# Kirkup Review into Liverpool Community Health

## Background to the review

The independent review was commissioned by NHS Improvement (NHSI) following concerns raised about care delivered at Liverpool Community Health NHS Trust (LCH) during November 2010 to December 2014. The findings of a Care Quality Commission (CQC) inspection at the trust in late 2013 identified a range of issues at the trust that required an immediate response to system failings identified.

Following publication of the CQC inspection report, NHSI oversaw a number of changes to executive directors at the trust. The trust board commissioned a quality, safety and management assurance review, carried out by Capsticks Solicitors LLP. The report raised concerns about the quality of the healthcare being provided to patients in the community and in HMP Liverpool and about the management culture of the trust and practices demonstrated by senior managers.

## The review findings

The review found that the trust experienced significant failings in care quality, including an inexperienced management and director team. The review found that the trust was focussed on its pursuit of Foundation Trust (FT) status and achieving very significant cost savings required by its commissioners. As a result of drastic cost improvement measures, the trust reduced staff numbers and the management lead for clinical quality was unclear.

The review also examined the role of the external bodies responsible for overseeing the trust. The report highlights that during the period covered by the review, organisational structures changed radically and responsibilities moved to new organisations. In 2013, clinical commissioning groups (CCGs) took on responsibility for the commissioning of services and performance management from primary care trusts (PCTs). In the same year, the strategic health authorities' (SHAs) responsibility for non-foundation trusts and PCTs transferred to the NHS Trust Development Authority (NHS TDA). In 2013, NHS England became responsible for commissioning prison health services. At the time, Monitor played a central role in authorising, monitoring and regulating NHS Foundation Trusts (FTs) and the CQC was responsible for inspecting that standards were being met.

The report suggests that all these organisations had insufficient indication of the problems in the trust to prompt a more complete examination of its services, and earlier intervention would have reduced the avoidable harm that occurred.

## Recommendations

While the review examined LCH specifically, its recommendations are likely to impact on the sector as a whole, including the role of the national bodies. These recommendations include:

- In approving trust board appointments, NHSI 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.
- 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.
- 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.
- The Department of Health and Social Care 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 Ministerial statement to the House of Commons 8 February 2018

## Next steps

Stephen Barclay MP, Minister of State, Department of Health and Social Care (DHSC) made a statement on the independent review on 8 February 2018 and stated that the government accept the recommendations in full. The DHSC will also:

- Write to all the organisations named in the recommendations, asking them to confirm what steps they will take to implement the recommendations, or to set out their reasons for not doing so.
- Discuss the terms of the review of the fit and proper person's test with the Rosie Cooper MP and appoint someone to undertake that review "within the coming days". The Minister suggested the review will need to address the operation and purpose of the fit and proper test, including but not limited to: where an individual moves to the NHS in another part of the United Kingdom; where they leave but subsequently provide healthcare services to the NHS from another healthcare role, such as with a charity or a healthcare company; where differing levels of professional regulation apply, such as a chief executive who is a clinician compared to one who is a non-clinician; where there is a failure to co-operate with a review of this nature and what the consequences of that should be; and reviewing the effectiveness of such investigations themselves when they are conducted.
- Review the effectiveness of sanctions where records go missing in a trust, or where records appear to have been destroyed.
- Advise on what disciplinary action could be taken against individuals in relation to the findings of the review.

- Ask NHS Improvement and NHS England to clarify the circumstances under which roles were found or facilitated for individuals identified in the report as bearing some responsibility for the issues at the trust.

## NHS Providers view

NHS Providers will be engaging in the above next steps and implementation of the recommendations. We will be seeking to understand the implications this report and its recommendations will have on the regulation and oversight of NHS trusts and foundation trusts, as well as working closely with the Department of Health and Social Care on its review of the fit and proper persons test. We have already had in depth discussions with a number of member trusts, CQC and NHSI about how the fit and proper persons test is applied and how trusts respond to concerns raised.

It is essential that DHSC and the national bodies take a balanced approach, mitigating the risk of another case of systemic care quality failings with proportionate and risk-based regulation.

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