarily because of repeated failure to learn.

3.64. Due to the poor standard of incident reporting and investigation, it was not possible to quantify how many patients were affected. We asked those staff we interviewed whether they considered that patients had come to harm as a result of the events over the Review period. We heard repeated answers from staff that they were either aware of instances of harm, or they were of the view that patients had been subject to delays (or hurried interventions) that increased the risk of harm.

3.65. It was clear to us that staff were greatly affected by the memory of these events and the effects of their actions on patients, and that this was also part of the harm that had been caused.

3.66. We had particular concerns about two specific areas – dental services and prison healthcare – and these are considered in further detail below.

Dental services

3.67. There were five never events in dental services over the review period: all of these were "wrong site tooth extractions". Every never event must be reported, thoroughly investigated and measures put in place to prevent its recurrence. Five never events in one service over less than three years is an extremely serious failure.

3.68. Reporting of wrong site tooth extraction nationally has been mandatory since 2014/15 as, prior to this, some NHS organisations were not reporting, despite guidance issued in 2011 that any treatment that deviated from the "consent to treatment" process, should be reported and treated as a never event.

3.69. Five never events occurred in dentistry between 2012 and 2015, two of which were reported by the Trust's former Risk and Governance Manager. Three, however, were not. Opportunities to prevent recurrence were missed in all cases, regardless of whether they had been reported as they should have been. Investigations were not robust enough to identify underlying causes or preventive measures. Those measures that were identified were not communicated effectively, and suggested improvements were ineffective and not properly followed through. There was a lack of openness with patients and relatives.

3.70. A retrospective review of the three never events that had not previously been reported was undertaken by the Trust in 2015, too late for the Trust to have learned lessons and prevent other never events of a similar nature, resulting in avoidable harm to the patients affected.

3.71. We were able to identify in interviews that meetings with clinical leads about the never events had been held at the time, but minutes of those meetings were not tied into a wider reporting structure and there were no clear objectives for the meetings. Investigation terms of reference were only formalised subsequently. We also identified that not all dental staff would fill out an incident form on the Trust's Datix[1] system, as they felt nervous about the consequences for themselves. Instead, they would create a local clinical improvement notice to flag the issue to other dental clinicians. It is clear from the repeated never events that this was ineffective, but it also forfeited the chance of wider learning across the organisation, particularly in relation to governance management. *"We did our own reporting – sometimes through Datix"* (Nicola Marshall, Clinical Director).

3.72. This sharing method in dentistry was not recognised wider by the Trust as part of the governance arrangements and, on review, the Assistant Clinical Director reported, *"To sign these as having been read may be a step too far"* (December 2014).

3.73. The dangers of running two systems in parallel, or not being clear which system was used for what, was not recognised and may have prevented staff from accessing the Trust Risk Management System to report incidents or near misses. This prevented a true picture emerging that would have enabled trend analysis.

3.74. The harm to patients caused by wrong tooth extraction should be clear to all and, at the very least, it constitutes a procedure for which the patient has not given consent. We were taken aback to hear from some of those interviewed that they thought that no harm had been caused as there had been no complaint or legal action and, in some cases, the clinical problem had been resolved by extracting the wrong tooth. One of these interviewees was one of the clinical directors for the service, which may have influenced the inconsistent reporting and action taken.

3.75. A tooth extraction protocol and verification process has since been put in place based on the World Health Organisation's checklist; it would have been more beneficial to patients if this had happened after the first never event, as it certainly should have been.

3.76. None of this is to deny that dental staff were working under difficult circumstances, with significant workload pressure and poor working relationships. The largest cost improvement programme in the Trust in proportionate terms had been imposed on dental services, and the effect on staffing and workload was significant. We heard that there had been little or no engagement with dentists on the design or implementation of the programme, and no clinical input into the QIA. We heard that members of staff had been suspended for questioning its feasibility.

3.77. The cost improvement for dentistry was identified as being almost half their current budget at the time (44%) based on a high-street dentistry model. There appeared to be little focus on quality impact; rather, the concerns highlighted were that the current model was costly, the dental division was overspending and commissioners were formally challenging the high costs. The drive for FT status and cost improvement was reiterated as the main driver by interviewees, who identified that the pressure to deliver the CIP was enormous and the tension in Transformation Board was palpable.

Conclusion

3.78. Governance in dentistry was internally focused to the service and operated outside of mainstream governance within the organisation, without escalation procedures or understanding of governance requirements. As a result of this, learning and improvements to practice did not take place to prevent reoccurrence.

Prison healthcare

3.79. Prison healthcare in HMP Liverpool was, in some ways, our biggest area of concern based on what we heard. All of the problems of governance, leadership and organisational culture that are set out above were replicated in the prison healthcare services. In addition, they operated at a distance, with significant hindrances to access for Trust headquarters' staff by the nature of a prison, and were dealing with a patient group that is both challenging and vulnerable.

3.80. Based on what we heard, it seems to us that the Trust was responsible for prison healthcare with no understanding of its requirements or how to manage it in a safe and effective manner. It became an "add on" to the organisation, seemingly motivated by a desire to expand the Trust to head off perceived challenges to its viability. We found no evidence that the senior management team took any steps to gain a detailed understanding of the nature and particular requirements of prison healthcare. There was a lack of regular senior and executive presence in the prison
– in fact prison passes had not been issued, meaning that the senior management team would not have been able to visit regularly. There was no systematic clinical governance within the service, and no attempt to integrate its clinical governance with the Trust's other systems (however flawed). Serious clinical concerns were not identified or managed appropriately.

3.81. One staff member reported: *"The paperwork was sent six to seven times to senior clinical, specialist and management leads to allow them to visit the prison, which were never completed and returned."* This point was also raised by another senior staff member.

3.82. Considering the risks associated with prison healthcare, the vulnerability of the client group, and the assurances that the Board should want to see due to their own inexperience of offender healthcare, we would have expected the service to feature regularly in Board discussions. In fact, we found little evidence in comparison to the rest of the organisation that this was discussed other than very occasionally, either at the Board or at the Integrated Governance and Quality Committee.

Clinical governance arrangements

3.83. There was little prison governance at the Trust, meaning that healthcare staff at the prison were largely working in isolation. This was the same theme that occurred in dentistry but the situation in HMP Liverpool caused us more serious concern because the governance within the prison and the ability of the staff involved were seriously lacking. Organisational staff said they lacked the capacity to attend governance meetings; there had been little apparent thought given to the monitoring and management of prison healthcare by Liverpool Community Health NHS Trust and there was no regular monitoring and reporting back into the main governance framework of the organisation.

3.84. Risks that were identified and raised regarding prison healthcare appeared to stop at management level and many were never raised to Board level. There seemed to be a lack of support for the team to lead service development and a lack of relationship- building from senior leaders of the organisation with the prison Governor to address challenges and concerns. One interviewee reported that *"LCH staff were not involved enough to know what was going on"* (Debbie Moore). Another reported that *"although the Datix system was always in place, it was not used".*

3.85. Prison healthcare managers lacked governance expertise and were reported to either decline logging incidents on the Datix system, or else incidents reported were not reviewed by the Trust governance team.

3.86. In other cases, incidents were accepted but downgraded, resulting in a loss of ability to effectively analyse trends or themes. This was coupled with a lack of divisional management oversight, an absence of governance and escalation by committees, and a general culture of not reporting SUIs. It seems to us that, as a result, the Trust Board was not as aware of the risks inherent in the service as they should have been. Given the unique and novel nature of the service for the Trust Board and staff alike, we believe that the Board should have taken the trouble to assure itself of the safety and adequacy of the service; they did not.

3.87. We heard from a former Interim Director of Performance that *"Prison Serious Untoward Incidents (SUI) were not reported or not interpreted as SUIs, with the culture in the governance team being to play down the incidents, which provided another barrier and then executives would also downgrade risks before going to the Board so the Board were not being sighted on incidents, so they only saw a summary and were not aware of all the issues."*

3.88. On reviewing the evidence, it seems to us that there was also a lack of professional responsibility displayed at a senior level, insufficient expertise and an inadequate infrastructure to manage the service. We had numerous concerns about the operation of the prison healthcare service, which included: lack of risk assessment of offenders, including areas such as their nutrition and hydration; mental capacity; infection control; falls and pressure damage management; management of long-term conditions such as asthma; pain management; cancer management; end of life care; and dental management.

3.89. Patients who were provided with an NHS appointment but failed to arrive were recorded as 'Did Not Attend' (DNA) and DNA rates within HMP Liverpool were unacceptable. These had a detrimental effect on patient experience and patient outcome – for example: failure to administer eye drops to relieve pain and inflammation while a patient waited for surgery; lack of management of prisoners with existing long-term conditions; and a lack of management of people with a high risk of suicide, including lack of proper documentation at handover.

3.90. Levels of concern about this were raised by the CQC following their unannounced visit. This came as a surprise to PCT staff as we had heard that previous visits by commissioners had raised no concerns.

3.91. For part of the period, the Prison Partnership Board was established as a multi-disciplinary meeting to include colleagues from all partner organisations (Adult Social Care, Liverpool City Council, the Trust providers and the Prison Governor), where participants could raise issues of concern and consider death in custody reviews. We heard, however, that mainly operational rather than quality issues were discussed and the prison healthcare Risk Register was not reviewed routinely at these meetings. Managers reported that they struggled to make sense of unfamiliar data and that key monitoring processes were not in place, including the review, monitoring and maintenance of equipment. This resulted in staff using equipment that was not fit for purpose.

3.92. Despite the poor processes and lack of integration of prison healthcare, some of the problems did, belatedly, come to the attention of the Trust, including staffing concerns, poor knowledge of governance arrangements in the service, and a high level of stress in prison healthcare staff. However, we could find no evidence that this prompted any specific action.

Medicines management

3.93. This was of significant concern at HMP Liverpool and the reviews of medicines management within the prison were extensive. The interim Executive Team established that there had been no safe and proper processes in place for the management of controlled drugs; there was no double-checking and no double- signatory when medicines were dispensed.

3.94. A review of past Controlled Drug incidents was conducted on balance checks at HMP Liverpool by Lucie Michaelson, Pharmacist in March 2015. This review highlighted that controlled drugs policies and procedures were not adhered to, and as a result, three patients' controlled drugs were unaccounted for. There was a lack of staff training identified and undertaken and also a failure to undertake regular controlled drug register audits and weekly balance checks at the time the incidents occurred.

3.95. Medicines management by staff showed a complete lack of understanding of the drugs they were dealing with, and no proper administration procedures. *"If a member of staff hadn't got the right dosage of drug, [they] snapped a bit off a tablet,"* (Debbie Moore interview).

3.96. The exit report by Amanda Pye, Interim Director of Nursing, identified concerns in May 2015 that Nursing & Midwifery Council (NMC) professional standards had been contravened within the prison and the NMC were duly informed. Due to the organisational culture in HMP Liverpool, unsafe practice had become accepted as normal.

3.97. Drugs were stored inappropriately and storage temperatures were not checked so the efficacy of the drugs being administered was unknown. A lack of staff competence and training updates compounded this culture still further.

3.98. In September 2014, an external review of an incident had already identified poor administration of drugs, equipment not being maintained and policies and procedures not being followed.

3.99. The minutes of an IG&QC Meeting (December 2014) identified an incident where a patient had not been given prescribed epilepsy medication, resulting in the patient having a seizure the following day. There had also been a "near miss" when another patient had not been administered their medication for four weeks.

3.100. A peer review into clinical risk, quality and governance of the integrated primary healthcare delivered by Liverpool Community Health NHS Trust to HMP Liverpool (January 2015), was unable to visit prison wings to sample and audit prescription record sheets due to lack of available escorting staff. Staff stated that they often worked on minimum staffing levels and that this impacted directly on patient care. Examples were given of patients needing to be locked in their cells while nursing staff assisted with the administration of medicines in other areas of the prison. Morale was clearly very low, with staff openly expressing concerns that they were under scrutiny, "*exhausted*" and "*about to be slaughtered*".

3.101. There were no policies and no standard operating procedure in place, although the January 2015 report identified pharmacy staff who were trying to address these issues.

3.102. The review of potential serious incidents in HMP Liverpool undertaken by Liz Craig (Former Director of Nursing at Liverpool Women's Hospital and later an Independent Nursing Consultant) in 2015 raised serious concerns regarding the management of medicines with incidents highlighted as *"A missed dose of Fragmin being reported; on review Warfarin was the drug listed on the system not Fragmin".*

3.103. In another case, *"a patient found with codeine in his blood sample when DF118 was the prescribed drug. If this patient was substituted one drug for another, it is a serious incident".* Review of this incident identified that staff were giving substitute medications if there was a shortage of the prescribed medication.[2]

3.104. It was also identified that there was pressure to administer medication to large numbers of patients within a limited time, resulting in staff finding ways to save time. Staff confirmed these as bulk signing of prescription charts to show that medication had been administered, administering stock medication without recording it on the relevant prescription chart and administering medication to one person that had been prescribed for another.

3.105. In a review of another patient's care, the patient did not receive his prescribed dose of hydrocortisone post-operatively and did not receive his medication again on another day. It also identified that limited wound care and limited nursing care were given.

3.106. In an investigation undertaken by Ann Ryan, Business Development Manager, Primary Care and Public Health at the Trust in February 2015 into a patient who had attempted suicide, medication errors were identified again:

"There was no medication sheet for the patient and requests for medicines' reconciliation by medicines management. It was also identified from documentation that the patient had not received his daily dose of Sertraline 50mg one tablet daily. The patient was not seen regularly by the GP either."

3.107. This review also highlighted the lack of care planning, which is a common theme throughout our review.

Assessment and screening

3.109. We were concerned at failures in the assessment of prisoners, and routine initial and secondary screening was not carried out effectively or consistently. Of particular concern to us was the lack of secondary screening for prisoners with long-term conditions or chronic illness. There may have been some retrospective screening in place but this was not undertaken in a sufficiently timely manner for it to be effective.

3.110. One interviewee with close knowledge of healthcare in HMP Liverpool told us of the difficulties:

"Secondary screening – used to have good attendance, then the core day changed and prison officers refused to bring prisoners over, so the percentage of prisoners screened dropped off. Local governance arrangements identified this and it was escalated via emails but, due to a lack of coherent governance arrangements in the organisation, this wasn't addressed in a timely manner".

3.111. Minutes of the IG&QC Meeting (April 2014) identified that Offender Health was unable to meet CQC requirements for secondary screening. *"We provide the appointment but it is up to the prison staff to ensure the appointment is kept."*

3.112. Due to a lack of multi-disciplinary working when patients were screened, a combination of poor care planning, record keeping and communication, resulted in messages not being received and acted upon.

3.113. In one incident that we reviewed, a prisoner admitted with complex needs did not see a GP on admission. He eventually saw a GP seven days later, causing a significant delay in receiving appropriate medication. The same inpatient missed out on patient appointments due to poor communication between healthcare and prison staff. This lack of communication then carried over to the main prison where there was no handover or concerns raised, so no plan of care was put in place.

3.114. Following a Safeguarding Audit in August 2014, instigated by the interim Executive Team, concerns were raised by the Trust regarding 10 clinical incidents reported at HMP Liverpool which potentially could be classified as SUIs. An independent reviewer with executive governance and patient safety experience was assigned to undertake a review of the 10 incidents. This identified the lack of thorough risk assessments and recommended a full systematic review of assessments.

3.115. Patient notes had been stored in numerical order by prison number which was a barrier to cross-referencing. Many historic records were paper-based and no older records had been scanned. This all added to the difficulties in effectively managing patient records.

Deaths in custody

3.116. We are aware that there has been a high number of deaths in custody in HMP Liverpool during the period covered by our Review and afterwards.[3] We have seen Serious Incident Reports covering 19 deaths in custody, but many of these were done retrospectively and may include an element of double counting. Between April 2013 and December 2014 there were six suicides, five by hanging. National guidance on deaths in custody[4] emphasises the need to learn from trends and themes, and highlights risk areas such as medicines management, record-keeping and management of long-term conditions. All of these factors were prominent among the concerns we found relating to HMP Liverpool. However, these themes do not seem to have been reviewed nor had any bearing on reviews and management of the healthcare system within the prison. Actions continued to be divided between prison and health teams, with a lack of coordinated working.

3.117. We were surprised to find that deaths in custody did not feature on the performance reporting dashboard to the Trust Board, and there was no mention on the high-level risk register being presented to the Board. Some deaths in custody were not even reported as serious incidents, and we found a lack of information being reported through the governance committees, together with a lack of assurance to the IG&QC.

3.118. An example of one of the reports made to the Board in April 2014 stated that the person was alcohol-dependent or had a history of alcohol and/or drug usage. The only risk control in place for one of these incidents described to the Board is that the patient was being treated by the GP for depression. There was no mention of risk assessments, management of medication or care planning. Another patient had team-level assurance as they had been in previous establishments prior to admission to HMP Kennet and they were a smoker. It is difficult to see how the Board took assurance from the Serious Incident Reports as there was little relevant information presented in them. There is no evidence that the Board challenged or even questioned the information that was provided to them.

3.119. On the basis of the evidence that we have seen and heard, it is clear that there were serious clinical governance deficiencies in the service delivered in HMP Liverpool, and serious deficiencies in the way that incidents, including deaths, were investigated afterwards. As a result, opportunities were missed to put in place measures to reduce the unwarranted incidence of future deaths in custody. These conclusions have already been drawn, including in the Prisons and Probation Ombudsman reports in 2011 and 2013. Problems were manifest in relation to medicines management, care planning, audit activity, DNA rates, and there was a complete lack of Board oversight and a lack of assurance in the Serious Incident Report papers presented by the Medical and Nurse Directors to both the IG&QC and the Trust Board.

3.120. Following a CQC visit to HMP Liverpool, areas for action were highlighted, particularly in relation to medicines management and secondary screening, especially for those patients who were mentally unstable and/or at risk of suicide attempt. On review of the Board minutes, we could find no evidence that these action areas had been considered by the Board, nor had an improvement plan been developed.

3.121. We can come to no other conclusion than that the Trust let these patients down very badly and, as a result, lives were likely to have been lost unnecessarily.

Records and record-keeping

3.122. There was insufficient governance in relation to records and a lack of systematic management of records. There were failures to sign records at handover and vital records went missing or took too long to be filed appropriately, leaving patients vulnerable, and the true state of their condition uncertain. In addition, due to the failure to reconcile and effectively manage records, previous medical interventions were unknown. There was no handover checklist in place for new arrivals to the prison, and healthcare staff were not aware of missing documents.

3.123. Following actions initiated by the interim Executive Team, eight years of prescription charts and five years of patient electrocardiograms (ECGs) had been found in a cupboard on the Healthcare Unit. We were told that it had been suspected that these records had been stored and not scanned to any patient records, potentially resulting in incomplete records being forwarded on to other prisons or HM Coroner.

3.124. A lack of robust tracking and tracing of paper documentation within the healthcare unit was also identified, as well as:

- inadequate storage space for paper documentation;
- poor records management;
- prescriptions and ECG records retained on paper;
- the service did not have appropriate means to scan paper documents back into the records system, resulting in hybrid paper/electronic clinical records; and
- lack of available storage space for paper prescriptions within the HMP Liverpool Healthcare Centre, resulting in prescriptions filed separately in boxes labelled by surname and year.

3.125. These were breaches of the Records Management Code of Practice retention periods. These actions also presented a fire hazard, as patient records were housed in a wooden filing cabinet in an environment containing flammable liquids. This required immediate action to resolve. The environment was identified as cluttered, messy with a lack of coordinated processes in place to ensure confidentiality and safety of records.

3.126. We heard that "staff reported ECG results found which, when sent to a cardiologist, *revealed some ECGs with abnormalities that had not been identified".*

Culture, people and environment

3.127. The culture was described as regimented and one member of staff described it as "bullying" in nature. Meetings were conducted in an aggressive environment, a practice that appeared to be demonstrated in the Trust at Board level, through middle management to frontline delivery.

3.128. Culture has been considered elsewhere in the Report but was identified as a particularly significant issue within offender healthcare. We heard from interviewees that staff were not allowed to walk along certain corridors and could not enter a manager's office if they were graded below Band 6 – conversations were conducted with junior staff standing outside their manager's office. We heard accounts of nursing staff bickering in front of others about decisions that were being made, showing a lack of senior leadership and management.

3.129. Any staff who "*in the eyes of the prison were becoming militant*", were reported, felt scrutinised, and were, we were told, ultimately moved out.

3.130. Healthcare staff were told that they should not report incidents on the risk management system (Datix) and that, if they did, they would be disciplined.

3.131. One previous manager reported: *"I was called to a meeting regarding cost improvement and vacancies were removed, which was the equivalent of 8 to 9 people, for example, a whole time equivalent GP was removed and funding ring- fenced for prison healthcare was removed"*.

3.132. Another interviewee was asked if they felt patients had been harmed in HMP Liverpool. *"Definitely – physically and psychologically",* was the response.

Staff training and competence

3.133. As a result of some ignorance of policies and procedures, staff did not always know what to do and some of their practice was extremely poor. They may have wanted to do the right thing, but the lack of training and development, and poor focus on values for staff and on the way they should behave and conduct themselves all contributed to a consistent failure to meet adequate standards within the unit.

3.134. Registered clinicians should have led by example and upheld their professional standards, particularly as stipulated under the National Medical Council Code of Professional Standards of Practice and Behaviour (revised 2016) for all registered nurse and midwives. Within this Code, nurses commit to delivering the fundamentals of care, maintaining their own professional competence and making sure that people's physical, social and psychological needs are assessed and responded to, and that they act within the best interests of people at all time, regardless of setting. These professionals failed to comply with the Code and let their patients down.

3.135. Only between 45% and 55% of offender healthcare staff were up to date with mandatory and statutory training requirements, including basic life support training which, in a high-risk environment, is of concern. Staff repeatedly identified that the reason for non-attendance of training was due to a lack of staffing levels. Staffing levels were insufficient and recruitment into the prison was difficult.

3.136. The Trust Chief Executive, Bernie Cuthel, felt that she saw nothing that impacted on patient safety, other than incidents that were reported to the Board as a result of failure, so she saw no significant difference from other areas where she had previously worked. On reflection, she considered that the Board was "*blind*" to the issues.

3.137. She also considered that the Head of Prison Healthcare was not showing sufficient leadership and that "*the team was institutionalised*". There appeared to us to be a lack of ownership of the issues, with everyone blaming somebody else. The truth of the matter is that there was a lack of governance systems, leadership, accountability, a lack of effective HR management, and a failure of management and oversight at all levels of the organisation.

Human Resources procedures

3.138. Some prison healthcare staff had been suspended from duty at HMP Liverpool pending investigation. These investigations failed to be undertaken in accordance with HR policies and procedures, resulting in staff being suspended for many months. This impacted on staff morale and on the efficiency and effectiveness of healthcare due to staff shortages.

3.139. "*It had been reported that a prisoner had climbed into a tumble dryer which had been turned on by a prison officer for one turn of the dryer."* This was reported to the Director of Nursing, Helen Lockett, and Medical Director, Craig Gradden. An investigation was eventually triggered by the interim Executive Team to establish why it had not been reported and investigated at the time. This proved inconclusive due to a difference in recollection by those involved and the inability to understand how the incident was communicated. This incident was never reported appropriately or shared within the organisation, to the Trust Board or to the prison Governor at the time. This practice was, regrettably, a common theme in both the Trust and within offender healthcare.

3.140. One interviewee described being suspended from their post alongside two other managers pending a review of risks in the prison, which had not been investigated at the time. Staff opted to resign rather than be subject to the Trust's procedures as they feared becoming a scapegoat for management and organisational failings. They told us that they would still be working within the organisation if they had been treated appropriately.

3.141. One of this group of affected staff was referred to the NMC; they told us that they were not advised who made the referral and expressed their distress that their case was only just being investigated in 2017. This raises a concern over the length of time taken for the process to reach a resolution.

Conclusion

3.142. The Trust failed to provide adequate healthcare in HMP Liverpool. Organisational culture was poor, there was no systematic clinical governance, and clinical competence was variable. There was little appreciation of the seriousness of incidents, including deaths in custody, and investigations, when undertaken, did not lead to improvements to reduce the risk for future prisoners. All of this demonstrates a basic lack of understanding of the prerequisites for a safe and effective service. While it is clear that there have been more general problems in HMP Liverpool,[5] we have no doubt that the extremely poor state of healthcare within the prison contributed significantly.

INTERNAL GOVERNANCE AND EXTERNAL SCRUTINY

The Trust

4.1. Liverpool Community Health NHS Trust came into being in November 2010, driven in part by the government's initiative, Transforming Community Services. In April 2011, it acquired the majority of NHS Sefton's community services. It also acquired community dentistry for Knowsley.

4.2. In 2011/12 the Trust employed around 2,500 WTE permanent staff, 80% of which were clinicians. Revenue for the same period was £143 million with a surplus of £3.5 million. In April 2014, the revenue had reduced to £135.7 million and staffing was approximately the same.[6]

4.3. Services included adult care, child and adolescent care, community dentistry, prison healthcare and public health.

4.4. The Trust was overseen by its Board, made up of both Executive and non-Executive Directors.

The Board

4.5. The Board and its operation are fundamental to an effective Trust. It shapes the vision of the organisation and the strategy designed to deliver that vision. It has responsibilities for and to the population it serves. It has responsibility to those who work for the organisation, ensuring that they are treated fairly and that they operate in a safe environment.[7]

4.6. The Board has two distinct groups of members – non-Executive Directors and Executive Directors – and their combined experience, strategic knowledge and professionalism contribute to the organisation's ability to build confidence within its stakeholders and with its staff. Key responsibilities are:

- the quality and safety of its services;
- proper use of its resources to deliver optimal outcomes;
- ensuring access to its services; and
- effective engagement with stakeholders to enable them to help shape services.

4.7. A Board needs to deliver all of its responsibilities, ensuring a balanced approach that enables best outcomes for its users and stakeholders. This is often challenging and requires strong leadership and experience.

4.8. In reviewing the contribution of the Board, we scrutinised written evidence and evidence from interviews. All non-Executives on the Board at the time covered by the Terms of Reference were invited to be interviewed. It is extremely disappointing to note that, with the exception of Trevor Lake (Interim Chair from 2015) and Jack Stopforth (non-Executive), none of the non-Executives responded to direct requests to be interviewed. Our conclusions have therefore been made on the basis of the information from written evidence and through other interviews.

4.9. Executive directors were more forthcoming. However, some key figures were not able to be interviewed, notably the Director of Nursing and Operations, Helen Lockett, and the Director of HR, Michelle Porteus.

Trust Board and Management

4.10. Having identified clear failures in the Trust's services and the difficult working conditions and staff shortages that led to them, we reviewed the leadership and management of the Trust. We sought to understand the factors that had led to the difficult context in which services had to operate and the reasons why the problems went undetected.

4.11. Board Leadership: The Board was created initially in shadow form. Its non-Executives were prominent local members of the community; however, their experience in managing within the public sector and community health services was limited. The executives were drawn from community health management within the existing services, from other community healthcare services and from external organisations, including the private sector. Executive directors had little experience at Board level. Leadership was focused through a strong partnership between the Chair and the Chief Executive. We heard that this partnership dominated the management of the Trust. It seems to have focused heavily on the external profile of the Trust, in which both the Chair and the Chief Executive were active. Given the state of the Trust, we question whether this external focus was at the detriment of the operational management of the Trust and the care of patients.

4.12. We had expected to find external support in place to provide advice to the new Board, both in terms of its development as a new organisation and at individual level – providing professional and managerial support. The natural sources for this would have been the PCT, the SHA, NHS TDA and subsequently NHS Improvement.
Partnering of the new executives with a more developed trust is not unusual, and support around a new chief executive and directors is common. While such support may have been given, it was not apparent to us. Certainly interviewees expressed the lack of support from outside the organisation.

4.13. The reasons for this may relate to the transition and reorganisation of the NHS that were underway at the time. The roles of new organisations were still developing, community health trusts were new entities and were few and far between, and the scrutiny and identification of areas where support was needed may have been missed.

4.14. There are lessons here that need to be learned. LCH was newly created; it had come from a very different organisational model within a PCT. It had an inexperienced Board, a chief executive in their first chief executive post, and external appointments to director posts with little or no experience of both the NHS and community services. And this was happening amidst a national organisational redesign. We believe that these factors indicated a sufficient level of risk to warrant special attention being given to the Trust. This does not seem to have happened.

Strategic vision, financial plans and cost improvement

4.15. In its Annual Report 2011/12, the Trust sets out its strategic vision. It states that the strategic vision was to:

"*improve the health and well-being of the communities we serve by providing high- quality care*[8]*."*

4.16. Four strategic objectives were set to enable the Trust to meet its strategic vision. They were to:

- provide high-quality services;
- become the first choice provider;
- reduce inequalities and improve health; and
- be employer of choice.

4.17. The vision was underpinned by the following values:

- Care for patients, their families, each other and the community;
- A community of professionals dedicated to providing best quality healthcare for the community;
- Collaboration across disciplines, with patients and the community to ensure best possible health outcomes;
- Courage to provide healthcare to challenging groups; and
- Commitment in our work, taking personal responsibility for our actions.

4.18. Choices made by the Trust are hard to reconcile with these objectives and values. The quality of many services was undermined by the financial strategy. CCGs expressed concerns about the provider, and the consequential break up and redistribution of services underlines the lack of confidence in the trust. Objectives to reduce inequalities and improve health were also undermined by the cost-cutting within the organisation, and staff have certainly indicated a culture of bullying and harassment that cannot have made them an employer of choice. The level of denial by the leadership of the Trust that there were problems does not align with the commitment to take personal responsibility for their actions.

4.19. As further investigations were undertaken, we formed the view that the stated vision was not the prime driver of the Trust. The real driver was to reach FT status. This was confirmed in interview with a previous non-Executive of the Trust. Plans were focused on this key driver. Critical to success was a financial plan that met the Trust's assessment of the criteria set out by Monitor. The financial plan became paramount and the achievement of the plan began to impact on the delivery of services.

4.20. Delivery of a financial plan relied on two strategic drivers: reducing cost; and acquiring new assets so that they could then be used to improve the financial viability of the Trust.

4.21. This had consequences. The trust undertook an aggressive CIP, targeting a £30 million reduction over five years. This represented a cut in resources of approximately 22%.[9] We were surprised that such an ambitious financial reduction was not scrutinised more closely – by both commissioners and regulators. Cuts of that magnitude require a significant step change in services and would rely on both redesign and, potentially, reductions in services. We would have expected both commissioners and regulators to have been alerted to financial plans requiring savings of this magnitude and would have wanted to understand the quality impact of the plans. We believe scrutiny was inadequate.

4.22. With the most significant costs within the organisation associated with staffing, the CIPs would have an inevitable knock-on impact on frontline staffing levels. The decision to reduce costs in services seems to us to be counter to stated strategic aims and certainly not properly explored with the clinicians providing the services. We heard of a management culture where meeting your savings targets was the prime measure of performance. Regular meetings were held which resembled star chambers, at which the manager was expected to justify any slippage in their cost reduction plans. We believe that the approach was used in a way counter to delivery of a quality service.

4.23. When acquiring services, there is a need to focus on those that offer a strategic fit to the organisation and enable efficiencies to be achieved, or at least costs contained. We do not believe that the Trust was equipped to manage prison health services, and certainly the organisation did not give the prison service the support and attention it required. Community dentistry was a more sensible strategic fit but the CIP assessment that nearly 45% of costs could be removed from the service is highly questionable. We were told in an interview that the benchmarking of the community dentistry service was made against high-street dentistry. This is not a viable comparison. Despite an alternative proposal being made by the clinical team to make savings of £1.5 million, the Trust seems to have moved ahead with its initial CIP. The clinical leadership was then suspended, for, justifiably in our view, questioning the viability of the proposed plans.

4.24. CIPs during this period were intended to be looked at together with QIAs. QIAs came into being following the findings of the Mid Staffordshire NHS Foundation Trust report by Sir Robert Francis. They underpinned a key principle – that NHS Boards should not be approving CIPs without receiving assurances that the impact of the proposed changes are, at worst, neutral but should be aimed at improving quality. These became a good indicator of an organisation's ability to manage change and to focus on quality improvement above simple cost reduction.

4.25. We heard during interviews that, while there was an expectation by NHS TDA and subsequently by NHS Improvement, that CIPs were done in conjunction with QIAs, other than checking to see if they had been undertaken (receipt of confirmation by the Trust that they had been completed) no scrutiny of the Trust's plans was actually undertaken in the first year of NHS TDA's existence. We heard again that this was due to the transition caused by NHS reorganisation, but we believe that even a superficial review could have identified potential flaws in the QIA's and the CIP's viability. This could have provided an early indication that there were potential problems in the Trust's plans.

4.26. NHS TDA also questioned the level of scrutiny local commissioners gave to the Trust's plans. We heard from CCGs about the difficulties they encountered in getting information from the Trust, who seem to have been reluctant to cooperate with their commissioners. Without crucial information, it may have been impossible to spot specific concerns. However, lessons learned elsewhere in the NHS, would indicate that organisations that are not open and able or willing to provide information may be hiding risks that more open organisations are not. Again the timing in terms of organisational restructuring will not have helped, and the CCGs did not have reasons to believe there were problems, due to the lack of concerns raised by predecessor organisations. But the signs were there if looked for, of an organisation unwilling to allow close scrutiny by external parties.

Conclusion

4.27. An inexperienced Board was appointed to a new Trust with insufficient support. The Board became fixated on becoming a FT. The resulting need to make a cash surplus, coupled with the Trust's unchallenging acceptance of future income reductions imposed by commissioners that were infeasible without reducing services, led the Trust to set aggressive cost improvement targets. CIPs were poorly designed, with significant impacts on services and staff, and implemented with rudimentary QIAs. Staff were expected to press on with CIPs amidst a climate of fear. At the same time, the Trust adopted an expansionist approach to service provision, while already struggling with prison health services, where inexperienced staff and poor design of supervision led to further significant service problems.

Staffing and management of staff

4.28. Within any organisation, success or failure is linked to its staff. In patient care, staff are the essential element of the service. In LCH, as in most community services, around 75% of expenditure was on staffing. This creates a number of challenges – the output of staff is essential to success, but it is also the single greatest element of cost. A successful organisation needs to balance the investment in frontline staff with utilisation of its resources. LCH did not. Instead, frontline vacancies were not recruited to, experienced staff were replaced by more junior and less-experienced staff and the expectations placed on the remaining staff continued to be raised. The impact, in our view, was slipping standards of care and mounting pressure on staff to deliver increasingly challenging portfolios.

4.29. A key indicator of staff attitudes and feelings is the staff survey. Even a cursory look at the surveys throughout the Review period indicates significant areas of concern among its employees. Staff felt pressured to come to work, even when unwell. Staff indicated high levels of stress, low responsiveness from managers to problems raised, little involvement in important decisions, bullying and harassment by managers and, separately, by members of the public. All these issues were raised by staff in the survey and showed higher levels of concern than national comparators. To any organisation, this should be concerning, particularly when trends from year to year showed a worsening position.

4.30. We heard from numerous members of staff that they were not listened to, that they were frightened to report issues, including bullying and harassment, and that they did not feel part of the decisions being made that shaped their area of service. These are consistent with the findings of the staff surveys at the time and should have been very worrying for the organisation and, in particular, for its Board.

4.31. The concerns do not seem to have been addressed or even acknowledged by the Board and the leadership of the Trust. NHS Boards should take steps to ensure that they are aware of staff survey findings, as well as using other less formal means to assure themselves of staff wellbeing. They should also keep close scrutiny on work to improve any shortcomings. We found little evidence of close scrutiny. There was sufficient evidence of concern that the leadership should have been well aware of the problems, but there is no evidence that the Board reacted in any meaningful way.

4.32. The Trust ran with significant vacancies, particularly in services such as district nursing. When the interim leadership team took over, we were told that the Trust was carrying 150 WTE vacancies, of which 78 were WTE District Nurse vacancies. We were told repeatedly of the difficulties this created and the major problems faced by frontline staff in relation to recruitment and staff retention. Despite this, frontline staff tried to provide the best services they could, often working long hours in difficult circumstances. We wish to acknowledge the hard work and dedication of staff.

4.33. We were very impressed with the commitment and dedication of many of the frontline staff we interviewed, and we saw the emotional and physical toll that this had placed on them. Vacancy levels were most acute in services such as District Nursing and were worsened by a growing gap between the numbers of skilled and experienced staff and newly qualified staff. Mechanisms for recruitment were bureaucratic and appointments were made, in many cases, without the involvement of the staff they would be working alongside. There was a clear picture of an organisation controlling cost through vacancies without due regard to the impact on frontline staff.

4.34. The HR function within the Trust was led by the Director of HR, Michelle Porteus. Despite strenuous attempts to contact and interview her, we were unable to do so. This is regrettable, but we were able to gain a consistent picture of how the function operated in the Trust from those who did speak to us.

4.35. Human resources within the organisation appeared disorganised and its actions poorly documented. There was a clear pattern of repeated interventions to suspend staff for reasons that were not documented or, apparently, not communicated to those concerned. In some cases, these remained in force for prolonged periods without explanation or any process for resolution. It is clear that the Trust's own policies and procedures were not followed, leading to grievances not being properly investigated and staff being pressured to accept sub-optimal roles or outcomes from flawed processes. Recruitment and the management of vacancies seems to have been designed to reduce cost rather than meet the needs of the organisation in delivery of care.

4.36. We found evidence that senior members of the organisation were closely involved in these poor processes and deficient handling of staff. We heard that these events, not surprisingly, impacted on the health and wellbeing of staff. When Sue Page arrived as the Interim Chief Executive with a largely new executive team, senior staff had to deal with unresolved staffing issues that should have been resolved many months before. This can never be acceptable.

4.37. HR support to staff was at best inconsistent, and sometimes much worse. We heard a first-hand account of an incident that occurred to a lone worker in a patient's home that involved a real threat to her life as well as actual harm to her physical and mental wellbeing. The grossly deficient handling of the response to this incident was appalling, dismissive and uncaring.

Conclusion

4.38. NHS Human Resources functions need, at a minimum, to follow the policies and procedures of the organisation. We found a repeated pattern of significant departures from policy and procedure, particularly in the handling of grievances, conduct and serious incidents. We believe that the misuse of policies and failure to follow procedures placed vulnerable staff in difficult and, in some cases, almost impossible positions. We believe that, on some occasions, this led to unnecessary stress and, in a few cases, harm to individuals.

The culture of the organisation

4.39. The culture of an organisation is based on shared values and beliefs. These values and beliefs inform the way staff behave within the organisation and strongly influence people in how they interact with others and perform their jobs.

4.40. The culture is established by the leadership of an organisation – from the top and throughout the tiers of management to those working on the frontline. Every organisation develops and maintains a unique culture, providing guidelines and boundaries for the behaviour of the members of the organisation.

4.41. The development of a culture is particularly important when new organisations come into existence and can take time to establish, particularly where the new organisation is created from different organisations coming together.

4.42. Culture is based on trust, particularly trust in the leadership and trust in the goals of the organisation. Where trust is undermined, the confidence in the organisation can quickly disappear and the culture can become toxic.

4.43. We spoke to more than 30 staff members of Liverpool Community Health NHS Trust. We heard repeated accounts of a bullying culture, where staff were afraid to speak out in case they were victimised. When some staff did speak out, they were harassed and, in some cases, subject to disciplinary action, including suspension. Genuine fear was expressed in a series of emotionally charged interviews and we were left with no doubt that the culture of the organisation was detrimental to its operation and, in some cases, to the health and wellbeing of staff. In a number of interviews, reference was made to staff coming into work in the morning and seeing colleagues crying in the car park outside the Trust headquarters. This was described as "not an unusual sight".

4.44. Staff approached Trust patient safety and incident reviews with trepidation. They were often blamed for incidents where the lack of qualified workers, proper supervision or expertise was the root cause. Error was not approached in an open and proportionate way. Mechanisms for managing patient safety and poor quality were based on blaming individuals, while organisational shortcomings were ignored or glossed over. Reporting of errors was seen as a slight on the external image of the Trust. This led to under-reporting of problems. Where problems were identified, they were either not escalated or risk-rated lower that they should have been and often ignored. The problems at the prison came to light when the new management team placed prison healthcare at the highest level within its risk rating – despite internal opposition.

4.45. We have been presented with evidence that shows the Trust as an organisation where problems were not tackled and where staff were blamed for problems they did not directly cause. As a consequence, patients received sub-optimal care and staff became stressed and unable to work effectively.

4.46. The main driver and measure of success within the Trust was the achievement of financial targets. Managers were set savings targets, often without consultation, and expected to deliver. The impact of the savings on frontline services and patient care seems to have been secondary to meeting the financial targets required. Strict measurement of the progress of financial delivery was in place and an aggressive enforcement of delivery undertaken. This led to a culture based on fiscal delivery rather than patient care and consequentially managers were driven to reduce cost, irrespective of whether it was in the best interest of patients and staff. This, in turn, led to a conflict between frontline staff's desire to provide the best care possible with a need to reduce cost.

4.47. A good example is the Community Dentistry Directorate where an assessment by an external consultant indicated that costs in the service could be reduced by nearly 44%.[10] The findings were not discussed with the service but a CIP was introduced. When the service leaders baulked at the cost reduction proposals, they were ultimately suspended – without proper reasons given or a proper investigation undertaken. We subsequently heard that the cost reduction had been based on a comparison with high-street dentistry costs – if true, a wholly inappropriate measure due to the differences in complexity of the patients being treated, and one that could have been easily discounted if there had been proper engagement with the staff delivering the service.

4.48. The culture was one of not reporting failure and one where fiscal targets were seen as the primary measure of success. The goal was to place the Trust in a financial position where it could obtain FT status. Consideration of the impact on patients and staff was secondary.

4.49. In some services, the culture of the organisation was more problematic than others. The prison healthcare system ran with a level of autonomy that surprised and concerned us. The service was left in isolation and adopted a concerning hierarchical structure, with little regard to acceptable quality standards. Board minutes show little reference to the prison healthcare service. While it is fair to say that the Board was not formally made aware of all issues, this was clearly because it was not applying the level of scrutiny necessary to discharge its duties properly.

Conclusion

4.50. The organisational culture of the Trust was poor, reflecting the Trust leadership. Bullying of staff was prevalent, and staff worked in a climate of fear that discouraged them from speaking out about the problems they experienced and that was detrimental to their wellbeing. Incident reporting was discouraged and incidents downgraded. Staff were wrongly blamed for errors instead of incidents being learned from, to the detriment of staff and patient care.

External organisations

4.51. As required by our terms of reference, we also reviewed the role of external bodies in overseeing the organisation. Given the serious nature of the Trust failures we identified, we were particularly concerned to understand why there had not been earlier identification of the problems and intervention to ensure that they were corrected.

External organisations: summary of responsibilities

4.52. The external management and regulatory framework was, and remains, complex. During the period covered by the Review, organisational structures changed radically and responsibilities moved to new organisations. The responsibilities are summarised below.

4.53. PCTs were the commissioning bodies for NHS services in England between 2001 and 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Until 31 May 2011, they also provided community health services directly, at which time community health services were separated from the PCTs. In this case, the hived-off services formed the Community Trust. In addition to the commissioning of services, the PCT was responsible for ensuring effective use of resources and quality of care for the services they contracted. They worked in conjunction with the SHAs to oversee NHS Trusts who had not as yet become NHS Foundation Trusts.

4.54. In 2013, the SHAs responsibility for non-foundation NHS Trusts and PCTs transferred to the NHS TDA. The NHS TDA became responsible for overseeing the performance management and governance of NHS Trusts, including clinical quality, and managing their progress towards FT status.

4.55. In 2013, CCGs took on responsibility for the commissioning of services from PCTs. CCGs were also responsible for the performance management of the Trust, both in terms of delivery against their contracts and service provision.

4.56. Monitor was established in 2004 under the Health and Social Care (Community Health and Standards) Act 2003, which made it responsible for authorising, monitoring and regulating NHS Foundation Trusts. Together with NHS TDA and some services provided by other organisations, Monitor became part of NHS Improvement in 2016. NHS Improvement took on the assessment of NHS Trusts as they applied to become NHS Foundation Trusts.

4.57. NHS Improvement remains responsible for overseeing NHS Foundation Trusts and NHS Trusts, as well as independent providers that offer NHS-funded care. NHS Improvement supports providers in giving patients consistently safe, high- quality, compassionate care within local health systems that are financially sustainable.

4.58. The CQC, an independent regulator, is responsible for the registration of health and adult social care service providers in England and they inspect organisations to assess whether they are meeting the required standards or not.

4.59. NHSE leads the NHS in England. It sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care. In 2013, it became responsible for commissioning Prison Health.

4.60. All these organisations interacted with LCH during the Review period or subsequently. We reviewed documents and interviewed relevant staff of these external organisations to understand their interaction and to investigate whether they were aware of any concerns about the Trust prior to the whistleblowing that led to the CQC investigation.

4.61. PCTs: Following the publication of the *NHS Next Stage Review* in 2008, it became clear that transforming community services would be a crucial element of the planned way forward to PCTs becoming purely commissioning organisations. Key milestones were put in place which included a review of current structures and a further look at organisational options for community services – with one option being the creation of a Community NHS Trust. The expectation was that such organisations would join the FT pipeline in the same way as other NHS Trusts. In the case of Liverpool, the route chosen was for the creation of an NHS Trust. This was achieved in November 2010.

4.62. From the creation of the Trust until the creation of CCGs, the PCT was responsible for the commissioning of services for the newly formed Trust. The SHA was responsible for performance, and had responsibilities in overseeing quality and patient safety alongside CQC.

4.63. We heard that the relationship between the PCT and the Trust was characterised by tension and reluctance by the Trust to share information, both on performance against contract and on adverse incidents. While this is not unusual for a newly formed organisation, it does underline the immaturity of the new Trust. A more experienced leadership would have worked with the commissioners constructively, helping shape the future strategic direction of services.

4.64. The PCT was also winding up business and preparing to be disestablished. Attention on a newly formed Trust may not have been a priority, particularly given the perceived generous financial settlement under which it was established. However, closer scrutiny by the PCT would have revealed early warning of the nature of the Trust's plans and may have led to earlier challenge. We accept that the scrutiny of the Trust was not the sole responsibility of one PCT, but a lead commissioner should be expected to take a lead in such areas.

4.65. We accept that, in the early stages of the Trust's existence, there were few signs that would have given concern. However, two factors stand out: one, the disruption to normal practice caused by the reorganisation of the NHS; and second, the lack of performance data on which to assess community trusts. When this is added to reluctance by the Trust to share information, an inexperienced board and leadership, and an agenda based on FT status, a pattern emerges.

The lack of information coming from the Trust should have led to a higher level of scrutiny, particularly when coupled with the knowledge that this was a new and inexperienced leadership team – but it did not. There may be mitigating factors but, in our view, more should have been done to investigate the signs.

4.66. SHA: SHAs provided strategic leadership, ensuring the delivery of improvements in health and health services locally by PCTs and NHS Trusts. They led the development and empowerment of innovative and uniformly excellent frontline NHS organisations. As part of this role, SHAs oversaw the leadership of local organisations and were directly involved with the appointment of new boards.

4.67. The North West SHA had responsibility for oversight of the Trust from its creation in 2011 until the SHA's dissolution in 2013. It worked under the management of NHS North of England in the transition up to the dissolution of SHAs in 2013.

4.68. Despite our efforts, we have not been able to speak with senior former SHA officials about their involvement with the Trust. This is a matter of regret, as we had a number of lines of inquiry we would have liked to explore. Our views have been based on our assessment on documentary evidence, together with other interviewees' statements.

4.69. With the dissolution of the SHAs in 2013, transfer of responsibilities was supported by briefings on organisations and functions. A *Quality Overview Report* was produced by NHS North (North West) in January 2013 as part of the handover and process for supporting Liverpool Community Health NHS Trust's application to progress to become a FT. This was supplied to its successor organisation, NHS TDA.

4.70. The Executive Summary states:
"*The Medical Director and Chief Nurse at NHS North of England support the Trust's application. The Quality team in the North West have regularly monitored and reviewed the Trust and have no significant concerns regarding the Trust's quality processes, procedures and outcomes.*"[11]

4.71. The document is quite extensive, detailing the assurance process, including CQC input, Board Vision, Commissioning for Quality and Innovation (CQUIN), patient staff experience, performance against the *NHS North West Quality Report Card*, and evidence submitted by the Trust. From these various sources, no major concerns were raised within the report. The report highlights the importance of QIAs and says the Trust was carrying these out and reporting to its Board. There is no assessment by the SHA of the quality and accuracy of the QIAs, on the grounds that it was too soon to judge their effectiveness.

4.72. It is likely that, given this lack of concern, the newly responsible organisations (CCGs and NHS TDA) would not have regarded the Trust as needing particular attention as they came to terms with their new roles.

4.73. We were surprised that the potential risks of a newly formed organisation with such inexperienced leadership were not raised by the SHA in its handover material. This was particularly important given the transition to newly created organisations to take on the functions of the SHA. Although the assessment by the SHA looks comprehensive at first sight, we are concerned that, on greater scrutiny, it lacks any real insight into the Trust, consisting largely of a re-statement of the Trust's own views rather than an assessment by the SHA.

4.74. Based on what we heard, it seems to us that the Trust was seen as low-risk from the outset, and received little attention in comparison to perceived higher risks, especially in acute Trusts. There were sufficient signs at the time that should have prompted concern.

4.75. NHSE: The main interaction between NHSE and the Trust was over prison healthcare. In 2013 NHSE took on responsibility for commissioning prison healthcare from PCTs. Within their new responsibilities in the North West were services at Liverpool prison. We heard from NHSE of difficulties in getting basic performance information from the Trust. We also heard that the information provided by the outgoing PCT was limited.

4.76. In the first year, 2013/14 NHSE focused on renegotiating the prison healthcare contracts. In the case of HMP Liverpool, apart from financial data, they were provided with very little information. This was despite the best endeavours of NHSE to obtain further information. Consequently, NHSE had little information on which to establish the contract and little evidence of any particular concerns.

4.77. We heard from the former Governor of the prison that there had been some scrutiny by commissioners prior to the transfer of responsibilities to NHSE. There were joint meetings between the prison and commissioners, and commissioners were visible on site. After the transfer, it was noted that the capacity to oversee the contract was significantly reduced, with NHSE staff taking on responsibility for more prisons.

4.78. The picture presented to us has been one of limited scrutiny by commissioners, deteriorating further following the transfer of responsibility in 2013 to NHSE. Performance information was sparse, and what was available was hard to obtain from the Trust. In our view, the level of scrutiny was inadequate and this enabled the Trust to provide inadequate standards of care without this being identified and rectified by the commissioners.

4.79. We were also told that, once problems had come to light, a close personal relationship was identified between one of the commissioning staff and a member of LCH staff managing the service. NHSE was sufficiently concerned about the potential conflict of interest that they moved the staff member away from the contract as they sought to establish how problems in the delivery of prison healthcare had arisen. This raises further concerns in our view as to why problems in the service were not identified and acted upon.

4.80. Monitor: This organisation was established in 2004 under the Health and Social Care (Community Health and Standards) Act 2003, which made it responsible for authorising, monitoring and regulating NHS Foundation Trusts. It has other functions, but this was its key responsibility in relation to LCH and the Review.

4.81. We were informed by a number of interviewees that LCH had been part of a pilot scheme for community health NHS trusts that were considered capable of rapid progression to become FTs. This scheme placed a focus on early assessment of the clinical quality of services in trusts, rather than initial assessment based mainly on financial robustness, only to find later that clinical standards had not been maintained. This early assessment of LCH gave the Trust a low rating for clinical quality, such that it was judged unsuitable to proceed to FT status. This is consistent with the clinical quality issues that were subsequently identified.

4.82. Given that Monitor had assessed the Trust as not ready to become a FT, we asked interviewees whether any of the concerns had been shared with NHS TDA or the commissioners. Interviewees were unable to confirm that concerns had been shared, and it appears to us more likely that they were not.

4.83. We believe that Monitor undertook its assessments well and highlighted key problems within the Trust's plans, governance, clinical quality and board. This is commendable. However, the vital intelligence they had gained from their assessment work as part of the FT process was either not shared or, if shared, was not acted upon. This was a missed opportunity that could have provided a chance for earlier identification of the Trust's problems.

4.84. NHS TDA: The NHS TDA was responsible for overseeing the performance management and governance of NHS Trusts, including clinical quality, and managing their progress towards FT status. Its formation came as a result of reorganisation of the NHS in England outlined in the Health and Social Care Act 2012. It is now part of NHS Improvement.

4.85. From the abolition of the SHAs to the creation of NHS Improvement, the NHS TDA was responsible for the performance management and overseeing of the Trust's journey to FT. As such, it would have been responsible for assessing the quality of clinical services within the Trust.

4.86. We discussed Liverpool Community Health NHS Trust with both representatives from the regional team and from the national team.

4.87. We interviewed staff who had previously been part of the TDA. We heard repeated reference to elements of the picture being the responsibility of another part of the organisation. We gained a clear impression of silo working and poor sharing of concerns and critical information, including between regional teams and the centre. Part of this can be attributed to the newness of the organisation, but it is disappointing to see that, by keeping information in different parts of the organisation, opportunities were clearly missed.

4.88. The regional team reported that the Board-to-Board scrutiny had raised concerns about the operation of the Trust Board. NHS TDA officials confirmed to us that NHS TDA was aware of the financial plans of the Trust. It had also asked for confirmation that CIPs were supported by QIAs and that this had been received. Sign-off by Medical and Nursing Directors at the Trust had been confirmed, as had presentation to the Board. However, due to the newness of the NHS TDA organisation and the resulting sparseness of staff, the detail of the plans had not been scrutinised. The Trust was not seen as requiring special attention and its assurances were taken on face value.

4.89. Closer scrutiny of the CIPs and QIAs would, in our view, have raised serious questions about their validity. The level of CIPs and the expectations for delivery were substantial and, while some QIAs had been done, they had not been done well and had, in some cases, been signed-off without the knowledge or participation of clinicians delivering the services.

4.90. We heard that, in its first year of existence, there was limited capacity within NHS TDA to undertake detailed assessments – particularly of trusts where no indication of serious concerns had been raised. As a result, the confirmation by the Trust that all was in place with regard to QIAs was taken at face value and further investigation was not undertaken.

4.91. Had further scrutiny been undertaken, we believe that significant issues would have been uncovered about the validity of the QIAs and of the deliverability of the CIPs. At the very least this should have led to greater challenge and scrutiny of the plans and working of the Trust. If this had happened we believe that earlier serious problems would have been identified and intervention could have happened earlier.

4.92. We spoke to both the Medical Director and Nurse Director of the NHS TDA at the time. The Medical Director described her functions as including joint overall responsibility with the Nurse Director, Peter Blythin, for patient safety/quality. For practical reasons, Peter Blythin had line management responsibility for the TDA's regional non-medical clinical quality team. Oversight of quality and safety remained a joint responsibility.

4.93. Peter Blythin, described a comprehensive process by which trusts were assessed in preparation for moving to FT status. We were impressed with the detail of the process the TDA had used to assess trusts. We heard how, in November/December 2012, he raised questions about their workforce plans, seeking further information through the Deaneries and from the Trust via the SHA. These questions were still live in January 2013. Mr Blythin was concerned about the predicted reduction of more than 500 staff within the Trust that were mainly clinical and wanted to understand what the reasons for this were and how services would be delivered. His concerns led to the Trust's assessment by the technical committee at the TDA being postponed.

4.94. We heard that this was followed up by multiple organisations, partly due to the transitional arrangements and the transfer of responsibilities consequent upon reorganisation. The SHA undertook a quality assessment and further assessment was carried out with the commissioning organisations. This apparently led to the NHS TDA being satisfied about their concerns, and the Board-to-Board meeting was rescheduled.

4.95. We were not able to ascertain what precisely had changed the view of the NHS TDA, but something did, turning a red flag to green. With the benefit of hindsight, however, it is very clear that something was missed by NHS TDA: they believed the quality issues were resolved. This was a missed opportunity to identify the serious underlying problems in the Trust and its services.

4.96. When we asked why this opportunity was missed, we received no convincing answer, although there was a clear acceptance by NHS TDA officials that they had missed something. We heard of the confusion of transition over roles and who was doing what, and that there were "too many players on the pitch", with SHAs, NHS TDA, CQC, and NHSE, all either finding their places in the new arrangements or relinquishing responsibilities prior to abolition. In the interim, it would seem that organisations were reliant on others to provide information and 'soft intelligence', and this was not always shared or reached the right part of the new organisations. We heard that there was an element of each organisation taking

others' lack of concern as reassurance that all was well, and that, given limited capacity, priority was given to known problems. Over time these difficulties led to an expansion in resources available to the NHS TDA in response to the problems coming to light in the organisations they were overseeing.

4.97. We believe that there were sufficient issues to alert NHS TDA to potential problems within the Trust. Some were identified, such as workforce, challenging CIPs and the need for robust QIAs. However, somewhere in the churn of a new organisation being developed, and for reasons we have not been able to ascertain, the concerns were deemed insufficient to intervene or to halt progress was allowed to continue towards FT status.

4.98. We can understand how, at the beginning of the NHS TDA's life, this could have happened, with more than 100 organisations required scrutiny by the TDA and limited capacity at the beginning. However, we note that, even after the CQC investigations and the introduction of the new management team under Sue Page, the FT application continued to be progressed. It was eventually pulled when Sue Page advised the Trust Board that it should withdraw from the process.

4.99. CQC: The role of the CQC as an independent regulator is to register health and adult social care service providers in England and to inspect whether or not standards are being met. Since October 2014, a new inspection model has been used by the CQC.

4.100. In assessing the interactions between CQC and the Trust, we have been provided with documentation, including a timeline sequencing CQC interactions with the Trust in general and with Intermediate Care and with HMP Liverpool healthcare services. We have also spoken with members of CQC and other regulators. We have found some differences with the timeline described by Capsticks, although these differences do not materially change the events. We have based our understanding of the sequence of events on the information provided by CQC as a primary source of evidence.[12]

4.101. The first interaction between CQC and Liverpool Community Health NHS Trust was in 2010 when the Trust was registered by CQC.

4.102. On 31 May 2013, an inspection was carried out of Ward 35A at Aintree University Hospital NHS Foundation Trust under the compliance methodology. The service was found to be compliant. A further inspection against compliance was carried out into the Trust's intermediate care services at the Alexandra Wing at Broadgreen Hospital on 28 August 2013, following the Trust alerting CQC to concerns on bed base. This led to an assessment of non-compliance in two outcomes: management of medicines; and supporting workers.

4.103. In 2013, CQC were contacted by Rosie Cooper MP, who passed on her concerns over the number and nature of reports of staff bullying and harassment that she had received. Staff at the Trust were contacted by CQC on 29 October 2013, and reported significant concerns, regarding not only bullying and harassment, but also Trust leaders' approach to management and leadership.

4.104. CQC instituted a responsive inspection of two locations: the Trust HQ; and Ward 35A intermediate care service at Aintree. This took place on 28 and 29 November 2013 and 2 December 2013. As a result, the CQC identified a series of problems within the Trust:

- an overarching oppressive culture with reports of intimidation and bullying;
- increased acuity of patients and the lack of clear admission criteria in Intensive Care Units;
- high sickness absence and turnover in Intensive Care Units;
- poor staff survey results in community services;
- medicine management concerns on Ward 35A;
- lack of effective clinical supervision and appraisals;
- poor quality of support to district nursing service;
- community equipment not accessible in a timely manner; and
- poor governance.

4.105. The report also led to significant regulatory action. Four items required action on Ward 35A, two of which led to warning notices being served. Five required action Trust-wide, including two where warning notices were served.

4.106. A comprehensive Inspection took place in May 2014 against the five domains introduced by CQC that required services to be safe, effective, caring, responsive and well led. The report, published in August 2014, assessed services against four of these as "requires improvement", with only caring being assessed as "good". In addition, the Trust was still bound by two previous required improvement actions relating to staffing levels and support to staff.

4.107. In February 2013, a document internal to the Trust, entitled *Intermediate Care Incident Report*, had highlighted serious concerns within intermediate care, warranting a systematic review of the service. Although it was not shared with the CQC, it is hard to reconcile the inspection results 14 months later with the picture set out in this report. We believe that this inconsistency illustrates significant flaws in the process being used at the time by CQC, which appears to have relied heavily on prior notification of a problem before being able to identify major concerns.

4.108. Alongside CQC's involvement with the main community trust services, there was also regulatory scrutiny of the prison health service at HMP Liverpool. Between 14 and 25 October 2013, HM Inspectorate of Prisons undertook an inspection of HMP Liverpool. The report covers all aspects of prison service, but makes specific reference to healthcare provision:

"The majority of prisoners received appropriate healthcare support prior to release. Discharge planning was subject to clinical audit and the care programme approach (mental health services for individuals diagnosed with a mental illness) was being used for 50 to 60 patients at any one time, which was significant. Case management and communication with community services were good.

The gold standard framework in end-of-life care, promoted by the National Gold Standards Framework Centre, a training and coordinating centre, had been adopted and planning was underway to create a palliative care suite within the inpatient unit."[13]

4.109. This conclusion is at variance with the CQC inspection under its compliance methodology. CQC found the healthcare non-compliant with four regulations. The impact of non-compliance was deemed moderate and compliance actions were set.

4.110. A follow-up inspection was undertaken to review progress in March 2014, which found the service to be fully compliant with regulations.

4.111. When the interim Chief Executive commenced at the Trust, however, further information was forwarded to CQC about the operation of the service, and a CQC responsive inspection was undertaken in November 2014. This found the service non-compliant with four regulations, one of which, management of medicines, was described as having "major impact".

4.112. We found it impossible to understand how such different conclusions could be reached about the same service over such a short period. It is clear from subsequent events that there were significant shortcomings in the prison healthcare service that should have been consistently evident. Such inconsistency and variation damages confidence in the inspection regime and, we believe, raise significant questions over the effectiveness of the inspection regimes at the time.

4.113. Of equal concern is the lack of alignment between the HM Inspectorate of Prisons findings on healthcare and those of the CQC. Again in the light of subsequent events, it is clear that the favourable assessment of healthcare made by HM Inspectorate of Prisons was inaccurate. It seems to us that there is considerable benefit in coordinating inspections, as is now preferred practice, not only to avoid misalignment between findings but also so that each inspectorate can bring its own expertise and perspective to bear in a single assessment.

4.114. We do, however, recognise the work undertaken by the CQC once they had identified the serious issues in the Trust. The work with the new executive team was described as "positive and constructive" by both sides and illustrates that support following intervention can be effective when parties fully commit to improvement. The work across agencies, through Risk Summits, routine performance management and direct discussions and help by Sue Page and her team was, we believe, good and demonstrated the changes that have taken place in the CQC.

Conclusion

4.115. During the period covered by our terms of reference, there was significant change underway in the NHS and in regulatory systems. This impacted significantly on the ability to detect developing problems in the Trust and its service provision through external scrutiny. Reconfigured organisations were busy coming to terms with new roles, and had to prioritise their time and attention to established evident problem areas. Lines of communication took time to establish, and handovers were not necessarily seen as important. We conclude that this contributed to the delay in identifying that Liverpool Community Health was an NHS Trust in difficulty.

4.116. Nevertheless, there were warning signs that should have prompted further investigation, but scrutiny by commissioners was limited, including PCTs, CCGs and NHSE (for prison healthcare), and the opportunity was missed. The SHA did not identify the Trust as a priority for attention, and its assessments were lacklustre.

4.117. The NHS TDA was a new part of the changing landscape of NHS oversight, initially reliant on limited local assessments by others, but it was nevertheless able to pick up signs of concern. For reasons that we have been unable to determine, however, its assessment subsequently changed and another opportunity was lost.

4.118. Prior to the intervention by Rosie Cooper MP, it seems clear that the CQC had failed to reach a conclusion that there were systemic problems at the Trust, despite finding some elements of concern and the serious nature of the underlying problems. Although regulatory infractions were found, actions required and then assessed, we do not believe there was any recognition of the true extent and nature of the problems.

4.119. During 2013, the CQC re-examined its approach to regulation and concluded that significant change needed to be made, moving from compliance and registration to a "*new, strong, independent, expert inspectorate whose evidence based, professional judgements are welcomed and instructive."*[14] We believe that the CQC are now in a much better position to find and challenge unsafe care and poor standards.

4.120. All of these organisations, whether commissioners, regulators or oversight bodies, had sufficient indication of the problems in the Trust to prompt a more complete examination of its services. Had this happened, we now know that they would have found ample evidence to intervene to correct the serious problems that had developed. Earlier intervention would have reduced the avoidable harm that occurred to patients, and to staff, across the Trust's services.

SUBSEQUENT EVENTS AT THE TRUST

5.1. Our terms of reference covered the period from November 2010 to December 2014. While the subsequent events that have affected the Trust are therefore not covered by our terms of reference, it would be remiss of me not to refer to them and I have explained to NHS Improvement why I consider this is necessary.

5.2. Publication of the CQC report following its inspection of the Trust in late 2013 generated a significant reaction across partner organisations. NHS Improvement introduced a number of changes, initially aimed at providing immediate short-term stability and improving leadership within the Trust. This commenced with the removal, initially on secondment but subsequently permanently, of the Trust Chief Executive Bernie Cuthel. An interim Chief Executive, Sue Page, was appointed with a small Executive Team. Alongside this, a longer-term reconfiguration of services was initiated that would culminate in the abolition of Liverpool Community Health NHS Trust and the distribution of its services between other providers.

5.3. The great majority of staff told us that they had welcomed the change in management of the Trust. They felt that their concerns were listened to by the interim leadership team, and their views on stabilising the deterioration of services sought. This feeling of optimism did not, however, extend to the break-up of community services among other providers, and we heard repeated concerns that service fragmentation would jeopardise the hard-won recent reversal in declining standards and threaten continuity of care. Fragmentation is a risk of any service reconfiguration of this nature, but is particularly significant here, given the damage that has been caused by previous events. Consequently. it is important that steps be taken to mitigate the risk.

5.4. An additional element of concern was strongly expressed by a number of staff. As we have set out, one of the particular features of the events at the Trust was the extent of a bullying culture among some senior Trust staff and middle managers. This was addressed by bringing in new leadership but, as is very often the case, those managers who had been the subject of complaint often moved to other posts. In the case of middle managers, these were often in nearby trusts providing similar services. By their nature, these are the very organisations assuming responsibility for the broken-up services and their staff, raising the deeply unappealing prospect of staff whose allegations of bullying had been upheld finding themselves working once again for the managers concerned but now in a new organisation.

5.5. During the response to the 2013 CQC report, changes were initially made piecemeal. Although Mrs Page was able to bring in some new individuals to work as part of the executive team, the previous Chair, Frances Molloy, and her non-Executives were left in situ. We were consistently told, however, that there had been a strong working relationship between Frances Molloy and Bernie Cuthel, and that the decision to retain all of the Trust's non-Executive Directors until their terms of office expired created an additional layer of challenge for the interim executive Team and sent mixed messages to Trust staff about where responsibility for the Trust's failings lay.

5.6. The interim management team faced great difficulty in assessing the situation at the Trust and in establishing new and more appropriate ways of working. As well as the difficult task of establishing baselines, obtaining accurate reports and data, evaluating risks, engaging staff, representatives and stakeholders, introducing best practice and persuading the Trust Board to investigate incidents and take corrective action, they were operating in a hostile and unreceptive environment with the existing Chair and non-Executive Directors. This situation did not get any better until the appointment of Trevor Lake, an experienced non-Executive Director, as interim Chair when Frances Molloy's period in office ended.

5.7. As a result of the protracted negotiations to reallocate the Trust's services through contractual discussions – including the delays caused by the initial decision to transfer some services to Bridgewater Community Healthcare NHS Foundation Trust that was subsequently deemed an unsuitable provider for the LCH functions – the interim Executive Team was in situ for significantly longer than initially anticipated and, during its tenure, the Trust had four consecutive Acting Directors of Nursing. This can only have increased uncertainty for the nursing professionals in the Trust as well as for those in partner organisations responsible for developing effective working relationships with the Trust's Executive Team.

5.8. While the Board's decision to extricate the Trust from the delivery of prison healthcare was based on a sound rationale – notably its inability to deliver the standard of healthcare prisoners required – we heard from the senior leadership team at HMP Liverpool that the frequency of change of provider and continued difficulties in meeting contractual requirements, were matters of concern that it had raised with NHSE, the commissioners of prison healthcare.

5.9. Liverpool Community Health NHS Trust endured a turbulent short life and we were not persuaded that it had been provided with sufficient leadership support, by the former North West SHA, the former NHS TDA and later NHS Improvement to enable it to develop and deliver a strategic and clinical plan to deliver effective and efficient community health services over a sustained period. When new and more effective leadership was put in place in the Trust, the decision appears to have already been taken that the Trust would be dissolved.

RECOMMENDATIONS

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

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

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

6.4. Regulators and oversight organisations should ensure that, during both local and national reorganisations and reconfigurations, performance and other service information is properly recorded and communicated to successor organisations. Action: Care Quality Commission, NHS Improvement, NHS England.

6.5. The Department of Health should review the working of the Care Quality Commission fit and proper person's test, to ensure that concerns over the capability and conduct of NHS executive and non-Executive Directors are definitively resolved and the outcome reflected in future appointments. Action: Department of Health.

6.6. Organisations taking on former Liverpool Community Health NHS Trust (LCH) services should review the handling of previous serious incidents to ensure they have been properly investigated and lessons learned. Action: Trusts providing former LCH services.

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

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

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

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