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INVESTIGATIONS – REVIEWS – INQUIRIES

An independent review of governance at Liverpool Women's NHS Foundation Trust

A report for
Liverpool Women's NHS Foundation Trust

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1. Introduction

1.1 This report provides an independent review of the clinical and corporate governance arrangements in the gynaecology directorate of Liverpool Women's NHS Foundation Trust, including the Aintree Centre for Women's Health. It also addresses corporate and clinical governance arrangements in the trust generally.

1.2 The board of the trust commissioned the review as part of its response to a serious incident in the urogynaecology service.

1.3 The trust was formed in 1995 as Liverpool Women's Hospital NHS Trust, when all services for women and babies from three former sites (Liverpool Maternity, Liverpool Women's, and Mill Road hospital) combined at the new premises of Liverpool Women's Hospital at Crown Street, Toxteth.

1.4 In December 2000, the trust took on the responsibility for Aintree Centre for Women's Health, formerly part of the University Hospital NHS Trust, Aintree (AUH), providing services to women in north Liverpool and surrounding areas.

1.5 The Liverpool Women's NHS Trust became an NHS Foundation Trust in April 2005, one of the first wave of new trusts with more stringent governance allied to greater financial and corporate independence. The trust accounts to Monitor, the Foundation Trust regulator, and to local people through its membership and governors.

1.6 The trust employs 1450 staff and has an annual turnover of over £85 million. It provides a range of acute hospital care for women and babies in its area and specialised services to women on a regional basis.

1.7 The latest (2007/8) Healthcare Commission rating of the trust is that it provides "good" quality services and "excellent" financial management. It achieved the best possible risk rating of 5 from Monitor and the highest level 3 ratings for risk management from the NHS Litigation Authority.

1.8 The trust delivers services from two main hospital sites: Liverpool Women's Hospital at Crown Street and Aintree Centre for Women's Health seven miles away on the

site of University Hospital, Aintree. It also provides services from a number of community-based facilities, including Tower Hill and Manor Farm primary care resource centres.

1.9 The trust is in the strategic health authority (SHA) area of NHS North West. It is technically independent of the SHA but contributes to formal and informal networks of NHS organisations in the north-west of England.

1.10 Liverpool Primary Care Trust manages the NHS budget for the health care of local people. It is the main funder and commissioner of services from the trust, although the trust also provides services to women living in other PCT areas, principally Sefton and Knowsley, and to patients from farther afield who require specialised services.

1.11 Gynaecology services are provided to women living in Liverpool and the surrounding area, mainly from Liverpool Women's Hospital at Crown Street and the Aintree Centre for Women's Health. The gynaecology service was managed as one of six clinical directorates in the trust until this year; it is now planned to become part of one of four new clinical business units.

1.12 In December 2007, the trust board was formally notified of senior managers' serious concerns about the practice of a consultant working in the urogynaecology service at Aintree Centre for Women's Health. The consultant ceased working, by agreement, early in 2008. The trust sought advice from the National Clinical Assessment Service and the Royal College of Obstetricians and Gynaecologists. It reported concerns about his practice to the General Medical Council, the strategic health authority, the Healthcare Commission, Monitor and other relevant agencies.

1.13 The trust took steps to review the consultant's practice and address the problem this posed. These included establishing a clinical incident review team to investigate the matter internally, asking internal consultant medical staff and a recently retired consultant and then external assessors to review the treatment of a large number of patients over a period of years. In January 2009, Liverpool PCT agreed to arrange for local GPs to review the care of the consultant's patients between 2001 and 2004 and this began in April. The trust made a public statement in April 2009 about the recall of some of the consultant's patients.

1.14 The trust also commissioned this independent review of governance in three parts: covering services at Aintree Centre for Women's Health, the gynaecology directorate and governance of the trust as a whole.

1.15 The review was carried out between October 2008 and April 2009 when a large number of documents were considered - covering the period 2001-2009 - and interviews were held with a range of trust staff and others. This report describes the situation and analyses the issues as at April 2009. Some of the issues were discussed with members of the trust's executive during and after the review. Any changes that have taken place within the trust since April 2009 and any actions taken by the trust in response to the review can be reported by the trust in an action plan that can be read alongside this report.

1.16 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Ed Marsden, managing director of Verita, Hilary Scott and Martin Hawkins, associates with Verita, carried out this review. All three have wide experience of managing health services and conducting reviews and investigations.

2. Terms of reference

2.1 This independent review (the review) was commissioned by Liverpool Women's NHS Foundation Trust.

2.2 Our findings are set out in two main sections. In the first, we consider the past and current governance of the gynaecology directorate and its relationships within the trust. We then consider more specifically the past and current services at Aintree Centre for Women's Health, and summarise the events and governance findings related to the consultant involved in the serious incident in the urogynaecology service. In the second section we examine the trust's governance in terms of both its policy and practice since Liverpool Women's NHS Foundation Trust was formed in 2005.

2.3 The original purpose of the review was threefold: to establish the circumstances and events that led to the trust's initial investigation into the urogynaecology service and to this review of governance; to consider the appropriateness of the current corporate and clinical governance arrangements for services at Aintree Centre for Women's Health; to provide assurance to the trust about its corporate and clinical governance. The terms of reference originally set for the review were:

- To consider the current clinical and corporate governance of services provided at Aintree Centre for Women's Health and, in this context, the safety of those services.

- To provide a comprehensive chronology of the circumstances and events that led to concerns within the trust about the performance of a consultant (consultant X) working within the urogynaecological service.

- To review the corporate and clinical governance arrangements across the trust as a whole (the scope and focus of some of this part of the review, and the completion date, to be confirmed with the chief executive).

2.4 Appendix A sets out the detailed requirements within each of the three original terms of reference.

2.5 After the review began we spoke with the chief executive and the director of nursing about the part of the review concerned particularly with consultant X's work. The trust had established a clinical incident review project team to help it make a comprehensive response to the concerns raised by consultant X's practice. The clinical incident review comprised several strands of work including the work commissioned from Verita. It was agreed the Verita review would focus on producing a review of governance in gynaecology services. This would include a chronology of governance relating to the issues concerning consultant X, but would as far as possible rely on and not duplicate other work being managed by the clinical incident review group and its project manager. At the request of the trust, we have not interviewed consultant X.

2.6 We conducted the work in a manner agreed with the trust, including notifying the chief executive of matters of concern as it progressed.

2.7 We have provided regular updates to the trust - meeting with the chief executive and with other directors in March 2009 and on other occasions - and have advised the project manager of the clinical incident review of progress.

2.8 This report and its recommendations fulfil the requirement to report by the end of March 2009 (extended by agreement with the chief executive). It identifies a number of issues that could be pursued on a timescale and in a manner decided by the trust.

2.9 This review is not part of any disciplinary process.

3. Executive summary and recommendations

3.1 This report provides an independent review of the clinical and corporate governance arrangements in the gynaecology directorate of Liverpool Women's NHS Foundation Trust, including the Aintree Centre for Women's Health. It also addresses corporate and clinical governance arrangements in the trust generally.

Background and purpose

3.2 In December 2007, the trust board was formally notified of senior managers' serious concerns about the practice of a consultant working in the urogynaecology service at Aintree Centre for Women's Health. The concerns were to do with the interpretation of test results and selection of treatment for some patients. This review of governance was commissioned as one component of the trust's response to these concerns.

3.3 The purpose of the review is to consider the appropriateness of the current corporate and clinical governance arrangements for services at Aintree Centre for Women's Health and to provide assurance to the trust about its corporate and clinical governance. The review is not part of any disciplinary process.

Methodology

3.4 The review compares practice at LWH with standards drawn from published governance guidance. In conducting any governance review, we examine some or all of seven aspects of corporate and clinical governance which represent benchmarks for good governance. They are:

Benchmark one: organisational purpose, board roles and business structure
Benchmark two: performance analysis and assessment
Benchmark three: assurance and risk
Benchmark four: organisational development
Benchmark five: partnership working
Benchmark six: public accountability
Benchmark seven: adapting to change

The benchmarks are described in full in appendix E.

3.5 The review was undertaken in private. It comprised interviews and discussions with more than 40 people and an examination of all available relevant documentation. We considered reports about the trust and its services by a range of auditors and external regulators, including Monitor, the Care Quality Commission, and the NHS Litigation Authority. We also considered reports by the Royal College of Obstetricians and Gynaecologists, by a clinical consultant employed to review patients' cases, and by the project manager employed to coordinate the internal investigation of the serious untoward incident in respect of the urogynaecology service provided by the consultant at the Aintree Centre for Women's Health.

Conclusions

3.6 We concluded that Liverpool Women's governance arrangements are generally strong. A clear commitment to excellent service is shared and understood at all levels in the organisation. There is a particularly strong unity of purpose among board members and senior managers and clinicians. The trust has kept its governance arrangements under review, scrutinising the reports of regulators and acting upon them, and commissioning other support where it believed its practice fell short.

3.7 However, governance arrangements in some areas should be improved. The gynaecology directorate has the same sound governance policies as the rest of the trust and many operate satisfactorily. In some important areas, however, they could be applied more consistently and to better effect. For example information about services is not collated and analysed so as to direct managers' attention to areas of concern. Financial and activity information is not coupled with outcome data to provide a rounded picture of the impact of services on patients' experiences.

3.8 Furthermore, some essential clinical governance arrangements are missing from some services. Not every service takes a multi-disciplinary team approach to managing complex cases, nor collects and considers clinical outcome information, nor gives appropriate priority to clinical audit. These are deficiencies which the trust must address.

3.9 The trust employs some consultants who have completed sub-specialty training programmes and some who have not. There is no clear understanding of the implications this could or should have for caseload.

3.10 The trust is clearly committed to effective appraisal for all its staff and mandatory training. There is evidence that more staff are involved in appraisals and training which help them do their best work, but the picture across the trust varies and this represents a risk to services.

3.11 There are gaps in governance arrangements which mean that the trust cannot detect 'weak signals' about areas of risk, and which would take it beyond 'serious incident' and 'near miss' to early detection and intervention when problems emerge.

3.12 The strategy for the gynaecology service does not support the delivery of a consistent and high level of service. There are legitimate differences in women's experience of care at Crown Street, ACWH and the community clinics. There are also unjustifiable differences. The strategy should assure a one-service, multi-site model of care.

3.13 There are two particular problems which compromise governance arrangements for services delivered from ACWH. First, although there has been significant capital investment there is no widespread understanding about the part the services now located at ACWH will play in the trust's plans. Second, the trust's work to address the cultural divide between the staff working at ACWH and at Crown Street has been only partly successful. There are also operational problems of long standing which compromise service quality. The trust is working to deal with these problems.

3.14 The board's recently revised committee structure and operating methods are a sound response to the deficiencies identified in successive studies commissioned from auditors and independent reviewers. The action plan and review mechanism it has decided on are also sound.

3.15 The trust's organisation development work focuses on the individual's capacity to do their best work. A broader-based organisation development strategy would give necessary attention to developing systems (including IT systems and ways of ensuring effective action is taken when services defects are reported) which also support staff in their work.

3.16 The trust's work with patients and members of the public in developing services has focused on the work of the council of governors, and patient exit cards introduced in

2007. These have been well received and could provide the basis for a strategy which will engage women in work to develop services.

3.17 Staff at all levels in the trust have worked to develop clinical, operational and strategic relationships with its external partners. An explicit partnership strategy would help ensure that both formal and informal partnerships bring the greatest benefit for patients. A more effective relationship with Liverpool PCT, in particular, would help assure effective clinical pathways for all patients cared for by the trust and its partners in primary care. We acknowledge that all parties to a relationship must invest in that relationship.

3.18 The trust will greatly reduce the risk that recent events will recur if it assures effective analysis of activity and financial information and data about clinical outcomes, constructive challenge to practices that lie outside the norm, and ensures that modern approaches to clinical management (including multi-disciplinary team work and case audit) operate in all its services. It will respond more effectively to serious incidents if it reviews the threshold for initiating its serious untoward incident process and ensures it is applied in all cases.

3.19 We were asked to consider whether the trust's governance arrangements were such that patients could expect a 'safe service'. A review of this type could not cover the full range and complexity of practices, systems and measures that make up a 'safe service'. The gaps and inconsistencies we found in the way governance arrangements operate day to day may lead the trust to conclude that it should look closely at this in some or all of its services. This would provide the board with assurance that all its patients receive a 'safe service'.

Recommendations

3.20 We make recommendations under four headings:

- Strategic development of the gynaecology service
- Strengthening governance arrangements
- Organisation development

- Operational management at ACWH

Strategic development of the gynaecology service

R1 We recommend that the trust reviews its strategic plan for the gynaecology service. The resulting strategic plan, which should be based on the work already done on demand for service, and on discussion with Liverpool and Sefton PCTs, must:

- describe the trust's intentions for services delivered from Crown Street and ACWH, and for any expansion of community-based services

- provide a sound basis for operational plans which support a single, coherent service that is delivered from several sites.

Strengthening governance arrangements

R2 We recommend that the trust takes steps to ensure that:

- its governance polices are applied in practice

- the very good practice evident in some of the trust's services are taken up by all services

- information about services is collected, collated and considered in a way which tells the trust about the volume and quality of its services and provides early warning of potential problems

- and that all these components of effective governance arrangements are connected.

We recommend in particular that the trust:

Governance policy and practice

R2a Includes comparisons between governance policy and practice as part of its clinical and internal audit cycles.

R2b Designs and implements a system for reporting action taken in response to an adverse clinical event back to the person who made the report in the first place, and a similar system for ensuring that the outcome of an investigation into a complaint is reported to those involved in the care of the patient.

R2c Evaluates the way the complaints policy operates to ensure that complainants are satisfied with the way the trust investigates their concerns and that changes in practice follow justified complaints.

R2d Reviews its incident reporting processes (adverse clinical event report, serious untoward incident process and the whistleblowing procedure) to ensure they complement each other and that staff have easy access to guidance about what to do if they have concerns about care provided to a patient.

Effective governance practice across the trust

R2e Establishes and supports a multi-disciplinary team approach to care in all services.

R2f Ensures that all services have established clearly described clinical pathways for the care of the majority of their patients.

R2g Requires all services to collect, collate and report on outcome measures, and to include patient-reported outcome measures where that is appropriate.

R2h Improves the resources available for clinical audit so that more staff are engaged in audit work, and audits are completed.

R2i Distributes the resources available for clinical audit so that aspects of all services are subject to regular scrutiny.

R2j Invites clinical business units to report on the implementation of audit findings and their effect on services.

R2k Requires clinical business units to review the way that they identify and record risks, and monitor action designed to mitigate those risks.

Information about services

R2l Requires clinical business units to report on combinations of information about services (i.e. reported outcomes, complaints, activity, financial performance, performance against targets set without the trust) with other indicators (e.g. sickness absence, vacancies, content of exit interviews) so it can be sure that both 'strong' and 'weak' signals about performance are considered and acted upon.

Organisation development

R3 We recommend that the trust develops a comprehensive organisation development strategy and focuses in the meantime on three areas of its organisation development work:

- The new board committee arrangements and changes to board and executive team operations
- Achieving cultural change
- Increasing management capacity

We recommend in particular that the trust:

Board committee and operations

R3a Keeps the new committee arrangements under review to ensure that the governance and clinical assurance committee plays a major part in raising the level of reporting about clinical matters; the audit committee pursues the goal of integrated governance; and that finance, performance and business development committee sustains a strong focus in these areas.

Achieving cultural change

R3b Considers whether the clinical business unit arrangements will address the concerns about a gynaecology service delivered from several sites described in section 7 of this report, and acts accordingly. This includes concerns about the focus of responsibility

for services at ACWH, and how far support systems and operational decisions are focused on the needs of the service as a whole.

R3c Addresses directly and resolves the "them and us" cultural divide between staff providing gynaecology services mainly or solely at ACWH and those working mainly or solely at Crown Street.

R3d Renews its work to support all members of staff with effective appraisal.

R3e Introduces a comprehensive medical workforce recruitment and development strategy to support its service development intentions.

Increasing management capacity

R3f Boosts capacity by pursuing secondments into the organisation and joint appointments with partner organisation for critical management tasks.

R3g Clarifies where the responsibility lies for leading and managing work on risk management and governance, so that clinical business units have the necessary support for this work.

Operational management of gynaecology services at ACWH

R4 We recommend urgent action to address operational difficulties at ACWH. Work should continue to focus on three critical areas:

- the numerous operational problems both parties to the service level agreement with AUH perceive with the support for services at ACWH

- management of clinical records and the support for both inpatient and outpatient services

- ensuring that equipment is up to date and that contingency arrangements are in place which will sustain services in the event of an equipment failure.

DETAILS OF THE REVIEW

4. Background to the review

4.1 This review of governance was commissioned as one component of the trust's response to a report of serious concerns about the practice of a consultant working in the urogynaecology service at Aintree Centre for Women's Health.

4.2 Two aspects of the consultant's practice prompted concerns. Those concerns related to the interpretation of test results and the choice of treatment for some patients. The medical director reported these concerns to the board in December 2007. During 2008 the trust excluded the consultant from working in the NHS and a number of internal measures were taken to see if the concerns were well founded. Then an external review of clinical cases was commissioned while internal reviews continued, and finally the trust referred the matter to the General Medical Council.

4.3 The trust initiated its serious untoward incident policy and established an incident review project team in October 2008. This now steers the continuing review of the consultant's clinical practice and of any proceedings that may result from the review, and communications with patients, members of the public, staff and other NHS organisations about the incident and the action taken.

4.4 This governance review was commissioned in that context, as part of the trust's requirement for assurance about the origins of the problem, the operational implications for gynaecology and for other services, the safety of services at ACWH, and the trust's corporate and clinical governance generally.

5. Governance context

5.1 NHS organisations are established with clear statutory duties and operate within readily available good-practice guidelines. These include the Department of Health's constitutional guidance for NHS trusts and foundation trusts, guidance on governance standards for public services, the NHS codes of conduct, NHS handbooks on integrated governance, board and committee working, and audit processes. NHS foundation trusts (FTs) are established under an NHS Act of 2003 and have a more complex constitution and governance arrangements than other trusts, relating to their local membership arrangements, local governors' roles, and greater financial and operating independence. The constitution and performance of FTs are overseen by Monitor, an independent NHS regulator, which published the latest code of conduct for FTs in 2006 and the latest compliance framework and financial reporting guidance in 2008. References to Monitor's guidance and other sources of guidance on NHS governance and leadership are shown at appendix E.

5.2 A distillation of all governance guidance undertaken by Verita is summarised below in the form of seven categories of governance roles and responsibilities, which appear in detail in appendix E. In conducting any governance review, we examine some or all of these aspects of corporate and clinical governance in order to benchmark elements of good governance. They are:

Benchmark one: organisational purpose, board roles and business structure
Benchmark two: performance analysis and assessment
Benchmark three: assurance and risk
Benchmark four: organisational development
Benchmark five: partnership working
Benchmark six: public accountability
Benchmark seven: adapting to change

5.3 We believe that any acute services NHS foundation trust existing at the time of the concerns about aspects of the urogynaecology service provided by the Liverpool Women's NHS Foundation Trust, and currently, could reasonably be expected to operate with at least these minimum benchmarked structures, roles, responsibilities and procedures in place and effectively performed.

5.4 It is common in the NHS to refer to governance using three particular phrases; corporate governance, clinical governance and integrated governance. The interpretations we use in terms of these divisions are:

- Corporate governance covers the systems and processes by which a whole organisation sets, directs and controls its functions and behaviours in order to achieve its organisational objectives, safety and quality of service, and good relationships with patients and carers, the wider community and partner organisations.

- Clinical governance is concerned with the framework through which an NHS organisation improves the quality of its services, articulates and accounts for that quality and its improvement and safeguards high standards of care by creating an environment in which excellence in clinical care can flourish.

- Integrated governance is a concept used in the NHS to encourage organisations to move to optimal governance arrangements, recognising that the distinction between clinical and corporate governance is often false.

6. Approach and structure

Approach

6.1 This section sets out how we approached this review and describes the structure of the findings, conclusions and recommendations that follow in sections 7 to 10.

6.2 The review was undertaken in private. It comprised interviews and discussions with staff and an examination of all available relevant documentation.

6.3 We interviewed 39 people who had been identified from documentation or suggested by the trust and who agreed to participate. This included members of the trust board, senior managers, senior clinicians and relevant staff of the gynaecology and obstetrics directorates. A list of interviewees is given in appendix B. We did not interview consultant X, at the trust's request.

6.4 We offered interviewees the opportunity to comment on the factual accuracy of interview transcripts or to add to them and to comment where appropriate on relevant extracts of this report while it was in draft.

6.5 We asked for many documents relating to the business of Aintree Centre for Women's Health, clinical and corporate governance arrangements in the trust generally, the trust board, its committees, and management processes. The trust provided all the documents that were available, and these are summarised in appendix C. We appreciate the help the nominated senior managers gave with this.

6.6 We considered reports about the trust and its services by a range of auditors and external regulators, including Monitor, the Care Quality Commission, and the NHS Litigation Authority.

6.7 We also considered reports by the Royal College of Obstetricians and Gynaecologists, by a clinical consultant employed to review patients' cases, and by the project manager employed to coordinate the internal investigation of the serious untoward incident in respect of the urogynaecology service provided by the consultant at the Aintree Centre for Women's Health.

6.8 This report considers events that occurred over a number of years and in some cases the names of organisations and the titles of posts have changed. The most recent nomenclature has been used except where indicated otherwise.

Structure

Chronology and digest of events and themes

6.9 Before considering any findings from interview testimony, we established a month-by-month chronology of events relating to the management and provision of the urogynaecology service at Aintree Centre for Women's Health and to the corporate and clinical governance of services at Aintree and across the trust generally.

6.10 The chronology has been used to inform the sections of this report that follow. It is attached in summary form at appendix D. It is presented in three colour-coded categories:

- corporate and clinical governance facts and events trust-wide (black)
- corporate and clinical governance facts and events in gynaecology services (green)
- corporate and clinical governance facts and events regarding Aintree Centre for Women's Health (red)

Findings

6.11 Section 7 describes the findings about governance of the gynaecology directorate; findings in relation to the position of services at Aintree Centre for Women's Health against relevant areas of governance; and findings in respect of the events and management of the issues surrounding consultant X's work.

6.12 Section 8 describes the findings in relation to clinical and corporate governance across the trust generally against the seven benchmarks Verita uses to identify good governance.

6.13 Both sections contain findings based on documentary evidence and on interviews. We have quoted some interviewees and paraphrased the material from others. The

quotations we use illustrate evidence from more than one source. We usually identify those quoted by only a generic title or description. In a few cases we identify an individual directly to strengthen the point being made or to acknowledge that they would be readily identified by readers.

Conclusions and recommendations

6.14 In section 9 we summarise the main conclusions drawn from the findings and comments about governance in gynaecology services and at Aintree Centre for Women's Health and about governance in the trust generally.

6.15 Finally, in section 10 we make a number of recommendations for consideration by the trust. They also identify some areas that the trust may wish to review further.

6.16 We make findings, comments and recommendations based on our interviews and the information available to us, to the best of our knowledge and belief.

FINDINGS

7. Gynaecology services and Aintree Centre for Women's Health

7.1 This section is in three parts: we review the past and present governance of the gynaecology directorate and its relationships within the trust and then consider more specifically the past and present services at Aintree Centre for Women's Health. Finally we summarise the events and governance findings related to consultant X.

7.2 One: in paragraphs 7.5 to 7.59 we consider the structure and strategic objectives of the gynaecology directorate, its clinical organisation and sub-specialisation, the directorate's management, performance assessment processes, the induction and appraisal of staff, and clinical governance arrangements including clinical audit and risk management. We also make a brief comparison of governance arrangements for the gynaecology and the obstetric services, and comment on our findings in this section.

7.3 Two: in paragraphs 7.60 to 7.90 we look at the past and current configuration of services at Aintree Centre for Women's Health (ACWH), the strategy for services there, the management arrangements, and the corporate and clinical governance of ACWH.

7.4 Three: in paragraphs 7.91 to 7.115 we illustrate through the case of consultant X some of the themes and organisational issues identified during this part of the review.

One: Governance of the gynaecology directorate

Structure and strategic objectives

7.5 Liverpool Women's operated a management structure based on six clinical directorates and a number of corporate directorates in its first four years as a foundation trust. Gynaecology was one of these six directorates. The trust plans to introduce a new management structure in 2009 in which gynaecology services will join critical care and theatres to form one of four new clinical business units (CBUs).

7.6 The gynaecology directorate provides a wide range of care including an emergency room, general gynaecology and specialised services such as urogynaecology, oncology, and reproductive medicine. It also provides a range of specialised clinics including, for

example, menstrual disorders, endocrinology and cancer screening, and specialist diagnostic services such as hysteroscopy and colposcopy.

7.7 The staff in the directorate work at various locations. Most are based at Liverpool Women's Hospital at Crown Street but a significant number of staff work seven miles away at the Aintree Centre for Women's Health (ACWH) which is on the site managed by University Hospital, Aintree (AUH), a separate NHS trust. Some staff also provide services in community-based clinics.

7.8 The directorate is responsible for delivering on a number of national service targets including, for example, for cancer – two-week waits, one-month diagnosis to treatment; reduction in cancelled operations; reduction in MRSA; achievement of convenience and choice initiatives and reducing waiting time for elective care to 18 weeks or less.

7.9 The directorate was managed between 2005 and 2009 by a clinical director, a directorate manager and a small management team including a business manager and risk manager. The management team is responsible for directorate services on all the trust's sites. The clinical director has been in post since 2007 and is a consultant gynaecologist and gynaecological oncologist. He is part of the corporately responsible directorate management team and is accountable professionally to the trust's medical director (a post held by a consultant in the gynaecology directorate). One person held the post of directorate manager from 2006 to December 2008. A new directorate manager has recently been appointed, who previously managed the trust's critical care directorate. The overall accountability for the directorate rests with its manager under new CBU arrangements.

7.10 The directorate works in the context of the strategic direction set for the trust overall, which emphasises the pursuit of clinical excellence, strong financial performance, maintaining its position as the provider of choice and providing a positive experience for patients in the trust's care. Other important factors in the trust's strategy are developing services in community settings; working more closely with clinicians in primary care; and forming strategic partnerships with health care organisations in the NHS and the independent sector and with higher education institutions.

7.11 The directorate has an annual operational plan. The 2008/9 plan sets out a range of qualitative, organisational and financial objectives including: delivering quality patient-centred services through patient feedback and engagement; delivering robust risk management and clinical governance strategies; refurbishing Aintree site entrances and shared foyer; and identifying robust management that supports business units.

7.12 The operational plan is drawn up in conjunction with directorate staff at an open forum attended by consultants, nurses and administrative staff. One interviewee involved with preparing operational plans explained how staff were given a broad idea of the outline work programme and priorities for the year and were asked for their comments; the feedback was used to help finalise the operational plans. One manager felt that ward staff would have a clear picture of these objectives because an outline was given and information was shared at the open forums.

7.13 The directorate disseminates to staff the executive summary of the plan and uses away days during the year to take stock and adjust action as needed. The intention is that the plan should inform individual objectives, appraisals and professional development plans. An interviewee described the purpose of the directorate as being to treat women with any gynaecological disorders in a timely and reasonable manner.

Comments on gynaecology services structure and objectives

- ***Gynaecology is a large and important directorate in the trust, providing a wide range of services on a number of sites. It brings in significant income. It is expected to deliver testing national and local targets.***

- ***There is good evidence of clinicians being involved in the management of the directorate.***

- ***The operational planning process is well established in the directorate and aims to engage staff.***

- ***The focus of gynaecology services is widening, providing more of its services in a community based setting and improving access to services as a result.***

Directorate management and assessment of performance

7.14 A number of interviewees said the directorate management team had struggled with the demands of managing the directorate and had often needed the support of the trust's team of executive directors. One executive director said executive level staff very often felt it necessary to intervene in the management decisions of the directorate. The interviewee thought this reflected the lack of strength and depth in the directorate team. It may also have reflected the preferred style of corporate managers. Other interviewees pointed to practical problems with for example, the way services are organised and the way changes are managed as evidence of a lack of management capacity at directorate level. An interviewee said the roles and responsibilities of the management team had not been clear. They thought this had resulted in confusion about accountability and in an uneven distribution of work.

7.15 The directorate has several meetings intended to contribute to the oversight and management of the directorate. They include: directorate meeting (monthly); management team meeting (weekly); quality team meetings (weekly); list planning meetings (Crown Street and Aintree/weekly); key performance indicator meeting (weekly).

7.16 The directorate management team meets every week. The team also has a wider meeting each month, chaired by the clinical director, to which all consultants and senior team members are invited. Representation from Aintree at these meetings has improved considerably in the past two years. A key performance indicator meeting is held weekly to consider performance. It is chaired by the service development manager and focuses on a quantitative assessment, involving managers and clinical staff as appropriate. A weekly directorate quality meeting focuses on wider aspects of service performance.

7.17 Members of the trust's executive team meet with all directorate teams on a quarterly basis to review aspects of their performance. The papers we have seen suggest that an appropriate range of issues is discussed at these meetings; but they do not appear to have a strong connection to other performance management arrangements.

7.18 Several interviewees described work to achieve and sustain good performance, while others were concerned that problems with services and with individual performance were not always addressed directly. Senior clinicians were concerned by the slow pace of

development in some areas of the directorate's work, including updating equipment, and the impact this had for patient care. Yet a senior member of staff said that when members of the gynaecology team were asked about aspects of service performance that were a cause for concern, they always said all was well. One view was that managers were not seeking to mislead but that they lacked understanding of what was expected of them.

7.19 The directorate management team is and has been based largely at Crown Street. A middle manager, rather than a senior manager, has been responsible for the ACWH services since the trust assumed responsibility for the centre at the end of 2000. One senior clinician acknowledged this meant there was a lack of management grip. A number of interviewees spoke about the "them and us" culture and the reluctance of staff at ACWH to adopt the same systems and processes as the directorate based at Crown Street.

7.20 Interviewees said the trust does its best to involve clinical staff in trust-wide governance systems and described how senior staff had tried to spend time working at ACWH and with the staff based there. Nonetheless, the view of many Aintree interviewees was that senior staff, including clinical directors had no real interest or involvement in ACWH at all.

7.21 The two main parts of the directorate have found it difficult to collaborate. A number of interviewees said that nursing and administrative staff from ACWH were unwilling either to adopt new ways of working or to provide help at Crown Street. On the other hand, some people at ACWH felt that procedures and practices were being forced on them. One manager thought that if something was done particularly well at ACWH, that was not taken into account, because the trust always wanted it done the way it was at Crown Street even if that turned out to be less successful.

7.22 Some managers based at Crown Street told us that going to ACWH was not an enjoyable part of their job. One interviewee described the hostility they encountered when visiting ACWH: they felt there would always be a frosty reception. Some senior clinical staff made them feel unwelcome and they encountered a resistance at all levels to consider changes to established systems and processes. Senior staff at the trust invested a lot of time in trying to deal with the sources of resistance to the new management arrangements. Nevertheless, staff based at Crown Street told us that when they discussed their concerns about dealing with operational and other problems at ACWH with a senior colleague they had been left feeling that the problems were too "political" to tackle.

7.23 Personnel changes have reduced some of these tensions and medical and administrative staff on both sites work in a more closely integrated way. A number of interviewees spoke positively about plans for more consistent and effective senior management support for ACWH services. The chief executive has asked the clinical director and directorate manager to spend more time at ACWH.

Comments on gynaecology directorate management and assessment of performance

- ***The directorate management team has not been especially strong and the corporate executive team has found it necessary to intervene to ensure targets are delivered.***

- ***The system by which the directorate is routinely held to account for performance is not strong enough. The papers we have seen suggest that greater formality and discussion of a more comprehensive range of performance measures at quarterly performance monitoring meetings would help the trust identify problems and take the necessary action.***

- ***The management team has struggled to integrate ACWH services into the directorate although relationships have improved significantly in recent years.***

- ***There have been recent improvements in senior management support for ACWH services.***

Induction and appraisal of gynaecology directorate staff

7.24 A number of interviewees commented positively about the induction of new staff into the organisation. New staff start during the week of the trust's corporate mandatory training. The trust's induction programme lasts three days. A two-day local induction into the directorate follows this. The induction for a new nurse would include, for example, an introduction to the computerised record-keeping system, manual handling and hand-washing. A recently appointed directorate manager spent two weeks 'shadowing' colleagues after her induction into the trust. Consultants and junior medical staff are subject to similar arrangements.

7.25 The clinical director appraises all consultant medical staff every year. Appraisals and job planning discussions are conducted in conjunction with the directorate manager and the service development manager. They include a review of performance – supported by information about the practice of the individual – and a discussion about service and personal development. The clinical director said he discussed matters of personal performance. Appraisals appear now to be documented although this was not always the case in the past.

7.26 The appraisal system was extended to the trust's medical staff at ACWH at the time of the merger. Flexible arrangements were made so that consultants there had some choice of appraiser without compromising the system's purpose.

7.27 Managers and other staff in the directorate also receive appraisals, though some are conducted in an informal manner – particularly those with junior administrative staff. A number of interviewees questioned how far effective staff appraisal had penetrated the organisation. An executive director said the trust was looking at new and imaginative ways of conducting appraisals and keeping the process in line with the annual operational planning cycle.

Comments on induction and appraisal of gynaecology staff

- ***Induction and appraisal appear to be well established in the directorate. The management team works together in conducting appraisals for consultants.***

- ***However the regularity and rigour with which appraisals are conducted and recorded are not consistent and could be improved.***

Clinical organisation and sub-specialisation

7.28 Until 10 years or so ago a consultant in obstetrics and gynaecology in the NHS carried out clinical work ranging from delivering babies to surgery for gynaecological cancer. This practice has changed in recent years, although not in all trusts. More consultants specialise in a particular area of clinical practice. This is the case at Liverpool Women's, where all but one consultant practises either obstetrics or gynaecology.

7.29 In the last 10 years sub-specialties in gynaecology have become well defined and follow prescribed training programmes. For example, a recently recruited consultant to the trust trained in a sub-specialty carried out the equivalent of two years' training and a year of research before being accredited. Her accreditation in her chosen sub-specialty appears on the GMC register.

7.30 Doctors who trained and became consultants more than 10 years ago did not undertake formal sub-specialty training. However, they are likely to have received training from senior colleagues which in many cases is extensive and possibly accompanied by a higher educational qualification, such as a doctorate. Consultants from this older generation assume what is called a "grandfather sub-specialty identity". They do not appear on the GMC register as sub-specialty trained even though they may have considerable clinical experience and are effectively sub-specialists.

7.31 The move to focus on obstetrics *or* gynaecology and on sub-specialties in each discipline has proceeded at different paces in different trusts and parts of the country. Some employ sub-specialty trained consultants, others consultants "with special interests" and some others a combination of the two. This provided one of the points of contrast between services at Crown Street and at ACWH on their merger in 2000.

7.32 The trust provides the sub-specialty of urogynaecology on both the Crown Street and Aintree sites. Urogynaecology is a sub-specialty of obstetrics and gynaecology. The British Society of Urogynaecology (BSUG) – part of the Royal College of Obstetricians and Gynaecologists – describes the purpose of the sub-specialty as "*the management of female pelvic floor dysfunction including, but not limited to, urinary incontinence, pelvic organ prolapse and faecal incontinence*".

7.33 BSUG aims include promoting and helping establish appropriate standards and clinical management guidelines, training gynaecologists in specialist urogynaecological skills, overseeing continuing medical education and certification and accreditation in urodynamics special skills training.

7.34 A number of interviewees commented about the diagnostic and treatment challenges of urogynaecology. One interviewee told us that specialists have developed several new responses to urogynaecological conditions, including surgical procedures, in

the past ten years but there was neither a national consensus nor enough research evidence to indicate which procedure should be used in every circumstance.

7.35 The trust has five consultants in urogynaecology, including the trust's medical director and consultant X who both have grandfather status. Two consultants are accredited sub-specialists. The most recently appointed consultant is an obstetrician and gynaecologist with a special interest in urogynaecology. The trust has an important role in developing the sub-specialty and manages a large training programme.

Comments on clinical organisation and sub-specialisation

- ***The directorate has operated for some years with two clinical systems: sub-specialisation and consultants with a particular interest.***

- ***The trust did not address the implication this had for delivering effective service directly. It has now come to a view on this aspect of clinical organisation: subspecialisation will form part of a recruitment and development strategy for its medical workforce.***

- ***There are recognised diagnostic and treatment challenges in urogynaecology.***

- ***Sub-specialty training is available but doctors have sub-specialised without it. This happens in trusts other than LWH and is an inevitable consequence of developments in clinical practice. One of the aims of strong and flexible clinical governance arrangements must be to ensure that the work of all practitioners, regardless of qualification and experience, is safe.***

Clinical governance

7.36 A consultant gynaecological oncologist leads the directorate's clinical governance programme. He oversees the risk management team and provides the directorate's link to the clinical governance committee and the trust board and reports on clinical outcomes, risk management and infection control. He reports to the clinical director.

7.37 The clinical governance lead for the directorate was split between Crown Street and ACWH until 2006. The current clinical director was the governance lead at Crown

Street and a consultant based at ACWH was responsible for clinical governance there. A new single lead post was created in 2006 and the current clinical governance lead was appointed to it.

7.38 The directorate directs and monitors its clinical performance in a number of ways including by: national, regional and local clinical guidelines; patient pathways for particular clinical presentations; multi-disciplinary team decision-making and management; performance information such as infection rates; adverse clinical event (ACE) reports; the risk register; and a range of directorate and trust-wide meetings such as the monthly gynaecology risk management forum. Each makes an important contribution to its governance arrangements.

7.39 Multi-disciplinary team working is also an important component of clinical governance. This is an approach to care which ensures all the clinicians contributing to a patient's care are involved in devising the care plan and evaluating its effect. The model can take different forms, depending largely on the type of care and needs of the patients involved. The multi-disciplinary team model of working is well established in the gynaecological oncology sub-specialty. This follows the need to meet the expectations of national and local clinical guidelines and achieve better clinical outcomes for patients with cancer. One interviewee described a system based on collective decision-making about the care of individual cases. This meant there was always scope to rein in unusual ideas and to support innovative practice. Clinicians took collective responsibility for decisions about care, and provided each other with collective support. The oncology multi-disciplinary team meets every Wednesday morning for two hours to discuss new patients and to agree clinical management plans. Results of investigations are brought back to the team when necessary to agree how this affects the plan of care for a patient. The team consists of doctors from a number of disciplines, specialist nurses and therapists.

7.40 A number of other interviewees said that multi-disciplinary team working was not in place throughout the directorate. For example, the approach is less well established in the urogynaecology sub-specialty. Consultant staff have tried to set up such an arrangement, but this has not yet resulted in a regular multi-disciplinary team meeting.

7.41 One interviewee said that sub-specialists, nurse specialists and physiotherapists were usually involved in decisions about case management, and a urologist and a

colorectal surgeon were called on as appropriate. The interviewee accepted this was not true multi-disciplinary team work as it had developed elsewhere, but said it was a process that sufficed. A number of senior medical staff said that such a meeting was particularly important for the sub-specialty because the clinical presentation of a patient with urogynaecological problems could be complex to diagnose and treat. One interviewee said it was important to agree the remit of the multi-disciplinary meeting and whether it was an advisory or decision-making body because they felt each person uses the meeting for different purposes. Work to apply a multi-disciplinary teamwork approach to urogynaecological care continues.

7.42 In common with other trusts and specialties, urogynaecology has struggled to collect and log outcome data which go beyond the standard measures of, for example, returns to theatre and delayed or failed treatment. The urogynaecologists at LWH recognise that this is a challenge and two of them have been centrally involved in establishing and developing a national outcomes database, hosted by BSUG. Data about outcomes for LWH patients and patients of several other trusts is loaded onto the BSUG database. It has proved difficult to draw useful information from the database because the resources needed to interrogate it are not available. One interviewee said that becoming expert in the use of outcome information would complement the trust's expertise in urogynaecology, recurrent miscarriage and other specialist areas of work.

Comments on clinical governance

- ***The directorate is committed to clinical leadership and demonstrates this by placing the responsibility for governance in the hands of a clinician who is appropriately qualified and committed to the role.***

- ***Multi-disciplinary team working is well established in some parts of the directorate but less so in urogynaecology, although the team is committed to making it so. Multi-disciplinary teamwork is critical to sound clinical decision-making – especially for complex cases.***

- ***The urogynaecology team has been unable to make use of the outcome data it contributes to the BSUG database and has not devised other methods of evaluating the outcome of its work.***

Clinical audit

7.43 The directorate has a dedicated clinical audit lead, one of five across the trust. His role is to advise and guide the directorate about what audits are needed, to ensure that any audit proposal benefits the trust as a whole, to feed audit findings into the clinical governance committee and to advise the clinical guidelines committee. Audit leads usually have two hours a week in which to discharge their responsibilities.

7.44 Topics for audit come from a variety of sources: individual clinicians, the trust's clinical governance and audit committees following an incident and, in some instances, national guidance – particularly NICE guidelines – which may require an audit of a particular clinical activity. We asked interviewees about the priorities and programming of clinical audits and the fit between governance and audit. One senior interviewee involved with audit said that designing local audit protocols which tested, for example, compliance with national guidance was sometimes difficult. At the same time, local suggestions for audit topics did not always fit with national audit frameworks.

7.45 Audits in gynaecology represent a declining proportion of all audits in the trust. The directorate carried out 27% of all audits in the trust in 2005 and 15% of all audits in 2007. Two interviewees said junior doctors often took on audits but did not complete them. They thought the trust's audit work was not of a uniformly good standard.

7.46 The outcome of some audits results in changes to practice. For example, the directorate has recently completed an audit on the management of menstrual disorders. This looked at the various therapies offered to patients and their appropriateness. The audit highlighted gaps in data collection that have now been rectified.

7.47 A number of interviewees said the trust was effective in acquiring and disseminating information about clinical advances, including new technologies. An explanation for this was that trust clinical staff were at the forefront of clinical practice and research. However, two clinical audit leads said it was more difficult to disseminate the outcomes of the audit and ensure they were implemented.

7.48 One interviewee with extensive experience of clinical audit in the directorate said it was taken seriously but that most of the trust's audit resources were applied to its highest risk services. This meant there had been an imbalance: the trust had recently

acknowledged the need for additional investment, or a more even distribution of audit resources.

Comments on clinical audit

- ***The directorate is committed to clinical audit and some outcomes of audit lead to change in practice.***

- ***However, audit does not seem to be clearly linked with the directorate's plans and is not neatly integrated with clinical governance. At least one interviewee thought that audit was an area for improvement.***

- ***The proportion of audits undertaken by gynaecology has declined over recent years. It is not clear why this is so.***

Risk management and the risk register

7.49 Responsibility for directorate risk management lies with the management team. The directorate has developed its own assurance framework. This is based on the trust board's framework. The intention is that key risks should be assessed, scored and added to the directorate risk register so that they can be monitored and evaluated regularly.

7.50 A number of interviewees said risk management had not always been taken seriously in the directorate. One director reported that there was a prevailing view in the organisation that this was down to the assistant director because that person is responsible for the standards, so there is an issue about individual and professional responsibility within directorates. We were told that a former gynaecology risk manager was not well supported within the directorate and when he left the organisation, the post remained vacant for about nine months. This meant, for example, that training "blockbuster" days, designed to keep staff up to date with mandatory training, did not take place with consequences for the directorate's mandatory training compliance rate. The current risk manager has been in post since the middle of 2008.

7.51 Interviewees told us that some of the directorate's procedures for identifying and managing risks were lacking: its relatively low level of compliance with mandatory training

and the consequence of that were given as an example. The directorate currently achieves about 70 per cent compliance compared to 85 to 90 per cent for other directorates.

7.52 Directorate staff have recently had an away day to discuss risk and have agreed to mirror the systems in place in critical care. These include a weekly meeting about planned patient treatment lists to maintain an effective focus on performance against targets. They also agreed that risks identified through complaints and adverse clinical events will be added to the directorate risk register as they occur.

Comparisons between obstetrics and gynaecology

7.53 We were asked to consider how governance arrangements had developed in recent years in the obstetrics and gynaecology services as this might provide some more information about the merger of ACWH and Crown Street services. Both are large, high-risk services and we would expect to see parallel development in their governance arrangements.

7.54 The trust is one of the largest providers of obstetric services in the country. Eight thousand babies are delivered on the main hospital site each year to women from a wide geographical area. The service enjoys a national reputation and is at the forefront of maternity practice. In 2007 it was one of three trusts in England to have achieved clinical negligence scheme for trusts (CNST) level three. Consultants work in sub-specialties and play a major role in the delivery suite. At the time of the merger of services at Crown Street and Aintree, the consultants at ACWH were not working in sub-specialties. They provided both obstetrics and gynaecology. One interviewee – an obstetrician - spoke of the effort that had gone into managing the integration of the obstetric services provided at ACWH. This was achieved by working with the Aintree consultants and midwives to reshape practice and service provision.

7.55 In 2009 (and since 2004) all obstetric inpatient services are provided at Crown Street while antenatal clinics, a midwife-led day unit and foetal medicine services continue to be provided at ACWH. Integration is such that a consultant told us things were now running so well that the former role of obstetric consultant lead for ACWH became redundant and the clinical director is able to manage without needing extra input from someone else. The same interviewee also pointed out that there were lessons to learn

from the midwives at Aintree because some practices there were more advanced than at Crown Street.

7.56 Obstetrics has a reputation in the trust for the rigour of its clinical governance. One interviewee – an obstetrician - said there was an appetite to learn from adverse incidents and avoid a culture of blame. Consultants were committed to reviewing adverse incidents although the same interviewee also said implementation of learning from such reviews was not as good as it should be.

7.57 The duty consultant regularly reviews any incidents in the delivery suite and discusses them with junior medical and midwifery staff. Significant issues are also discussed at the monthly business meeting. An adverse clinical event (ACE) form is completed if necessary. One interviewee said that finding solutions to some incidents was not as straightforward as it appeared and that this sometimes led to the introduction of processes that were more time-consuming and that detracted from other things.

7.58 Like all directorates the obstetrics risk management team produces a quarterly review of all incidents and looks at their management and potential for improvement in care. Matters of performance are also taken up with individuals. Adverse clinical events are also discussed as part of the appraisal process. One interviewee said that obstetrics was a leader in risk management and that this had been driven largely by the requirement to achieve the standards required by the clinical negligence scheme for trusts. Other directorates in the trust are making efforts to learn from their experience. However in the case of gynaecology, some interviewees said that there were factors that made this more difficult. Some directorate managers felt that the gynaecology directorate was more target driven than the others and that some people saw targets as ends in themselves rather that a means of improving service quality.

Comments on obstetrics and gynaecology

- ***The obstetric directorate redesigned its service soon after the merger of ACWH services with those at LWH. This led to early integration of services delivered from the two sites.***

- ***The national focus given to obstetric services by the review of maternal deaths and the organisation of the service at NW London NHS trust (Healthcare***

Commission 2005, 2006) and the publication of Maternity Matters (Department of Health 2007) focussed the obstetric directorate's attention on clinical organisation and improvement and reinforcing service integration.

- ***Together, these explain to some degree why the obstetric directorate's work on service integration, risk management, audit, incident management and outcome measurement is further advanced than it is for the gynaecology service.***

- ***A similar, proactive approach with identified clinicians taking a leading role, might serve the gynaecology service as well.***

7.59 The findings and comments in this section form the basis for a number of conclusions and recommendations made in sections 9 and 10 below.

Two: Aintree Centre for Women's Health

Configuration of services

7.60 Liverpool Women's Hospital NHS Trust assumed responsibility for services delivered from Aintree Centre for Women's Health in December 2000. The centre had been part of Aintree Hospitals NHS Trust. It provided the full range of general obstetrics and gynaecology services and some specialist services to women living predominantly in north Liverpool.

7.61 There were several organisational and cultural differences between the two units. In the early 1990s the Aintree obstetrics and gynaecology department employed six consultants practising in both clinical areas. About 4,500 babies were delivered each year and the hospital was a tertiary centre for neonates. The department routinely managed high-risk obstetric cases and provided the full range of services save for foetal medicine and the treatment of some cancers. One interviewee said the Aintree service was then a large, by British standards, stand-alone obstetrics and gynaecology unit providing more or less all services. At the time clinical links with the Liverpool Women's trust were limited to referrals concerning foetal medicine and cancer. Interviewees said that when Liverpool Women's took over the management of the Aintree obstetrics and gynaecology

department that created an unsettled atmosphere with people wondering what would happen to them and their job.

7.62 Moving services from ACWH had an impact on the workload of consultants: they also had to deal with "culture shock". A clinician in the directorate talked to us about the differences in experience and approach between the "expert specialists" at Crown Street and the "expert generalists" at ACWH, and the effect this had for both the obstetric and gynaecology services.

7.63 The local NHS had discussed a change in management arrangements for some time, culminating in 2002 in a public consultation on options for service change. The debate concerned mainly the obstetric service: changing patterns of training and work among medical staff caused difficulties with assuring cover for the labour ward and for the neonatal unit at Aintree. This, together with the falling birth rate, meant changes to services were inevitable. The consultation document *Shaping the future of women's and maternity services in north Merseyside* recorded, among other problems, that Liverpool Women's Hospital was designed to care for 8000 births annually yet was operating at around 6000. It also said that ACWH did not meet national standards as it had no routine consultant cover on the labour ward, and that because of staff shortages, LWH had on occasion not been able to fulfil its role in taking admissions from elsewhere in the region. The consultation document outlined three service solutions: it was agreed at the end of the consultation that the obstetrics and gynaecology services provided at that time by the two separate trusts would merge.

7.64 Whatever the published rationale for the merger, few, if any, members of staff at Aintree welcomed the change. Staff at ACWH acutely felt a loss of identity and distinct differences in clinical style: the merger largely ignored the practical and cultural differences in the way the parties operated. One interviewee said that in the beginning, people at ACWH did not like being part of Liverpool Women's just because it was not Aintree, and there was no particular reason other than that there had been a merger and things were done differently. Another interviewee thought that this might have been caused by complacency, brought about by the relative ease of the earlier mergers that created Liverpool Women's. There was no relationship between the two trusts, or strong clinical links. One interviewee said there was no close professional relationship between the two and the changes had no local resonance.

7.65 Services provided at ACWH were drawn into the appropriate clinical directorate of the Liverpool Women's hospital trust. They were: high and low risk obstetric services, an ante and post natal community service, secondary level gynaecology services (including an assessment service for urgent cases), an early pregnancy assessment clinic, outpatient and inpatient care, day surgery, diagnostic and therapeutic services (e.g. colposcopy, urodynamics and hysteroscopy) and, as part of the Mersey Cancer Network, investigation and diagnosis of gynaecological cancers. The neonatal unit at ACWH provided 12 high-dependency and special care cots and a neonatal transfer service.

7.66 The new management arrangements addressed some of the problems that had led to the change but it soon became clear that further changes to services were needed. There were concerns about the quality of training in paediatric medicine, about the shortage of appropriately-trained nursing and advanced practitioners and the effect of the European directive on working patterns for medical staff. A review of obstetrics and gynaecology services for the whole trust concluded that the obstetric delivery service and the neonatal service should transfer from ACWH to Crown Street. This was implemented in March 2004.

7.67 The analysis of service change options included an assessment of the impact for gynaecology services, but most attention focused on the needs of the obstetric service. The change decided upon had a significant impact for gynaecology services. Moving obstetric and neonatology services to Crown Street meant changes to the number of junior medical staff at ACWH. This meant, in turn, that urgent gynaecology services could not be sustained at Aintree and so this service was also transferred to Crown Street. All women with acute symptoms are now assessed in the dedicated gynaecology emergency room at Crown Street. Those requiring subsequent admission for planned surgery may be admitted to ACWH or Crown Street.

7.68 The gynaecological cancer service provided at Crown Street was a designated hub within the network of cancer services in the North West. The service at Aintree was an accredited satellite site. It was decided that the service provided for women at Crown Street, which was delivered by sub-specialty trained consultants working within clearly defined clinical pathways, must be extended to all women served by the trust and so the work carried out at Aintree was drawn into the designated hub at Crown Street.

7.69 These changes, over eight years, have had a significant impact on ACWH and its staff. While acknowledging the external pressures on ACWH services which made them unsustainable, one interviewee said that re-locating services to Crown Street, and particularly the emergency gynaecology service, changed things greatly at Aintree.

7.70 Service changes continue at ACWH. The Aintree project board was set up in September 2006, chaired by the director of finance, with the aim of improving activity levels and financial performance of gynaecology services at ACWH. Senior staff from both sites considered the use and costs of ward, clinic and theatre time. Conscious of the wider context for the service, the board looked at several service models and options. The board's work led to a reduction in the number of theatre sessions, improvements to the ward, clinic and office spaces, closure of the inpatient ward every other weekend, and changes to the service level agreement between Liverpool Women's trust and AUH. These led to better financial performance.

7.71 In 2007, Knowsley PCT said it would support the development of services closer to people's homes, and not on hospital premises, approaching the trust to work as its principal partner for gynaecology services. The trust established a project team to develop this service and to maintain close links with the Aintree Project Board over the volume of outpatients likely to transfer from the Aintree site to community based clinics. Clinics have been running in Knowsley (Kirkby and Manor Farm) since April 2008.

7.72 Revised terms of reference for the project board were agreed by the trust board in May 2008. These focused the board's work away from financial performance to finding the most effective way of delivering services to women.

Comments on configuration of services at ACWH

- ***Many changes have taken place in obstetrics and gynaecology services for women in central and north Liverpool, both before and since services at ACWH were combined with those at Liverpool Women's trust.***

- ***Discussions about the transfer of services from AUH to the Liverpool Women's trust lasted two years. This created uncertainty which led to initial hostility to the merger among some ACWH staff.***

- ***In the years after the merger, the volume of services delivered from ACWH diminished markedly, with a number of services moving to Crown Street. These changes are seen as a loss to Aintree, rather than as positive and inevitable responses to new and developing demands for care.***

Vision and strategy

7.73 Liverpool Women's trust has a clear determination, shared by everyone we spoke to, to provide excellent services. This is reflected in the operational and service plans for all directorates. But staff are uncertain about the future of services at ACWH, leading to uncertainty and loss of morale and confidence. Confident practitioners (ie practitioners who are confident about their own practice and the support available from the system they work in), provide services of a consistently high quality. They make effective use of systems designed to ensure the quality of services and adapt those systems as clinical treatments, technologies and techniques develop. Interviewees working at ACWH told us that they feel the service is regarded as a satellite of the Crown Street service rather than as part of a multi-site service operated by the trust.

7.74 There has been significant capital investment at ACWH in recent years and senior trust staff said ACWH services were critical to the development of the trust's portfolio. However, this picture is not always reflected in day-to-day practice. People working at ACWH feel and behave as if they are not part of the mainstream service, and they cite some actions on the part of their Crown Street colleagues which appear to reinforce this. They include decisions to centralise the appointments function and the patient tracking team at Crown Street and some recycling of equipment to ACWH when new items were installed at Crown Street. Interviewees said junior medical staff were regularly called away from ACWH to cover absences at Crown Street, often at short notice. Resources rarely flowed in the opposite direction. This has led to cancelled theatre procedures and seriously delayed clinics.

7.75 We asked senior trust staff for details about their plans for services at ACWH. Several told us its base there was "business critical" and were clear that if care could not be provided for women at ACWH they would prefer to travel to trusts other than Liverpool Women's. But they could not point to substantial plans for ACWH. The Aintree project board has undertaken a considerable amount of work on the gynaecology service model, and their work has been reported to and adopted by the board, but this does not amount

to current, high-profile work focused on the future of ACWH services. They conceded this contributed to the impression that the future of those services was uncertain.

7.76 There was also a range of views among board members. One said ACWH had always been very much an asset, a foothold in the north of the city, and something the trust definitely wanted to keep and to have properly functioning. This was why the Aintree project board was established in 2005/6. Another said commitment to running services from the north of the city meant the trust really should get out of the old facilities and put a brand new centre up at Aintree. However, another board member said that in the fullness of time the trust ought not to have a facility at Aintree. Most senior managers and clinicians thought that ACWH had an important part in the future of the trust. Clinicians' views tend to support development of some services there while moving inpatient services to Crown Street.

7.77 The absence of a strategy for the gynaecology service has made a series of considered service changes feel, for many working at ACWH, more like a succession of cuts that will lead, eventually, to closure. We interviewed a consultant from AUH who works closely with ACWH colleagues and who had the feeling that activity would continue to decline: several of the ACWH staff we interviewed had the same feeling.

Comments on vision and strategy for ACWH

- ***The absence of a strategy for womens' services at ACWH has a negative impact on its staff is, therefore, a significant weakness. It may compromise the quality of those services and the trust's intention that women receive the same quality of service, whether at Crown Street, Aintree or a community clinic.***

- ***Statements from senior trust staff saying that ACWH services are critical to the development of the trust's portfolio are not always reflected in day-to-day practice.***

- ***Some significant capital investment at ACWH, however positive for staff and patients, cannot replace investment that is part of a strategic development plan.***

- ***Changes in services provided from ACWH have been made in response to important service and policy imperatives, but these have not been part of a coherent strategy for the trust's gynaecology service.***

- ***Senior managers appear to agree that the trust can provide an important service to women in north Liverpool, but are yet to translate that into a development plan for ACWH.***

Management culture

7.78 There are clear differences in culture and attitude between the staff working at ACWH and those at Crown Street. These were evident at the time of the merger in 2000 and after.

7.79 The effect of board-level management and service changes to ACWH resonate through the services at ACWH and at Crown Street. Most interviewees highlighted "them and us" divisions between the two groups of staff. All reported that the nature, intensity and effect of the division had changed, but still had some impact. Staff at ACWH or Crown Street gave examples of the effect of this cultural divide: our observations reflected their experience. In 2006, minutes of performance management meetings for the gynaecology directorate referred to services "at ACWH" and "at LWH" rather than at Aintree and Crown Street. Operational problems at ACWH were discussed at those meetings and elsewhere, including the Aintree project board and the service level agreement users group. Achieving resolutions appears to take comparatively low priority.

7.80 Most interviewees made thoughtful comments about the apparently poor relationships between staff on the two sites. They said staff on both sites had experience of mergers which had helped them form views about their present situation. One view was the apparent ease with which the merger of three hospitals in 1995 to form LWH had been achieved meant that the challenge of the later incorporation of ACWH had been underestimated. Another was a significant shift towards specialisation and sub-specialisation at LWH since its formation, which set it apart from Aintree services. All the Aintree consultants practised both obstetrics and gynaecology, while all the Crown Street consultants practised one or the other. Some interviewees told us that unwelcome changes in service were attributed by some staff to "the takeover" when they were, in fact, the result of the implementation of PCT or even national policies. One interviewee

said staff at Aintree had been dealing with issues of poor equipment before the merger and then all of a sudden it seemed to become the Liverpool Women's fault that they had poor equipment. Staff from both sites conceded they had demonised colleagues working "over there" and thought this was unreasonable.

Comments on management culture

- ***There were significant cultural differences between services at ACWH and Crown Street when they merged in 2000. Some of the differences have disappeared, or have less impact, but some persist.***

- ***Staff on both sites are aware of these cultural differences, the risk they pose for services, and the need to address them.***

Corporate and clinical governance

7.81 We were asked to evaluate corporate and clinical governance at ACWH. We saw or heard about several examples of good practice: in physiotherapy services, the clinical alliances made with colleagues at AUH, particularly in urology and colo-rectal surgery, support given to women by nursing staff in gynaecology outpatient clinics and the development of community-based ante- and post-natal services as part of an integrated obstetric service delivered from several sites, including Crown Street and ACWH. We saw no examples of poor practice by clinicians that might give an immediate indication of ineffective clinical governance. We know, of course, that the care of some patients who attended the centre before December 2007 is under review. We cannot comment further on the safety of services at ACWH without an extensive investigation: we can say that discussion of recent problems among senior staff has brought heightened awareness of safety matters and this should help proof services against both poor practice and poor support for effective practice.

7.82 Several matters need to be addressed if services at ACWH are to benefit from effective governance arrangements. Strong management and clinical leadership for services require attention, as do systems supporting service delivery, and systems ensuring service quality.

7.83 Patterns of 'visits' to ACWH by senior trust and directorate managers and successive clinical directors have been established and amended several times in the eight years but have not ensured the delivery of effective support or leadership for services. One interviewee said some managers had never been to Aintree and wondered how they could then be responsible for a unit and say it was part of their remit and that it was very important. Several interviewees said they felt their concerns were not heard. There are plans to introduce a management presence at ACWH, at a level which will give the right support to ACWH services.

7.84 Operational problems pose a significant risk. We found administrative errors and other problems which we reported to the trust. Clinical record-keeping and communication with and about patients are poor and some equipment is not fit for purpose.

7.85 Service support systems are weak. Eight years after the change in management arrangements, staff still use different email and IT systems. Most of the resulting communication difficulties have been resolved (or worked around), but the differences are important. For example, ACWH staff do not have access to the trust intranet so, for example clinical protocols must be printed and stored. ACWH staff working at Crown Street find it difficult to use the online prescribing system that operates there and not at ACWH.

7.86 The service level agreement between AUH and LWH has not always operated as intended. There are problems with the use of theatres, anaesthetist and junior medical staff cover, planned maintenance and building, notice of theatre session cancellation and case note management. Arrangements for monitoring the SLA were revived and formalised last year and there has been a concerted effort in recent months to address several of the other operational and system support problems.

7.87 Many of the processes for ensuring acceptable performance are in evidence at ACWH, as elsewhere in the trust. There are regular activity monitoring meetings, staff engage in quality monitoring meetings and complaints are dealt with thoroughly and generally, promptly. The content of ACE reports is recorded in some detail, together with the action required. The same is true with reports about complaints received from patients. But these do not produce a *system* that ensures service quality. Many of the

components of such a system are in place (and we can confirm the regulators' reports on this point), but they are not fully connected to one another.

7.88 The performance management, quality review and planning groups have members, including senior members of staff, in common. Consequently, they share information, but this also has the effect of dispersing responsibility for action. People discuss operational problems in several forums, but do not completely resolve them. Some problems are "*worked around*". Similarly, the Aintree project board discussed the future of its services, but did not fully address the strategic task, nor engage the entire directorate in a discussion about the future of the gynaecology service.

7.89 In summary, the most important weaknesses of governance at ACWH are the absence of strategy and the limited success of the trust's work to address cultural problems. This leads to deficits in management, leadership and systems. The inconsistencies in governance arrangements mean the trust has underestimated the risk of service failure in this part of the gynaecology service.

Comments on governance at ACWH

- ***There are no recent examples of poor clinical practice which might give an indication of ineffective clinical governance.***

- ***There are practical problems with the way performance is measured, reported and acted upon. They are, however, just symptoms of two underlying problems: a lack of vision for ACWH services, and a failure to address cultural divisions.***

- ***Differences exist between some of the systems and processes that support service delivery at Crown Street and ACWH services. There are several reasons for this. Some stem from the fact that the "host" for ACWH is AUH, and some practices (for example maintaining a safe environment) which should be consistent for both. Some stem from historical differences in practice that may not be justified but have not been reviewed. Practices at Crown Street and ACWH do not have to be uniform - there is no need to impose the practice of one upon the other. Practice should be consistent, and justifiable (indeed, necessary) differences agreed upon and reviewed regularly.***

- ***Staff have expressed concerns about operational and other matters and that they have not been addressed effectively. Cultural distance between staff working on the two main sites will remain a barrier to resolving and anticipating problems.***

- ***Like services at Crown Street, ACWH has access to some good support services for urogynaecology; for instance from urology and colo-rectal services.***

- ***Both parties perceive problems with the SLA between AUH and LWH. SLA monitoring meetings must take a problem-solving approach so as to ensure effective service support.***

7.90 The findings and comments in this section form the basis for a number of conclusions and recommendations made in sections 9 and 10 below.

Three: Governance issues relating to consultant X

7.91 Some of the findings and comments about the gynaecology directorate and about services at ACWH are illustrated by the concerns about consultant X and the handling of those concerns.

Appointment and role

7.92 Consultant X joined the trust in 2000 as an existing member of the clinical staff of the obstetrics and gynaecology service provided from Aintree. He was first appointed to Fazakerley Hospital (now AUH) in 1993 as a general obstetrician and gynaecologist.

7.93 Consultant X stopped providing obstetric care in 2004. He had a declared interest in urogynaecology and agreed with his clinical director to pursue work in this sub-specialty. He did this in addition to other general gynaecological work, such as a menopause clinic. The extent of his training in urogynaecology is unclear, but it appears that he spent at least one year training with a "grandfather". By contrast, the trust's medical director – also a practising urogynaecologist - spent five to six years training with a 'grandfather' and also has a doctorate in the field of urogynaecology.

7.94 Consultant X was the clinical governance lead at ACWH between 2001 and 2006.

Matters for concern

7.95 Consultant X's work came to the notice of senior members of staff during 2004 and 2005. Members of the directorate team were concerned about the number of women awaiting surgery at ACWH, and how long they had waited. At about the same time, consultant X spoke with his appraiser about sustaining effective practice.

7.96 In July 2004 managers attending the directorate's weekly key performance indicators (KPI) meeting noted that consultant X's patients were waiting 22 weeks for an outpatient appointment after surgery or an earlier consultation. The minutes of a KPI meeting in August 2004 report that consultant X was to spend some time at Crown Street to operate with consultants there. They also note that of his ten patients then awaiting dates for surgery, nine were listed for major surgery. His waiting list had significantly increased in the previous six months. On these measures, consultant X's performance was significantly at variance with other consultants doing similar work. On occasions, his waiting lists were between 18 and 20 weeks, compared to six or eight weeks for colleagues. Interviewees who were present at these meetings said that the explanation consultant X gave for his pattern of work was his practice of carrying out multiple procedures on a single patient during one operating theatre session. A number of interviewees said that consultant X's waiting list performance was discussed regularly at these meetings some three to four years ago. Reflecting on those discussions, one said that whenever people were monitoring performance, if there was an outlier, it was always [consultant X]."

7.97 In February 2005 a board discussion about corporate performance against activity targets included concerns that the number of outpatients was masking under-performance in elective and day-case care. The medical director advised the board about "*the major inpatient problem surrounding a particular consultant and particular sub-specialty.*" His report continued: "*the consultant concerned would now be doing clinics and operating at LWH resulting in a reduction in waiting time.*" This is taken as a reference to consultant X. No reaction to this report or discussion of it was minuted.

7.98 The KPI meeting papers show that in April 2005 consultant X was the only consultant with patients waiting more than six weeks and significantly high numbers of patients waiting in all categories. In September that year the KPI meeting considered questions about consultant X's workload and conversion to surgery rates (ratio of new

outpatient consultations to patients undergoing surgery). The medical director and the directorate manager agreed to speak to consultant X about this.

7.99 Consultant X appeared to carry out more surgery than his colleagues and to perform more than one procedure on a patient during a single session (a practice referred to as 'bundling'). Consultant X also took a more invasive approach to surgery than his colleagues, for example, approaching through an abdominal incision rather than through the patient's vagina. The relatively high surgery rates and the complexity of the procedures he performed accounted for the longer waiting list.

7.100 At about the same time, concerns were emerging through appraisal discussions with consultant X. One former clinical director said that consultant X had a regular appraisal with either the medical or clinical director. We have not seen documents to support this. Appraisal discussions with consultant X raised the clinical director's concerns about the organisation of the consultant's clinical practice – particularly the range of his work, the cross-cover arrangements between the Aintree consultants, his isolation, loss of skills and difficulty in acquiring new skills.

7.101 The same clinical director said he had encouraged consultant X to establish effective relationships with urogynaecology colleagues at Crown Street. He recognised that consultant X kept his own counsel and did not mix easily.

7.102 The trust has received few complaints about consultant X. There are four ACE reports about his patients, in 2006 and 2007. Some of the notations are unclear but it appears that one of nine unplanned returns to theatre and two of five cases where treatment failed or was delayed, and recorded during that period, related to consultant X's patients. There was one further record of unexpected blood loss in respect of one of his patients.

7.103 In 2006 the directorate management team became aware of a patient of consultant X who had been waiting eight months for a date to come into hospital for surgery. It commissioned an audit of outpatient attendances at ACWH which revealed that the outcome of several consultations had not been recorded correctly and that there were a small number of women waiting an unacceptable length of time for elective surgery. As a result the directorate team carried out a major review of patient administration systems

and discovered significant administrative and procedural differences between Crown Street and ACWH. The review was confined to administrative systems.

7.104 In 2006 the trust decided to appoint a urogynaecologist to help with the waiting list problem at ACWH. Consultant X appeared to welcome this but when an appointment was made he and the new appointee found it difficult to reach an effective working arrangement. The new consultant focused on work at Crown Street.

7.105 In November 2007 the trust's medical director, a urogynaecologist, had four clinical cases referred to him from consultant X for a tertiary opinion. He became concerned about the treatment the women had had and what was proposed for them.

Handling the concerns

7.106 Responses to the concerns raised at KPI meetings from 2004 onwards, and followed up with consultant X, were not recorded. Directorate staff told us on reflection that they were satisfied with his explanation of his long waiting list. They did not consider seeking another explanation for the figures, even though consultant X's figures were much higher than those of other consultants. They did not follow up the reported high conversion rate, or explore the ratio of new to follow-up outpatient appointments, which might have highlighted women whose condition did not improve. They did not collect information about allied services, for example referrals for physiotherapy or requests for investigations, that might have helped them understand apparent differences in practice.

7.107 In part two of the board meeting in December 2007, it is minuted that the trust's medical director gave an oral report "*to apprise the board of concerns that had come to light*" in the clinical practice of consultant X. This was the first report to the board centred on consultant X's practice and the first reference to him since (we understand) the anonymised February 2005 report about waiting lists and waiting times. The board approved proposals to review 400 cases from 2006 and 2007, planned over three months. A retired consultant of the trust started the work with the agreement of the medical director and consultant X.

7.108 A part two board discussion about consultant X took place in April 2008. An external review of cases was needed and there was discussion of disciplinary processes. The same month, the medical director told the internal clinical case reviewer that no

more case reviews were needed as assessors from the Royal College of Obstetrics and Gynaecology (RCOG) would be reviewing a sample of cases. He said that consultant X would need to be retrained.

7.109 By May 2008, it was reported to the board in part two that consultant X was on sick leave, that he would need to undergo retraining on his return and that assessors from the RCOG were to visit in June and review some of his cases.

7.110 The medical director made the first formal written report about consultant X to part two of the board in September 2008. It noted the RCOG report made in August, which concluded that there had been poor clinical decision-making. It recommended "*training in interpretation of urodynamic tracings*", that consultant X must attend MDT meetings and discuss all cases there, that managers should audit consultant X's activities six months after his return, that there was no clinical reason to recall any patients, and that urodynamic facilities at ACWH were unsatisfactory.

7.111 The RCOG report was received in a month when the board was not due to meet and separate arrangements were made for nominated members of the board to consider it. Reaction was mixed. Some members felt it was a balanced and professional view, to be accepted. At least one non-executive was uncomfortable with what they saw as a lenient report, saying that this was a quite serious matter and it struck them that although there was a serious tone at the beginning of the report the action proposed at the end was not of a similarly serious level. The interviewee was concerned about the board's reaction to the RCOG's recommendations, saying that there had been an issue about not wanting to create any kind of a stigma for consultant X. A new chief executive then joined the trust and also had reservations about the recommended action. In September 2008 the trust's new chief executive discussed this matter with the medical director. They agreed to a change of plan, and that the concern about consultant X's practice should be referred to the General Medical Council, the strategic health authority and other relevant regulators.

7.112 In October 2008, part two of the board meeting considered a detailed written report by the director of nursing and quality, which included information about the recently established serious untoward incident review. The board agreed to complete the 2005/07 case reviews and a sample of other cases dating back to 2001, to develop a strategy to handle the case and its communication, and a review of services at ACWH. A project group was set up, initially meeting weekly, later regularly, but less frequently.

7.113 The chief executive met with Liverpool PCT in January 2009 about consultant X and the handling of the case. The PCT agreed to arrange GP input into the review of past patients. The chief executive revised the role and membership of the review project group at this point, taking the chair of the group herself. She appointed an external project manager to support the group.

7.114 Since early 2008, when consultant X went on leave and was later formally excluded from the trust, his workload has been taken on by a locum consultant with a special interest in urogynaecology. He is not sub-specialty trained, and he sees former patients of consultant X who have complex conditions. Arrangements have been made for him to discuss complex cases with sub-specialist colleagues and to transfer the care of some patients to one of them where that is thought necessary. The locum consultant has recently been appointed to a substantive general gynaecology post in the trust. The trust plans to recruit a sub-specialist in urogynaecology in the near future.

Comments on matters relating to consultant X

- ***There was no clear plan for adapting consultant X's working arrangements after the merger of ACWH and LWH services.***

- ***His move into sub-specialty work appears to have been sanctioned by the then clinical director. Consultant X had been providing urogynaecological care for some time but it is not clear what specific steps the trust took to assure itself of his ability to practice in that field.***

- ***The extent of consultant X's sub-specialty training is unclear but is significantly less than his "grandfather" counterpart in the trust.***

- ***The appraisal system and other informal discussions among medical staff brought to light concerns about the activities of consultant X.***

- ***Colleagues and managers were aware that consultant X's clinical practice, in terms of waiting times, conversion rates and case complexity, was at variance with that of other clinicians in the trust. They did not make in-depth enquiries into the reasons for the variance.***

- ***The trust appointed a consultant colleague to work with consultant X and share his urogynaecological work. Despite consultant X's apparent support for this, this arrangement did not work.***

- ***The quality measures used by the directorate (returns to theatre, unexpected blood loss) can provide 'strong' signals of practice that may be deficient. Some of the concerns raised at KPI meetings about consultant X's practice, and the concerns he raised about being isolated during appraisal were among 'weak' signals that something might be wrong. If these had been put together or investigated they might have highlighted problems that later became clear. The trust needs a system that responds appropriately to both types of signal.***

7.115 The findings and comments in this section form the basis for a number of conclusions and recommendations made in sections 9 and 10 below.

8. Governance at Liverpool Women's NHS Foundation Trust

8.1 This section examines the trust's governance arrangements in policy and practice since it was formed in 2005. We focus on recent and current arrangements and record earlier arrangements where that completes the picture. We consider the position of the trust against each of the seven elements of good governance Verita uses to review and benchmark organisational governance. (The full list of issues Verita covers in governance reviews appears in appendix E). Several of the issues emerging from our review of governance in the gynaecology directorate have trust-wide relevance. We address these in this section, and some new themes.

8.2 This wide-ranging part of the review draws on the organisation's policy and guidance documents and the views of managers and staff. We focus on what interviewees told us because this reflects the range of views in the organisation and the extent to which formally recorded procedures are applied in practice.

One: organisational purpose and structure

8.3 We focus on the structure at board and governor level, the executive structure and directorate management, the stated purpose, strategy and objectives of the trust, the clarity with which responsibilities are described and allocated, and the degree of integration of clinical and corporate governance.

Foundation trust governors

8.4 The Liverpool Women's NHS Trust was among the first to achieve foundation trust status when the new NHS system of greater flexibilities and local determination was introduced in April 2005. With FT status came a greater emphasis on governance. The foundation trust has a board of directors and a council of governors. A large number of local people are members of the trust.

8.5 The council of governors (known until September 2008 as the membership council) represents members' views about its plans for approving certain appointments, for reviewing membership strategy, for influencing the board and for promoting community links. The council of 33 includes 18 elected governors from the membership, governors representing staff, PCTs, local authorities and other partner organisations. The quarterly council meetings consider exception reports on service, financial and performance

matters, transacting membership business, and receiving information on current issues. An annual meeting reports to the full membership of the FT. Interviewees said a lot of effort had been put into setting up the structure of governors and forging links with the members.

The board

8.6 The board of directors is responsible for "*managing the business*", according to the constitution of the FT dated March 2005. The authorisation document issued by Monitor under section six of the Health and Social Care (Community Health Standards) Act 2003 requires the board to "*ensure the existence of appropriate arrangements to provide representative and comprehensive governance*" and to "*comply with the principles of best practice applicable to corporate governance in the NHS*".

8.7 The chairman of the trust chairs the board of directors and the council of governors and is responsible for the overall direction and performance of the organisation. The current chair joined the trust in August 2005, a few months after the establishment of the FT. His experience includes several health management roles, including chief executive of a health authority.

8.8 The board has five non-executive directors (the constitution allows six). One is the senior independent director. Three non-executives of the FT formed in 2005 had been on the board of the former NHS trust. Two were new appointees with commercial experience.

8.9 Four of the five executive directors who became board members in 2005 had been directors of the predecessor trust, including the chief executive and the current medical director, who has been in the role since September 1993. The FT created a new post of corporate director, with an independent role to ensure the smooth operation of the corporate affairs of the organisation and to advise the chair, the chief executive, the board and the governors of matters of concern about governance. The executive team changed considerably over four years, with new or interim post-holders or managers acting up to cover others for maternity leave. A new chief executive has been in post since September 2008.

8.10 The board of directors has met monthly since March 2007, having met every two months in the previous two years, when the full board met also as a committee known as the corporate assurance and standards committee (CASC). Board meetings are held in private in accordance with the FT constitution, though for a period in 2005 and 2006 three meetings a year were held in public. Minutes of part one of the board meetings are posted on the trust's website.

8.11 The formal papers of the board, including the private papers from part two of the meetings, show a range of business and style of agendas and minutes like that expected of any trust in the NHS. The governors' meeting papers indicate a similarly normal and controlled range of appropriate business. The minutes of the board and governors' meetings are of the normal standard for NHS trusts. However, they sometimes lack context. Members of the public who read them may not gain a clear picture of particular issues or their significance.

8.12 The structure of meetings and their minutes show that relationships between the chair and the board, the chair and the chief executive, and the board and the governors were largely clear and worked well. This implies that roles and responsibilities are clearly defined and understood at all levels and it is clear how problems can best be discussed and escalated. The board has focused too much on operational issues at times but this is being addressed. One non-executive said that on joining the trust they found the nature of the board very refreshing, in an environment where everybody was genuinely heading in the same direction and working together for common aims and to take the business forward.

8.13 Board minutes show that challenges to the executive by non-executive directors are mostly in finance and strategy and "countable" performance rather than in areas such as service outcomes and clinical direction. A non-executive said that while board members had good relationships the situation had a danger of becoming too cosy. They felt it was important in their role to be quite challenging of some of the issues. The interviewee said they had seen a change in the board, which was now looking at other horizons in a way it previously had not.

8.14 At executive directorate level, the roles of finance, service development, human resources, nursing and quality, and medical directors are clear on how issues are handled and reported to the board. However, this led in the executive directors' team to a

tendency for issues to be handled "in compartments". One non-executive board member said of the executive team that it was five businesses under one umbrella. The contribution of each individual director to corporate trust-wide issues is unclear from documentation and interview evidence. A non-executive observed that there should be more dialogue between the whole board and that there had been situations where the executives had not appropriately challenged other executives about something. Issues had been debated among executives before reaching the board but it was felt that too often they were brought into the board with the view that they had already decided a matter. The interviewee added though that the executives responded well to non-executive challenge.

Committees

8.15 Below board level, the FT established a number of committees in 2005. They were most often referred to as sub-committees but were actually full committees. In March 2007 the committee system changed and it operated until early 2009 with nine committees reporting directly to the board.

8.16 The FT's initial focus was to set up good governance through the audit committee, the finance and contracts committee, the remuneration committee, and the membership council. Non-executive focus was in these statutory committees, but there was also input to the other committees that covered HR and charitable funds. The audit and finance committees operated well and control of these matters has been good. The audit committee has a rolling action sheet indicating how and when previously agreed actions have been taken, among other examples of good practice.

8.17 The new FT set up the large formal corporate assurance and standards committee (effectively the whole board) to fulfil an FT application promise to improve the previous NHS trust's structure which a pre-FT assessment in 2004 did not consider fit for purpose. One aim of the CASC was to meet FT standards and "*to move the trust to a single risk-sensitivity process covering all the trust's objectives, supported by co-ordinated collection and inspection of information.*" In fact, the CASC's standard agenda mirrored the normal range of NHS trust board business. The board discussed the relationships between CASC and the audit committee, and CASC and the governors but not the apparent overlap between board and CASC business.

8.18 The FT's clinical governance committee took the same form as that set up by the predecessor trust in 1999. It changed it to a board-level clinical governance committee (CGC) in March 2008.

8.19 The medical director has chaired the clinical governance committee since 2004. For the first two years of the FT, the committee reported to the board through the CASC and the audit committee. In March 2007 the committee was revised after a review by internal audit. A new system of twice-yearly reports from each directorate began in an attempt to take a more focused approach to directorate governance. By January 2008, the committee was recording that directorate reports "*are getting better but there are a few gaps to close*". Since March 2008, the committee has reported directly to the board rather than through the audit committee. From a non-executive perspective, one board member said that reports from the clinical governance committee have a cycle where reports are issued and then there is a headline presentation that is very helpful. However, the interviewee felt that the trust needed to find a better way of summarising issues and bringing them to the board; one of the problems was that the key clinical activities that are not measured are those that can cause the trust a problem.

8.20 For some years the trust has had a formal process for identifying and managing risk – first through the CASC, then in March 2007 through a new committee reporting directly to the board. A 2008 review of the trust's board-level processes, commissioned from an independent organisation, concluded that "*board attention to internal risk appears robust*".

8.21 The trust set up an information management and technology committee in 2005 to lead this area of work and to enable the trust to meet central reporting requirements. Its status as a board committee was unclear and it has tended to operate below statutory committee level.

8.22 An informal weekly meeting of executive directors and a formal monthly management executive board (MEB) comprising all executives, service heads and the clinical and managerial directors of services links day-to-day management of the organisation to the board and the formal committee structures. The MEB's terms of reference were revised in September 2007. The board minutes confirm that the MEB is not a board committee but "*a subsidiary of the board, an operational arm*". The MEB suffered from having a large membership and a multiple role. It transacts business, informs directorates and receives views from them, and there is some duplication of

business with the weekly executive directors' team and with the board and its committees. Nevertheless, it is the one forum where all business is brought together.

8.23 Committee chairs and the relevant executive leads agreed to meet in April 2008 to review the schedule of items to be reported to the board. This established another means of linking up business.

Current and future structure

8.24 The trust's structure has undergone regular review. The trust analysed its fitness for the new regime before FT status in 2004. Aspects of the structure were found to be unsuitable and a new one was established in April 2005. Mersey internal audit reviewed this again in October 2006. The review was positive but found that some committees were too focused on operational matters – especially CGC – and that committee members had no induction to their roles. Board papers were also twice as long as those from other FTs. One reason for this was that the board met less often than others because of the CASC system. In fact, the CASC was transacting business as the board.

8.25 The trust commissioned a review of its performance in 2008. This was part of the planned introduction of clinical business units to replace the former clinical directorate structure in April 2009. An independent company provided the board with 73 points for consideration. These included: that the board should look forward and be more strategic; should be clearer about where their marketing work was leading; should reduce their committee structure; should reduce NED involvement in executive level committees; should reconsider the length and style of meetings; and board members should have greater contact with staff and the membership council. In March 2009 the board considered and agreed a number of actions to progress these recommendations.

8.26 The committee structure of Liverpool Women's NHS FT from September 2009 will comprise five board-level committees. Three of these (audit, remuneration and charitable funds) will run as before, while two will be renamed and refocused – finance, performance, and business development; and governance and clinical assurance. Other former committees will become more operationally focused groups which support the work of board-level committees. For instance, marketing will have a primary association with the business development committee, and clinical governance and risk management with the governance and clinical assurance committee.

8.27 The weekly executive directors' meetings, now more formal, remain as an executive committee. The former management executive committee, which includes senior managers and clinical directors from the operational directorates of the trust, will report to the executive committee.

8.28 Since 2005 the trust has had a management structure below corporate executive level based on six directorates: neonatology, reproductive medicine, gynaecology, obstetrics, critical care, and genetics. Here, key responsibilities lie with the clinical directors and the directorate managers.

8.29 In April 2009 the trust intended to start a two-phase programme introducing four clinical business units – maternity, theatres and gynaecology, reproductive medicine and genetics, and neonates and pharmacy - to replace the six former directorates. This programme revises the roles of service management teams and the responsibilities of individuals like the clinical directors and the CBU managers. The programme was devised to comply with Monitor guidance on *Implementing Service Line Management* and focuses on meeting requirements under the headings of structure and leadership, planning, performance management, and information support. Some corporate services are integrated into CBUs and others are subject to service-level agreements. The first phase, implementation, has gone "live" in one directorate with the other three still to be authorised. There will be a second phase of work designed to assure the quality of the new system.

Purpose, strategy and objectives

8.30 The constitution of the trust describes how "*the FT's purpose is to serve the community by the provision of goods and services for the purposes of the health service*". The trust has made various statements of aim and purpose in its annual reports. Since it became an FT these have typically described an aspiration to excellence and world-class performance. The mission statement that applied between 2005 and 2009 was "*We shall deliver clinical excellence in all our services; We shall deliver strong financial performance; We shall ensure all patients have a positive experience in our care; We shall be the provider of first choice for women and their families; and we shall promote our status as a premier University Teaching Hospital and Centre for Research*". In October 2008 the board agreed a new brand and logo, a new statement of mission and new statements of vision and values: *"Our mission is to provide excellent health care for*

women, babies and their families in a safe, friendly and caring environment; Our vision is to be the recognised leader in health care for women, babies and their families; The values we want to be recognised for are: specialism, excellence, compassion, commitment, unity, integrity, and progress".

8.31 Interviewees' interpretations of these statements varied. A senior clinician said the trust wanted to be nationally and internationally recognised as one of the best providers of care for women while another said there are people who work in the trust who are national figures in their specialty and are opinion-givers in the Royal Colleges, and so they give the trust a national standard. Some clinicians and senior managers pointed out that it varies according to the service. For example in genetics and neonatology the trust is a regional specialty centre, which is quite different from the situation in obstetrics and gynaecology. For some, the international aspiration interferes to an extent with the process of service delivery. Others said the trust's profile as a leader in the field meant that people there sometimes lacked insight about the areas of work that fell short of acceptable standards or were slow to develop. One senior manager, reflecting on the recent change in vision, said that it had gone from being the world leader and world class health care to something more focused in wanting to provide high quality, very safe services that are measurable.

8.32 Board and committee papers and annual corporate and clinical reports show that the FT board paid considerable attention to the trust's overall strategy, to ensuring the viability of its niche services and to its financial and organisational viability. The trust set out its service strategy in a number of annual reports and service plans. It is due for renewal in autumn 2009 alongside phase two of the CBU implementation. The board approved the current *Service Strategy 2007-2010* in March 2007. The document describes three strategies for achieving the corporate aims of the mission statement: pursuing productivity and efficiency, pursuing service growth and pursuing world-class outcomes. The principal service developments are a new model of obstetric care, community-based gynaecology services, increased access to assisted conception services and active links with the private sector.

8.33 The trust also publishes strategies on other than service issues, for example on maintaining trust membership and information management. No single document comprehensively links these strategies together or with the service strategy. The trust does, however, make an annual plan available to its principal regulator, Monitor.

8.34 As described in section 7, the strategy for ACWH remains unclear, even though many interviewees described either the need or desire to maintain and develop services at ACWH.

8.35 Strategy for clinical services has been developed specialty by specialty and has focused on the relatively short term, as dictated by the funding cycle. The trust has only recently developed a comprehensive clinical excellence strategy: *Safe Healthy Successful*. In February 2009 the board agreed a process to finalise this after discussion with stakeholders.

8.36 The process for producing annual directorate and corporate plans is clear: and they are presented under headings that reflect the trust's vision and aims. However, the trust's high-level, aspirational objectives are not a close match with the directorates' objectives. Annual operational plans reflect the trust's overarching objectives, local objectives designed to sustain and assure services are missing.

8.37 Managers said the operational planning process was driven from the top. One middle manager said the operational plan each year is written to fit with the trust's objectives. Although one senior manager in gynaecology felt that the operational plan was firstly to maintain and sustain the services delivered and then to adopt new methods if required, generally the evidence from the content of operational plans suggests that staff have not appreciated that corporate objectives are about both sustaining *and* developing truly effective services.

8.38 The directorate management posts in NHS trusts are typically filled by promotions from junior management or fast-track management training schemes, or by nurses and other clinical professionals moving into general management roles. This is true at Liverpool Women's, which has a cohort of middle managers from a variety of backgrounds. It is a relatively small trust so it has the extra challenge of ensuring the capacity to cover all necessary functions.

8.39 In December 2006 CASC received an internal audit report on directorate business which said: *"there is a long record of corporate and business items not being addressed by directorates, resulting in a lack of engagement by some clinicians"*. In June 2007 an internal audit recommendation on directorates said there was a need for better governance documentation, better embedding of assurance work and better feedback

both ways between the management executive board and the directorates. It added: in the directorates, "*gynaecology needs a governance review.*"

Comments on organisational purpose and structure

- ***The trust has a well-formed and stable structure and operating arrangements at membership and governor levels. About half its board members have been in position for a comparatively long time and several came from the previous organisation. Turnover among executive directors in the past two years has been considerable.***

- ***The processes of the board and governors' meetings are of a good standard, compliant with FT and other guidance.***

- ***Each committee was properly established and organised but its collective impact on how the trust is managed is not as it was intended, particularly in the cases of integration of governance, clinical governance and risk. The trust recognised this and has made a sustained effort to improve these processes.***

- ***We support the aim to define more clearly board responsibility and management group roles. The trust must implement and monitor their progress on action recommended in the 2008 external board analysis report. This includes agendas more focused and greater quality control of reports and conduct of meetings.***

- ***The trust has had a well established directorate structure and effective strategic and operational planning processes. Recent change from the former directorate structure to new CBUs allows improvements in organisation and integration of governance.***

- ***The relationship between directorate management teams and the trust's executive management team may have been more distant than was appropriate, except when significant problems gave rise to periods of intense scrutiny and involvement from above.***

- ***The trust has not clearly stated the strategic future of ACWH, nor stressed its clinical importance in the trust or its value to the trust's business and to local patients in north Liverpool.***

- ***The trust has an annual process of setting objectives at corporate and directorate level. Directorate objectives are defined in the trust-wide framework. It is less clear that this translates to the individual objectives of managers and key members of clinical staff.***

Two: performance analysis and assessment

8.40 This section focuses on achievement against stated aims and objectives, reporting to the board, engagement of clinicians, executive control, and clinical governance capacity.

Corporate performance

8.41 The trust, like many in the NHS, has recently moved from topic-based reports to the board on separate aspects of performance – finance, activity against targets, progress in implementing particular national initiatives – to a more planned and wide-ranging "dashboard" indicating where the organisation should focus its efforts. The trust follows good practice guidance in compiling reports and reflects the key issues that regulators, auditors, board members and local stakeholders want managed well. This pattern of performance-reporting is mirrored in each directorate.

8.42 Directorate and finance committee papers, operational and audit reports show that statutory matters and financial and service performance against budgets, deadlines and targets are appropriately reported. The trust acts on auditors' recommendations and on external regulators' advice.

8.43 External scrutiny of the trust's activities and the resultant star ratings, Monitor ratings and NHSLA/CNST ratings has brought good results. The membership council minutes in July 2007 noted that the trust was one of only five in the country with top ratings for finance and governance and that the chair had advised the council that "*the trust can now present itself as a very successful organisation*".

8.44 Board-level interviewees said they had spent a lot of time in the first two years of FT status trying to make sure that performance management, budgetary control and activity levels were right, and that they were thinking about the financial control and business focus that was required of them. However, in a relatively small trust this approach led to some executive team intervention in directorate-level operations. One director felt that at the time of the gynaecology performance problems in 2005/2006 there had been far too much detailed executive conversation about gynaecology and some debate about whether the gynaecology team could actually manage their performance issues. The preferred solution was to manage the performance problem from above rather than to address the deficiencies in directorate management or capacity.

8.45 Corporate reports to the board regularly include statistics and trends about the performance of staff and the human resources systems that support staff and management. Policies and procedures are comprehensive, largely up to date and discussed appropriately with staff representatives and board-level committees. However, board-level discussion of HR issues and performance is limited to concerns about sickness absence, bullying and lack of response to staff surveys.

8.46 As in many NHS organisations, information management and technology services in the trust have been managed by staff at corporate level who are not board members, but who report to an executive director of the board with responsibility for these services. The trust's IM&T management group reports to senior managers through the management executive meetings. Regular updates are provided to the board of directors. The trust has made attempts over the last five years to improve the availability and resilience of information management and coding. The work has focused on implementing national IT strategic objectives, improving the IT infrastructure and working with other corporate and clinical directorates and their needs.

8.47 Reports to the board on information have focused on IT systems and processes. Those processes have traditionally centred on basic financial and contracted activity data and on meeting the standards required by auditors and regulators. Recently, much more attention has been paid to collecting and analysing information about clinical services for management and governance purposes.

8.48 The trust has also started to give more consideration to the problems of data quality and data about quality of service. In October 2004 a data quality group was

established to ensure improvement in this area of work. This was in part a result of disagreements with AUH about service level agreements. A board meeting in October 2006 decided that clinical information was not substantial enough for board purposes. Several interviewees commented on data-related issues. One felt that on a day-to-day level the clinical records were poor. Some clinicians felt there was no accountability for effective records management among the support staff. Another issue raised was the lack of electronic systems to support archived information, and it was observed that people were scrabbling unnecessarily to fulfil any non-standard request for information.

8.49 Staff at various levels want better clinical information, either to help with day-to-day activities and decision-making, to enable better audit and planning or to allow more meaningful debate in directorates and at board level about the quality of clinical services and the outcomes for patients.

8.50 The information team collects information about services for report to directorates and to the board and its committees, partly in overarching corporate performance reports and partly through separate clinical reports to the CGC. In recent years directorate managers and clinical directors have made presentations to the board on key directorate issues.

8.51 The current dashboard reports from directorates to the board cover the following areas of clinical quality assessment: compliance with the hygiene code, infection control, complaints, lengths of stay, cancellation and readmission rates, participation in clinical trials, and staff sickness and turnover. Reporting to directorate level and to the clinical governance committee includes other areas such as adverse clinical incident reports, risk register and more detailed versions of the board-level reports.

Assessment of clinical quality, governance capacity and directorate reporting

8.52 Designated staff lead clinical governance work in every directorate. The corporate picture is drawn together, monitored and managed by an assistant director reporting to the director of nursing. Clinical governance activity is reported from directorates to the CGC at least twice each year, and on to the board. Directorate reports cover outcomes; risk registers, adverse clinical events (ACE) and risk management; infection control; complaints; patient surveys; performance against external standards; education and training; clinical outcome indicators; clinical audit; research; and medical staffing.

Various committees report to the CGC, including clinical audit, medicines management, infection control, and risk. The trust publishes an annual clinical report.

8.53 The role of the assistant director for clinical governance is to ensure reports are made from and to the right places at the right time, both internally and to external regulators, and to advise staff running the processes locally. The assistant director said there was a good system in place relating to the CGC, with all clinical matters going there and summaries being made to the board; information went back to directorates, each of which had risk management committees and medical staff committees that should feed down to the wards.

8.54 Interviewees said that clinical governance has been quite mechanistic. One said that when Mersey Internal Audit reviewed aspects of governance in 2007 the conclusion was that there was a lot of process, a lot of information, but that it was not necessarily effective in terms of decision-making and ownership, and at that time directorate-based reports had been introduced. Board-level interviewees told us they saw a lot of evidence to say clinical governance is working better and that the way the committee operates now is quite different from the way it did in 2007. There was now a greater understanding by clinical governance leads about what is required. However, we also heard those who felt that there was not a lot of coming together and sharing. For instance, one interviewee said obstetrics developed a very sophisticated risk management approach and yet that was not translated into other directorates. Some felt that it was unhelpful that quality is often seen as a nursing issue. Apart from the perceived onus on nurses to monitor quality in general, there was also a concern that there is no off-the-shelf tool to monitor clinical excellence for nurses. The assistant director responsible for clinical governance said directorates are supposed to quality assure and send reports in for additional assurance, but that often the reality is that the assurance is only done at assistant director level.

8.55 Interviewees described problems with clinical information in various ways. One director referred to the situation around 2007: every person they met described the trust to them as "a centre of excellence" but when asked to give some examples and the evidence, this was not as available as it should have been. In 2007 each directorate was given a challenge to set five clinical excellence indicators which it would apply, monitor and report upon. Guidance from the trust board in 2008 led directorates to develop 10 indicators which would be particularly useful, including those where information was not readily available.

8.56 A board-level manager said one of the things the trust continues to struggle with is the clinical information that comes to the board. They said there was no lack of clinical information, not least because of the requirements of external assessors, but that it was about focus and interpretation. Another felt that most of the board are non-clinical, so the metrics that come forward are too superficial and the board relies on asking the medical and nursing directors to help the others pick their way through what they need to know about whether the trust is performing well.

8.57 The challenge of combining clinical and non-clinical information to form a complete picture of a service is evident in the case of consultant X, where the connection between activity and finance, and clinical practice was recognised too late.

Engagement of clinicians

8.58 The trust recognises that enhancing the quality of clinical information requires, among other things, that clinicians engage with reporting and analysis systems. Feeding the performance reporting machine has largely been a directorate and executive management activity. Clinical directors and those clinicians with particular audit or governance roles contribute to information collection and analysis, and put it to use: but the wider clinical community does not see this as part of its routine work. Interviewees said recognition of the need for clinical governance was improving but there was still some concern about what felt like close scrutiny of individual professional practice.

8.59 During 2008 the trust developed a clinical excellence strategy "*to enable the trust to demonstrate the consistent provision of clinically excellent health care*." This strategy was approved by the board for action in 2009.

8.60 The strategy outlines a number of useful approaches to action which include the intention to provide better clinical information to support clinical business units; to set standards in each clinical directorate that everyone knows; to review and improve clinical audit; to benchmark the trust against Birmingham women's trust and international providers; to share clinical information with staff and patients and partner organisations; to work with commissioners on quality as well as contracts; and to review the health promotion and public health strategy of the trust.

Clinical audit, research and development

8.61 The trust has designated directorate leads for clinical audit as part of the overall clinical governance arrangements. A trust-wide clinical audit committee reports to the CGC (and presumably to the new governance and clinical risk committee). Successive annual reports and clinical annual reports have shown strong audit activity. The 2007/2008 clinical annual report reported 93 audits, of which 26 were in obstetrics and 14 in gynaecology.

8.62 Interviewees said audit planning was related both to the interests of particular clinicians and to the themes that emerged from national guidance and the trust's clinical governance and clinical audit committees. These interests and themes were not well connected to helping with the overall objectives and strategy of the organisation.

8.63 Interviewees said the trust had struggled to meet very good audit standards in terms of the organisation of audit and the research to support it. Several told us that obstetrics were good at peer review and at scrutinising each other's work. Interviewees felt that obstetrics conducted most audits (between 30 and 40 a year) partly because of the requirements of CNST and also because most obstetricians actively supported audit. Most people we spoke to confirmed it had not been the same in gynaecology.

8.64 Two interviewees said the trust-wide audit was not sufficiently linked to the strategic direction of the organisation or to corporate priorities. It was not well connected with the executive team and board and its programme of work did not fit easily with some national requirements. Resources and levels of administrative support available for the task were insufficient and audit staff lacked authority to make improvements. The outcomes of audits were often difficult to implement.

8.65 As a trust with specialist expertise in a number of services, Liverpool Women's undertakes more research and development than other trusts of its size. Clinicians said that across all the specialties patient activity is the largest or close to the largest in the country, and so the volume of research in the trust is different. However in February 2008 the CGC heard that research and development was not included in reports on clinical governance and that the trust "*was struggling with this*". The trust has appointed a lead director for research to address this issue.

8.66 The medicines management committee provides an approval process for considering and funding new treatments in the trust. This process was used in 2007 to introduce vaginal mesh procedures undertaken by consultant X and one clinical colleague. There were different opinions among interviewees whether this should have been handled as a research project, a new procedure or a new consumable to be approved through the medicines management committee. One senior interviewee felt that the trust's process for approving new treatments was not used very often and would benefit from a review.

Comments on performance analysis and assessment

- ***The trust performed at 3-star level for several years before the current assessment system came in and performed well against Monitor's financial level 5 and CNST 3 standards.***

- ***The trust has refined and improved standards in some elements of good practice. The KPI meetings process is an example.***

- ***The trust has recently started to develop better metrics for performance generally and for clinical performance in particular. This is leading the trust away from what had become a rather mechanical approach to assessing its performance and an over-emphasis on target-related activity.***

- ***The executive directors should ensure they have a robust process to challenge CBU management teams regularly and formally about their performance and progress the mechanism.***

- ***Information technology systems across the trust are not fully aligned and hinder optimum operational and reporting processes. For example, online prescribing systems operate only at Crown Street.***

- ***The trust has recognised the need for a greater focus on clinical performance and quality measurement. It has just produced its first comprehensive clinical excellence strategy.***

- *The board needs better assurance about clinical activity and this should be pursued from board meetings throughout the organisation. It has lacked the right board level process for discussing this.*

- *The trust has established clinical governance systems and processes. These have formed the basis for submissions to regulators and others. This review reveals, however, that trust systems do not all operate to a consistent standard. It is unreasonable to expect a foolproof governance system, but there is evidence of weakness in the work of the CGC, in the way performance is reported on and in action taken on reported concerns.*

- *Faster progress has been made on governance arrangements in some parts of the trust than in others.*

- *A question remains about whether some processes, for example quality assurance, should be led and managed at directorate or CBU level rather than at a trust-wide level.*

- *Clinical audit work is well advanced in some areas of trust's work but much less so in others. Investment is not balanced among the directorates. Some senior members of staff are concerned about the way audit findings are acted upon.*

- *Some senior staff are uncertain about how the trust introduces new treatments. This may have implications for safety and finance and the risk that the trust's services do not develop in line with the PCTs' commissioning plans.*

Three: assurance and risk

8.67 The review examined matters relating to the assurance framework, risk reporting, integration of risk, response to untoward incidents, clinical engagement, primary risk awareness, audit, and quality and output assurance.

Assurance framework

8.68 The purpose of a controls or risk assurance framework in NHS organisations is to bring together all risks to the successful operation of the organisation, and to demonstrate that systems exist to identify, minimise the effect of and monitor these risks. The trust's current risk management policy, agreed in 2007, identifies three types of risk - clinical, non-clinical and financial - that have the potential to affect adversely the trust's patients, staff, services, resources and reputation. The policy sets out mechanisms by which controls are effected and co-ordinated for identifying and prioritising risks, identifying the appropriate level at which risk management action should be taken, implementing a way the organisation can learn from its risks and incidents and assuring the board that effective decisions are made about managing risks.

8.69 The trust has reviewed its risk assurance arrangements several times. In July 2004 assessors for RPST (the risk pooling scheme for trusts) commended the trust's long-standing risk management strategy. As part of its preparation for FT status, the trust updated its risk assurance framework to focus on principal risks to the organisation (January 2005). This work was based on a risk assessment of directorates' annual operational plans. The FT board agreed its first board assurance framework in May 2005, and noted this "*is a live tool to help to understand the principal threats to the trust's business*". In June 2005 the framework described 73 goals and 16 priorities.

8.70 In March and April 2008 the board discussed and agreed an updated risk assurance framework, which described 19 high-risk areas. It also discussed whether the trust should include clinical outcome indicators themselves as a risk. In April 2008 MIAA gave an A rating for assurance but wanted "*tightening of the controls and more real assurance*".

8.71 Interviewees gave a range of views about risk management at the trust. Some clinicians and some of the trust's middle managers felt that risk systems were in place and well used. Others in the same groups described the opposite. Some senior managers recognised the problem of the divergence of views. One director-level interviewee described how a number of clinical risks were of longstanding and were difficult to address, giving 24/7 consultant cover as an example. This was a matter the medical director had raised with the board in November 2005. Other interviewees said the governance of locum doctors was a problem, and that there was a feeling that such problems need to be flagged up much more rigorously in risk registers. A senior director

felt that the organisation gears itself up for assessment against standards, but does not always maintain its focus on risk management between assessments. A non-executive said they did feel confident about the clinical governance process because the staff want to do well and are very keen about keeping up their external assessment ratings.

8.72 The new Care Quality Commission takes responsibility for monitoring NHS care standards from 2009 onwards and will make inspection visits to all trusts during the year. The commission has indicated that for 2009/2010 it will focus on three areas: safety and efficacy of clinical interventions; decontamination of medical devices; and public health activities.

Risk register

8.73 Liverpool Women's had a system for identifying and recording risk before it achieved foundation trust status. It was not until August 2005 that the board considered a full register of all risks. The new operational risk register was presented as "*an integrated electronic risk register for clinical and non-clinical risks to become operational via the Ulysses system*". The trust's risk management process uses a scoring system where the score reduces as a risk is resolved or mitigated. Eventually, the risk is removed from the register of a particular directorate or of the trust as a whole. The NHSLA is content with the trust's risk register arrangements. There is evidence that several directorates struggled with completing risk registers and it is still not clear that the system covers all aspects of clinical and non-clinical risk in an integrated way.

8.74 The March 2009 version of the gynaecology directorate's risk register shows 85 current risks dating from May 2006. The entries cover a wide range of operational issues from specific clinical events and their resolution to the induction of temporary staff, to the need to ensure that all clinical trials have written policies and have been authorised by the ethics committee. Issues arise about renewing and applying policies and procedures in response to past events or to perceived risks. Most of the entries have action plan completion dates that expired long ago.

8.75 The risk register policy written in 2006 describes the register as "*a repository for all risk information*" and underlines the diverse systems through which risks of all kinds are identified. It underlines that the register should be a live tool to help the organisation understand itself and address its problems. It refers to action planning against each risk

but does not go on to set out clearly how action plans are to be devised and managed. It does require directorate and departmental management teams to review the register at least monthly. Interviewees felt that departmental risk registers are regularly updated and owned at directorate level, but one clinician described the risk register as more of an administrative matter indicating whether a protocol is in place as opposed to saying whether staff adhere to the protocol.

8.76 Several interviewees were asked whether they felt the right risks emerge as principal risks for the organisation. Most agreed that the question remained about whether departments have really captured areas of corporate risk and whether there is a process in place for the organisation to do so. One director said that a look at the trust's principal risks now would show none to be clinical and that they would be around access targets or MRSA rather than infection in neonates or access to blood transfusion 24 hours. Staff also told us about a number of clinical risks not logged on a risk register. For example, one consultant in the gynaecology directorate was convinced that inpatient operations should not be taking place at ACWH. Another said the organisation did not readily enough identify and manage patients who became seriously ill after surgery.

8.77 The gynaecology directorate's operational plan for 2008/2009 lists three principal risks. They are all finance-based: cost escalation beyond budget, income recovery below planned levels, and reduced liquidity. We also learned about plans for a clinical risk forum where all risks could be registered and prioritised for action through the regular operational planning process. The trust's 13 priority risks at the end of January 2009 as reported in the board assurance framework included three under the corporate aim of delivering clinical excellence. These relate to risk of failure to maintain waiting list and waiting time targets and lack of funding for electronic patient records.

Reporting serious untoward and adverse clinical incidents

8.78 The trust provided us with three trust policies, covering the reporting of serious concerns and incidents about clinical and non-clinical matters. Serious untoward incidents (SUIs) are to be raised under the *Raising Concerns* policy or the incident reporting policy. The policy on *Raising Concerns* is part of the pack of HR policies and is effectively the "*whistleblowing*" process for trust staff about any serious matter of concern. It makes clear that the policy should be used "*where the interests of others or the organisation are at risk*" and "*should be used in relation to untoward occurrences*". It lists examples of

these, including abuse of patients, health and safety, fraud and corruption, and "*concern about standards of care*". The policy sets out what staff should do to raise concerns and describes various support processes. It says that managers will review any concern raised and explains that there is direct access to the senior board director or the chairman. It does not set out how the organisation's management or board might resolve or report the concern raised.

8.79 A separate incident-reporting policy dated July 2006, due for review in 2009, describes the roles and duties of managers and all staff in reporting clinical and non-clinical incidents. This is similar to the adverse clinical incident policy (see paragraph 8.83 below).

8.80 In March 2006, the board discussed assurance about clinical events. The chief executive assured them that this would come through SUIs being reported to the board "*as a matter of course*". The board minutes of May 2005 demonstrate this. The medical director reported an SUI and an internal inquiry about a death in gynae-oncology. In July 2005 the medical director informed the board about an SUI in operating theatres. There is an SUI report on part two of the board agenda of March 2009. However, there were no clear audit trails from all SUIs through to the clinical governance committee and the board.

8.81 The trust has three incident reporting processes. Staff and managers appear unsure which is which. Talking to interviewees about SUI reporting, the response was normally related to the different process of reporting adverse clinical incidents (the ACE policy). A middle manager felt that the trust has a reasonably robust incident reporting process which has taken time to evolve; people had once seen reporting as "snitching" but now the culture had changed to the point where staff feel that if something is reported somebody might respond to the problem. We were told that increasingly staff are willing to report incidents and that this is not just to cover themselves but because they can see the value of having actions taken.

8.82 Interviewees said the way serious clinical practice events were reported varied between staff groups and directorates. Managers involved with clinical governance processes felt that many clinicians did not have a clear idea about how the review of a single incident might lead to an addition to the risk register. Understanding varied between directorates.

8.83 The trust introduced its policy on reporting and handling adverse clinical incidents in 2002 and reviewed it in 2003, 2005 and 2008 and it is well established. It requires all staff to report any adverse clinical incidents and defines an ACE (or a near miss) as "*any unexpected clinical event which in the short or long term caused (or could potentially have caused) actual harm to a patient in our care*". The policy is clear about the responsibility of all staff to report all incidents as part of an open and honest organisation and as a learning mechanism. It underlines the intention that reported ACEs will be reviewed as systems and not used as part of a disciplinary process against individuals.

8.84 The ACE system, by definition, addresses specific clinical events rather than general systems or circumstances. Taking ACE reports in gynaecology, for example, the range of specific issues includes: returns to theatre and transfusions; administrative matters like missing notes, results, wrong details on theatre lists; equipment failures and absences; and lack of SHO cover in the early evening. Incidents are often reported by more than one person. The 2007 clinical audit report showed 11 per cent of ACEs were about clinical management against 24 per cent in 2006. The clinical incidents reported to the National Patient Safety Agency in 2008 included 9 per cent that were about clinical assessment. The trust reported at a rate of 5.52 per hundred admissions, placing the trust in the upper quartile against the 4.63 average for trusts generally.

8.85 All interviewees were familiar with the ACE system and could talk about it in some detail. Those working with patients directly felt that they or their colleagues used the system when appropriate and felt confident they knew how to react to an adverse clinical event. Most people also felt that the system was used more now, although some saw a reduction in usage, reflecting their uncertainty about its value: they said people either thought there was no point because no change results, or said they were too busy. One consultant at ACWH said they had given up using ACEs for this reason.

8.86 It is clear that most staff use the ACE system not just for incidents and near misses, but also to alert managers to staff shortages or equipment problems. People reporting incidents do not often receive enough feedback on follow-up.

8.87 Talking about what happens once something is reported, many people felt that the actual investigation is very much a tick box process and some thought that no action was taken as a result of a report. The PALS service often has to ask whether an ACE has been raised, and is often told "no" or "don't know". The PALS manager felt this was partly

because people do not see feedback and added that patients did not either. She felt that a matter may be investigated and whatever needs to be done implemented, but the most important person does not get to know about it. The forms and process instructions in the ACE policy are likely to be interpreted in this way, but they are clear and they underline the review process to be followed, which includes recording decisions about feedback to those involved.

8.88 The picture from the top of the organisation was mixed. An executive director said the trust must encourage people to report things and that there must not be a blame culture. A second director spoke of a feeling of confidence about adverse events because the trust seems to fare well with external assessors in that area. Another agreed that the process for reviewing each ACE was sound but said that the trust had not analysed all the ACEs in gynaecology and that might be an interesting picture.

Complaints

8.89 The trust has up to date policies for complaints and legal claims. They are comprehensive and of NHS standard. We looked at complaints summaries for obstetrics and gynaecology. These appear to include relevant detail and to treat complaints seriously, with clear action decided upon in most cases. Summaries are reported regularly to the CGC and high-level reports are made to the board. The trust makes creditable efforts to act on the results of complaints investigations. We found no evidence of evaluation of the complaints process.

8.90 We also reviewed the lists of legal claims in obstetrics and gynaecology. They are what would be expected in any NHS trust. This picture is reinforced by the range of opinion among interviewees. A manager involved with clinical governance felt complaints are very well addressed and that a lot of complainants are seen face to face in order to resolve problems. Another manager described complaints as a slick function in terms of response times but was concerned that the system is too mechanistic and that the trust does not take time to learn fully. It was mentioned that there have been a large number of formal complaints about attitude and that there had been a level of complacency about that. Some of this concern is generated as a response to the commissioners. We were told PCTs are now starting to focus on indicators and asking what has been done about complaints rather than whether the trust has got all its responses in on time.

Comments on assurance and risk

- ***The trust has sound policies and systems for producing risk frameworks, for registering risk and for monitoring actions to mitigate known risks.***

- ***The trust established an assistant director post to coordinate its risk management work. There is evidence, however, that risk management systems and processes rely too often on the assistant director to facilitate and enforce their appropriate use, rather than on coordinating the work of others. There is conflicting evidence about risk management in the trust. All the necessary policies and procedures are in place, but they are not applied consistently.***

- ***The culture among clinical staff is of trying to hand on responsibility for risk management, rather than accepting it as part of professional conduct.***

- ***Staff at the trust have attempted to introduce an integrated approach to risk but are yet to be fully successful.***

- ***The trust may not have fully addressed the issue of risk. "Risk" is understood differently through the organisation. Some staff address specific clinical risks while others evaluate the risk of not achieving corporate objectives.***

- ***The risk registers built up by directorates have not been assessed for gaps in the description of prime risks, either by directorate teams or the trust corporately.***

- ***The cultural and operational differences between the gynaecology services delivered at ACWH and Crown Street have never been listed as risks.***

- ***Issues remain on the risk register for long periods, and action plans to resolve them are not always realistic.***

- ***Systems are established for serious untoward incident reporting and adverse clinical incidents. However, there is more than one applicable policy for staff***

to follow and no clear policy on how a reported incident will be handled and managed.

- *Staff appear more inclined to report a problem, especially if it is to do with a systems issue. However, this is less likely if an individual is the focus of the problem. The criteria for completing returns are interpreted differently.*

- *Better feedback on individual adverse clinical incident cases and complaints, and routine action on the outcomes of these systems would encourage people to report problems.*

- *The trust applies its innovative policy on 'Standards for Behaviour, but with so far variable results.*

- *The trust is addressing operational and systems problems at ACWH which more than one senior clinician said might compromise patient services. This will provide the board with greater assurance about the quality of patient care delivered there.*

Four: organisation development

8.91 We considered aspects of culture and behaviour in the trust, induction, objective-setting, appraisals and personal development, HR policies and staff survey results in analysing how the organisation develops itself and individual staff members.

8.92 The trust does not have a separate strategy for organisation development. Board papers and the draft clinical excellence strategy reflect recent debate about necessary investment in organisation development work. The absence of an OD strategy is more noticeable in the context of the recent turnover in director posts and the introduction of the new CBU structure. Several interviewees mentioned the effects of these. Middle managers particularly notice change at the top. We were told that pervades down to the point where it does feel "slightly wobbly" at the moment. The CBU agenda demands strong clinical leadership and substantial change in the way services are managed. One director said the trust was working to make sure that leaders of the new divisions understood the considerable difference between the old and new arrangements and were equipped for the challenge this would bring.

Culture and behaviours

8.93 The trust has established a clear identity and the purpose and aims of the trust are well known. Staff are aware of the vision and that it is a "special" trust. The issue for the trust is whether the board then sets a culture and encourages behaviour consistent with that vision.

8.94 Most of the clinicians endorse the trust's aims and purposes because they reflect their own local aims and the specialised nature of much of their work. A senior member of staff told us the board is much closer to clinicians than elsewhere they had worked and that there is a great deal of trust between clinicians and the board generally because of the pivotal role of the medical director. Interviewees said that it is a very motivated organisation and that it is quite commercially driven. Interviewees also characterised the board as being very conciliatory board, quite informal and relaxed, and said that the trust has well-embedded structures but is still quite an informal organisation.

8.95 Clinician interviewees and some others said the tone set by the board had very little impact at ward level. One manager felt there was possibly a belief that the passing of assessments equated to actual delivery. The board's style was described as effective, friendly and open. One of the executive directors felt that the NEDs are as challenging as could be expected and another said the NEDs do challenge but in a supportive way. A NED concurred about the style but felt that the board works well and that the friendly atmosphere did not mean the executives have an easy ride.

8.96 Three further comments illustrate the impact that style and substance at the top of the organisation have elsewhere. One board member described how at the executive level matters are pulled together and made to work, but they did not feel comfortable that the trust had the skills and processes below that level on activity and the clinical side. Second, an executive director observed that the trust has tended to put corporate posts in to support directorates but not to integrate them into directorate business, and that the trust struggles to achieve ownership in directorates. Middle managers said the culture is about doing the best and that patients are the focus for most people but that there is a strong belief the trust has to succeed and that failure is not an option. They also observed that "grip" is driven by NHSLA standards and that what is missing is a hearts and minds commitment to organisation development.

8.97 The size and nature of the trust mean that it attracts different types of staff for different reasons. Generally, clinical staff aspire to come to the trust and stay; some managers aspire to come for good experience in a good hospital and then move on. Other managers may be based locally and focus on doing a continuing job in the trust. The challenge for leaders at all levels in the trust is to combine the varying talents and potential of staff in the service of patients.

Induction and appraisal

8.98 The trust has good and comprehensive policies and procedures for induction and for regular appraisal, from the chairman who undergoes a 360 degree appraisal process, through management and senior clinical levels to ward level. However, the statistics from successive staff surveys show that fewer than 70 per cent of staff had an appraisal and the trust has not approached the full compliance that might be expected. The view from human resources was that a strategy and policy were in place, with the supporting paperwork and processes, but that the trust has encountered problems with technical issues that led to low compliance.

8.99 Most interviewees said at first that they had had an induction, had regular appraisals and knew how their own objectives fitted with departmental objectives. At least half of interviewees qualified this substantially when we questioned them further. One senior manager, for example, said they had not had a formal written set of objectives for about 18 months. The interviewee knew what they were informally through the operational planning process, but accepted that little formal paperwork would be found about their objectives. Talking of the staff they appraise, a senior manager said there were people who would be clear on what they were doing week to week but not clear in the context of a bigger picture.

8.100 New clinical appraisal systems were introduced nationally in 2001 and again in 2006, designed to ensure professional development and transparent job planning. The medical director appraises clinical directors in the trust and clinical directors normally appraise their clinical colleagues. One interviewee thought clinical induction is quite good but felt the trust needed to improve the mentoring of new consultants. Another said they would like to think clinical appraisals were 100 per cent. They thought the process was improving, from initially a tick box exercise to a process now more focused on job

planning and personal development. However, one consultant said the appraisal process they had experienced was similar to coming in for a "chat".

8.101 Induction and appraisal systems are focused on people in their "day job", ie their operational performance. Less emphasis is put on appraisees' readiness to perform corporate roles, whether they know how to be and to act as, for example, a board director or a directorate manager. One executive director agreed that none of the executive team had been on a fixed development programme.

Personal development, education and training

8.102 Appraisals are translated into personal development plans and programmes of education and training during a sound annual cycle of work that also provides data for clinical professional and Agenda for Change returns.

8.103 Few people were in doubt about the process. A middle manager in gynaecology said everyone had an annual personal development review. Another described the change in processes over recent years: it was now much more structured with the NHS knowledge and skills framework and forms being returned to the human resources department. Equally, few interviewees admitted to having a good development plan that was being implemented. One director confirmed they had not had a structured development plan. Other senior managers, when asked about pursuing their personal development, said they had not done this as much as they should and often the reason given was lack of time. We found this theme went from the top through to ward level.

8.104 We identified two further themes. One was mandatory training where documents and interviews once again revealed a workable system for planning, logging and implementing the training that clinical staff and others require for their professional development and statutory matters like health and safety. First, one director observed that mandatory training was driven by standards rather than a real belief in its value. Second, we heard much about junior doctors being taken off what they saw as training opportunities in order to go to provide a service in clinics. We were also told that junior doctors were not valued by midwives.

8.105 The second theme here was about succession planning in the trust. The trust is relatively small in terms of turnover and activity. Many of its managers are progressing

through the NHS or have moved into general management from clinical or administrative roles. A senior manager said, in response to a question about how the trust identifies managers and clinicians for senior roles, that they were easily identifiable because there are not that many of them and because the trust does not have a strong learning organisation ethos. The issue with senior doctors was different. We were told that there were a lot of good doctors but that that did not necessarily make them good leaders.

HR systems and surveys

8.106 The trust has good human resources policies and procedures in addition to those for induction and appraisal. Policies covering terms and conditions, whistleblowing and equality and diversity are all in place and steps are taken to make these known to staff. There are examples of particularly good practice, like the trust's policy to address inappropriate behaviour at work. We were told that this policy had yet to prove of widespread benefit but the PALS manager gave an example of how the policy supported managers who were challenging unacceptable behaviour at work. She also said it helped patients by telling them what they should expect of staff. The trust has processes to keep in touch with staff, including a team-briefing system, staff newsletters and individual emails.

8.107 Many people have characterised the trust as a good and friendly place to work. Nevertheless, we note that staff turnover has run at between 13 per cent to 14 per cent in recent years and was 13.78 per cent in 2008/2009. Sickness has been high, especially in obstetrics, and we found a relatively new trend of sickness among junior doctors associated with impact of the EU working time directive. Board discussion of high turnover and increasing sickness rates goes back at least to April 2004. The overall sickness rate reported for 2008/2009 is 5.53 per cent. Successive staff surveys have shown reasonably high scores for training, for reported appraisals and for reporting incidents. In April 2008 the board registered concern about the low response to the latest staff survey. A few months earlier, the board heard about research among staff carried out for the new marketing policy. The researchers found people had a pride in work but also low morale in some areas. They also found frustration with the effect of Agenda for Change and a desire to know that the organisation really had patient care as its top priority.

8.108 The board has been concerned about the trust's relatively high incidence of bullying. The PCT also knew about it. The director of nursing in the period 2006 to 2008 explained that in those years one of her objectives was to improve behaviour in the

workplace, especially in terms of attitude among midwives, and that she had spent considerable time working on the trust's anti-bullying approach. This problem was manifested more in some directorates than in others.

Comments on organisation development

- ***The trust does not appear to have a strategy or a cogent approach to organisation development.***

- ***Staff are aware of the trust's profile – that it's a special trust – but they also know the day-to-day systems and practices do not always match that profile.***

- ***Board members are not accessible to the organisation as a whole. But more importantly they do not set a clear tone for the organisation by signalling priorities for delivery as well as a commitment to maintaining the trust's reputation good standing with regulatory bodies.***

- ***The trust is an attractive and prestigious long-term option for doctors. Senior and middle managers stay at the trust for a range of reasons and time periods. In both cases, the board should pay close attention to succession planning and personal development of staff.***

- ***Variable quality of middle management, with a lack of clarity about competencies, will have a significant impact on services if the move to clinical business units is not accompanied by an OD programme for this part of the organisation.***

- ***Clear policies on induction, on mandatory training, and on appraisal processes are in place, but the take-up and quality of these activities requires improvement.***

- ***Induction to the role of executive director or a directorate/CBU team member requires greater attention. The corporate role of these individuals is as important to the organisation as their professional roles.***

- ***The trust takes the results of the staff survey seriously. It is looking for ways to increase the response rate and to act on concerns about appraisals and development. The trust is aware of the incidence of bullying which is yet to be eradicated.***

Five: partnership working

8.109 We looked at how active and appropriate the trust's relationships are within the NHS and at the formal governance of partnerships. In the strategic health area of the NHS North West, this trust is part of a wider NHS system that comprises several PCTs and trusts. In the Liverpool area, the trust's activities relate to several different PCTs and a number of other general and specialised trusts. The lead PCT, funding and commissioning services from the trust, is Liverpool PCT. The trust attends a range of forums organised regionally by the SHA or locally by Liverpool PCT but the main focus of the relationship with the PCT is on formal commissioning and contracting meetings and day-to-day interaction about operational matters. Liverpool PCT commissions services from seven trusts locally; large general acute trusts like the Royal Liverpool or University Hospital Aintree, and smaller specialist trusts. The lead PCT for AUH trust is Sefton PCT, which also takes a particular interest in services provided from ACWH.

Primary care

8.110 In the trust's annual report for 2007/2008, we learned that "*the trust has developed a strong relationship with our host PCT*" and that "*collaborative working has improved*" so that "*we are working with our host to develop quality indicators and clinician-to-clinician relationships*". The relationship with Liverpool PCT was described by interviewees variously, from being average or good through to being distant or non-existent. By far the prevailing view was that the trust is relatively small, successful, financially balanced, and not a priority for the PCT. People felt that this was because the trust didn't cause them any trouble. There is frustration among trust staff that the PCT often cancels meetings with the trust, and at the lack of dialogue with the PCT about how the trust should develop, other than in respect of maternity services. The relationship with Sefton PCT was said to be sound and productive.

8.111 The national initiative *Maternity Matters* has provided a focus for PCT involvement with the trust. A recently established group is now looking at quality outcomes in other services. We were told that in the second part of 2008/2009 there was developed a group meeting with the PCT focusing on quality outcomes, and that this was because of the national drive on quality standards through the "Darzi" report.

8.112 The view we heard from the Liverpool PCT mirrors some of those held by people at the trust. The PCT published a 10-year strategy in 2005, followed by a strategic plan for 2008-2011 in April 2008. It monitors the trust against its contracts but generally focuses on other matters. It was accepted that a stronger team-to-team relationship is required at director level: this would help both organisations develop useful measures of quality and build on the trust's responses to practice based commissioners of service. The trust chair reported a good relationship with his counterpart.

8.113 The trust developed a good relationship with Knowsley PCT over the developing *Closer to Home* programme. The PCT named the trust as their principal partner for obstetrics and gynaecology and we were told about Knowsley PCT being very positive in wanting the trust to provide local services out of a base at Aintree.

NHS trusts

8.114 The trust is one of several providing services to local people. The PCT recognises that quite small service changes for any of the trusts could compromise its financial stability and that this could lead to inflexibility when service changes are needed. Interviewees said this was one reason why there was not more strategic partnership working locally, although on a day-to-day clinical level interviewees felt that relationships were good. The trust went through a challenging period of consultation and service change during 2006 – 2008, resulting in the loss of breast cancer services to Royal Liverpool trust.

8.115 The chair and chief executive frequently attended local meetings with community groups and members of the public after the trust achieved foundation status. They have also forged a wider set of links with FTs. The chair heads the NW FTs group and is on the national board for FTs both to contribute to FT development generally and to raise the profile of the trust. The trust has tried to forge some clinical alliances outside Liverpool, for example with mid-Cheshire Hospitals NHS Foundation Trust on reproductive medicine services.

Formal partnerships

8.116 The trust has few formal partnerships with specific governance structures and issues attached to them. In the main these relate to ACWH, to reproductive medicine, and to hotel services.

8.117 The formal arrangements with AUH concern the SLA (service level agreements) for the use of facilities at the Aintree site. Separate SLAs cover critical care; theatres; anaesthetics; support services. The agreements were set up in late 2001 as part of the changes to management arrangements and reviewed in February 2005 after the trust compared costs and activity and concluded that revisions were required. The trust paid AUH £5.2 million a year for a range of services. A middle manager told us there had been concern at the cost of the agreement at a time when there appeared to be several list cancellations because an anaesthetist was not available.

8.118 The review mechanism for the SLAs is the service level user group (SLUG). In governance terms, the revised service-level agreements are deficient because they lack a clear mechanism for resolving problems. The agreement for theatres and anaesthetic services, for instance, has a section headed "monitoring" that says SLUG will operate *"by means of a collaborative approach"* to review services, identify variances, monitor finances and plan and agree changes. There is no mechanism for resolving disputes.

8.119 The arrangements for managing the service-level agreement were revised in 2008: this has improved an otherwise rather distant and functional relationship between the organisations.

8.120 The trust has a formal arrangement with North West Fertility Ltd in areas of reproductive medicine and more patients have access to embryology and IVF services as a result. There is a new building scheme at the Hewitt centre for reproductive medicine.

8.121 The trust also has a formal joint management agreement with Sodexho, a company providing domestic and catering services. Cleaning services have improved measurably but concern remains about catering, reflected regularly in patients' feedback forms. The trust has worked with Sodexho to alter the management arrangements in an effort to improve the situation.

Outside the NHS: local authorities

8.122 The local authority structure surrounding the trust is centred on Liverpool, Sefton and Knowsley councils. There are some formal requirements of the trust in this respect, such as the consultation with councils on the elements of the annual health check returns by the trust to the Care Quality Commission. The overview and scrutiny committees of Liverpool City Council, Knowsley Borough Council and Sefton Borough Council are informed and consulted about these statutory matters, as well as about service changes, such as the "Big Push" redesign of maternity services.

8.123 Interviewees said there was little contact with the local authority on strategic matters, though the relationship is quite good on particular initiatives such as Sure Start centres. Some interviewees wanted better three-way planning between the trust, the local authority and the PCT.

Comments on partnership working

- ***The trust contributes to a number of NHS and FT networks locally, regionally and nationally, at chair, chief executive and some director levels.***

- ***Many interviewees said the overall relationship with Liverpool PCT has not been as good as they would like, despite functional relationships at some management levels and reported good links at chair and CE level.***

- ***Many interviewees did not consider relationships with GPs significant and there was little direct evidence of close and helpful contacts.***

- ***The PCT and general practitioners have, however, worked closely with the trust on reassuring and recalling women who were cared for by consultant X.***

- ***There are reports of good clinical working relationships with other local trusts.***

- ***External relationships with other trusts are limited and have been under strain in the cases of AUH and Royal Liverpool.***

- ***The trust has a small number of formal partnership arrangements, such as the AUH service agreement.***

- ***Little time is devoted to the active management of these arrangements, other than when an operational problem demands immediate attention. There is no meaningful partnership working with local authorities beyond matters of public consultation on services.***

- ***This may be an area for future attention for the strategic development of community-based services.***

Six: public accountability

8.124 Here we consider the trust's relationships with regulatory bodies, the trust's annual meetings and reports, and how the board keeps in touch with local opinion and public representatives.

Regulator relationships

8.125 The formal regulatory relationship of FTs is with Monitor, an independent arm of the Department of Health. This is a continuing and developing relationship, as well as a command and control mechanism. For instance, in January 2006 the trust sent comments to Monitor on the new draft FT code of governance. Formally, the relationship requires the trust to make annual and quarterly reports and to submit an annual plan. On the basis of these reports Monitor rates the trust and indicates areas requiring attention. Monitor's latest formal letter, for the second quarter of 2008/9, gives the trust the highest "*governance risk rating of green*".

8.126 In recent years, the Healthcare Commission ran an NHS star ratings system. The trust gained the maximum three stars for three years in a row up to 2005. Moving to a different FT system where the Healthcare Commission (now the Care Quality Commission) rates trusts for use of resources and quality of service, the trust has had the top rating of excellent for both resources and quality until 2008, when the quality rating dropped to good.

8.127 Legal and risk systems are regulated by the NHS Litigation Authority and the trust has achieved a high level 3 risk rating. Many interviewees described how the external scrutiny concentrates the mind and how the organisation has seen external reviews as a real focus for attention. A typical view was that the board gets some of its assurance from external accreditation assessments by regulators. As we have seen in regard to performance and risk, however, it is not certain that reported standards are always achieved in practice.

Annual meetings and reports

8.128 As required, the trust board holds an annual meeting with the council of governors and the governors meetings (formerly membership council) are attended by several board members each time. Governance of these processes seems satisfactory. The annual meetings are a matter of public record but the regular monthly meetings of the trust board have been held in private in accordance with the national guidance from the regulator Monitor to foundation trusts.

8.129 We have seen the trust's annual reports since 2001. They have always covered the minimum requirements of the NHS codes of governance, but after FT status the reports became more substantial and thorough. Annual reports paint a positive picture of the trust's activities and relationships. The trust also issues annual clinical reports that have also become more comprehensive. The chairman was concerned in 2006 that lay people might have difficulty making sense of them and initiated work on a form of report more accessible to lay people and which has clearer indicators and comparisons with others.

8.130 The chairman said the trust had put a lot of effort into developing relationships with governors and members but felt that there was still a long way to go. The problems that have emerged are not ones that might have been foreseen. We heard that staff found it difficult to keep some members from "going native" and that it was difficult for them not to "buy in" to the organisation's view and apologise for it rather than to perform their critical friend role.

Ways of keeping in contact with local opinion

8.131 The members of the FT act as a formal conduit for views of local people. Beyond this, the main formal means of keeping in touch with service user opinions is through the

patient advice and liaison service (PALS). The PALS function in the trust is strong, having been set up and run throughout by a manager who helped develop the role in the north west. PALS reports quarterly to the board on patient concerns, not just on formal complaints. The PALS manager felt there was an open door to her director and to the chief executive. Staff and patients use PALS as an intermediary to help resolve problems. The trust has not so far developed a systematic process of reporting patients' views to clinicians.

8.132 The trust recently appointed an experienced clinical manager as matron of patient-centred care, working with stakeholders and governors. There is also an impressive range of mechanisms for achieving user feedback; these include bright ideas leaflets, patients' exit cards, a patient information group and a patient quality group. One of the more innovative measures is the trust's use of "*You said, we did"* posters to show that the organisation has heard feedback and acted on it.

8.133 The trust tries to keep local people informed about its work through formal meetings and annual reports and also information and consultation programmes about service changes. The most recent example is the "Big Push", which is about the redesign of obstetric services.

8.134 The trust's website is perhaps the most immediate of the information and feedback systems. We found it provides good access to information about services for patients but does not offer the same access to people who might be interested in the way the trust goes about its work. The section on 'important organisational documents' contains a limited and out-of-date selection of papers and formal minutes of meetings. There is no access to the reports referred to in the minutes. The trust's website does not reflect the new position on vision and values as at mid-April 2009.

8.135 The trust links with local authority members through the formal overview and scrutiny committee. Members of Parliament receive a twice-yearly newsletter and the chair and chief executive otherwise relate to the dozen or so relevant MPs as appropriate.

8.136 Staff gave mixed reactions to a question about whether and how the trust listens to the views of women and their families. One senior manager said that connection with the public is one of the trust's strengths and a non-executive board member agreed the trust achieves a lot of feedback in many ways. But another senior manager felt the trust

only involved patients in small pockets and another said that on a scale of ten the trust was nearer a two than a ten.

8.137 The PALS manager said that staff generally have a reasonable and positive attitude towards PALS. The service channels people's views to staff where that is needed and she felt that 75 per cent of PALS issues are about communication. Interviewees told us the level of patient and public engagement differed across the organisation. One reason some gave for low levels of interest in people's views was that medical staff had a strong influence on the trust's work. They said that was good in many ways but some members of the medical staff did not believe that listening to patients' views was important, and that view was not challenged effectively.

Comments on public accountability

- ***The required FT membership arrangements are well developed but, as for many FT's, membership is not increasing.***

- ***There is a tension between the two requirements of all foundation trust boards: that they meet in private*** **and** ***that they give full account to the public. The trust has a good and active system for collecting feedback from and providing information to local people and public representatives but private meetings of the trust's decision making body may yet undermine confidence and accountability.***

- ***Questions remain about whether the trust could provide even greater benefits to local people by listening more closely to their views and acting on what it hears.***

Seven: adapting to change

In-year pressures

8.138 We looked finally at how flexible the trust is in reacting to in-year changes and pressures, and how actively it looks forward and plans for change. There is evidence at board and senior directorate levels of reaction to in-year events. In February 2006 the obstetrics directorate considered seriously whether any of the Healthcare Commission

findings and recommendations about maternity services at North West London NHS Trust applied to the service at Liverpool Women's. Again in November 2006 the trust quickly agreed to take action to minimise the impact of the loss of breast cancer services to the Royal Liverpool trust. In June 2007 the Aintree project board looked at new service plans in the light of the relocation of the breast cancer service.

8.139 A consultant said that when new techniques require new equipment, that is dealt with fairly quickly and that the trust was up to date in a lot of areas, though it was behind in others. Managers felt that the organisation was responsive to clinicians wanting to develop services and was good at putting those things in place quickly.

8.140 A senior clinical manager thought that in terms of clinical excellence the trust was at the forefront in those areas they were interested in. Colleagues from the trust were felt to have usually written the NICE guidance or been involved in some way. A senior manager agreed that there is a willingness to grow and develop, but some others were aware that does not always translate into successful growth. They felt that the approach to change sometimes is not properly organised or implemented and is not driven by a clear picture of what is to be achieved and how. People spoke of a lack of management capability or capacity to get some things up and running. This was backed up by an internal audit report early in 2009, reported to the board in March that analysed the trust's compliance with introduction of NICE guidance and gave a "limited compliance" rating.

Forward vision

8.141 Strategic and operational plans capture as much as could be expected of the external themes for change. The board is alive to this issue, and clinicians' involvement in professional networks, teaching and research mean that they know about debate and developments in science, practice and service. For the year just completed, 2008/2009, the trust's integrated operation plan identified what the trust saw as the "emerging drivers" for the year. These included national initiatives such as *Maternity Matters*, the Darzi Review, the cancer reform strategy and the NHS operating framework, as well as the Liverpool PCT strategy and the Liverpool maternity strategy.

8.142 Some interviewees had reservations about the trust's flexibility. They said that it works in obstetrics and neonates where staff go out and bring ideas and processes back, but that this does not happen in gynaecology. Despite the 60 contributions to professional journals mentioned in the 2008/2009 gynaecology operational plan, the view remains that the consultants are not normally part of national forums. The trust has, however, taken a well-planned approach to developing community-based gynaecology services as part of the *Closer to Home* programme.

8.143 A non-executive director without a previous background in public services said they found change in the NHS difficult initially but that they were increasingly impressed with the NHS. The interviewee added that their own learning has been that change is not about making money and being more and more viable but about improved client service.

Comments on adapting to change

- ***The trust pursues individual, mainly clinical service, opportunities for development and follows through with implementation plans.***

- ***Directorate annual plans acknowledge and plan for new requirements and in some instances operational plans change in-year to accommodate service developments.***

8.144 The findings and comments in this section form the basis for a number of conclusions and recommendations made in sections 9 and 10 below.

9. Conclusions

9.1 In this section we draw a number of conclusions based on our findings from documentary and interview evidence, and build upon the comments made in sections 7 and 8.

C1 The trust makes a clear statement about its commitment to excellent service which is shared and understood at all levels in the organisation. Unity of purpose is particularly strong among board members and senior managers and clinicians. The trust was one of the first to achieve NHS Foundation Trust status and the policies and procedures which describe its governance arrangements comply with the standards expected of FTs. Furthermore, the trust has kept its governance arrangements under review, scrutinising the reports of regulators and acting upon them, and commissioning other support where it believed its practice fell short.

C2 The trust pays close attention to activity and financial results, making comprehensive reports to the board. During the past two years it has revised the way oversees clinical governance matters, with substantial changes to the way its clinical governance committee operates. In recent months it has turned its attention to making more effective reports on clinical effectiveness and patient safety to the board.

C3 The trust is a relatively small organisation charged with significant responsibilities: delivering complex secondary and tertiary care services to a diverse community in Liverpool and beyond. Like many organisations of this type it lacks management capacity. This means it is often difficult to both manage the day-to-day delivery of service, and design and implement improvements in those services. The trust has combined these activities in only some of its services. This compromises service quality and safety across the trust.

C4 The gynaecology directorate has the same, sound governance policies as the rest of the trust and many of them operate in a satisfactory way. In important areas, however, they are applied inconsistently. The clearest example of this is the routine operation of multi-disciplinary teams, using clinical protocols and outcome measures to guide work in some services, and the absence of these processes from others (see C6 below).

C5 The trust has most of the clinical governance arrangements one would expect of an organisation at this stage of its development. However, there are areas where they do not operate effectively. For example, information about services is not collated and analysed in a way which always directs managers' attention to areas of concern. Financial and activity information is not coupled with outcome data to provide a rounded picture of the impact of services on patients' experiences.

C6 Essential clinical governance arrangements are missing for some services. Not every service takes a multi-disciplinary team approach to managing complex cases, nor collects and considers information about clinical outcomes, nor gives appropriate priority to clinical audit. These are deficiencies which the trust must address.

C7 The trust is clearly committed to effective appraisal for all its staff and mandatory training. There is evidence that more staff are involved in appraisals and training which help them do their best work, but the picture across the trust varies and this represents a risk to services.

C8 There are gaps in governance arrangements which mean that the trust cannot pick up 'weak signals' about areas of potential risk, and which would take it beyond 'serious incident' and 'near miss' to early detection and intervention when problems emerge.

C9 The strategy for the gynaecology service does not support the delivery of a consistent and high level of service. There are legitimate differences in women's experience of care at Crown Street, ACWH and the community clinics. There are also unjustifiable differences. The strategy should assure a one-service, multi-site model of care.

C10 The trust has no clear plans about the part the facilities at ACWH will play in the future. This and the fact that the trust work to address the cultural divide between the staff working at ACWH and at Crown Street has been only partly successful, have led to significant weaknesses in governance arrangements for services delivered from ACWH. There are operational problems of long standing which compromise service quality. The trust is working to deal with these problems.

C11 The board's recently revised committee structure and operating methods are a sound response to the deficiencies identified in successive studies. The action plan and review mechanism it has decided on is also sound. It will be important to monitor, review and ensure the successful implementation of these changes.

C12 The trust's organisation development work focuses on the individual's capacity to do their best work. A broad-based organisation development strategy would give necessary attention to developing systems (including IT systems and ways of ensuring effective action is taken when services defects are reported) which also support staff in their work.

C13 The trust's work with patients and members of the public in developing services has focused on the work of the council of governors, and patient exit cards introduced in 2007. These have been well received and could provide the basis for a strategy which will engage women in work to develop services.

C14 Staff at all levels in the trust have worked to develop clinical, operational and strategic relationships with its external partners. An explicit partnership strategy would help ensure that both formal and informal partnerships bring the greatest benefit for patients. A more effective relationship with Liverpool PCT, in particular, would help assure effective clinical pathways for all patients cared for by the trust and its partners in primary care. We acknowledge that all parties to a relationship must invest in that relationship.

C15 The trust will greatly reduce the risk that recent events will recur if it assures effective analysis of activity and financial information and data about clinical outcomes, constructive challenge to practices that lie outside the norm, and ensures that modern approaches to clinical management (including multi-disciplinary team work and case audit) operate in all its services. It will make a more effective response to serious incidents if it reviews the threshold for initiating its serious untoward incident process and ensures it is applied in all cases.

C16 We were asked to consider whether the trust's governance arrangements were such that patients could expect a 'safe service'. A review of this type could not cover the full range and complexity of practices, systems and measures that make up a 'safe service'. The gaps and inconsistencies we found in the way governance arrangements operate day

to day may lead the trust to conclude that it should look closely at this in some or all of its services. This would provide the board with assurance that all its patients receive a 'safe service'.

9.2 These conclusions and the recommendations that follow present the trust with a number of challenges and a body of work to be pursued. We believe the trust will meet these challenges, not least because of the common purpose we found in the trust between board members, clinicians, managers and staff generally, all working to provide excellent health care for women.

10. Recommendations

10.1 The following recommendations are developed from the conclusions drawn by the reviewers in the previous section.

10.2 We make recommendations under four headings:

- Strategic development of the gynaecology service
- Strengthening governance arrangements
- Organisation development
- Operational management at ACWH

Strategic development of the gynaecology service

R1 We recommend that the trust reviews its strategic plan for the gynaecology service. The resulting strategic plan, which should be based on the work already done on demand for service, and on discussion with Liverpool PCT, must:

- describe the trust's intentions for services delivered from Crown Street and ACWH, and for any expansion of community-based services
- provide a sound basis for operational plans which support a single, coherent service that is delivered from several sites.

Strengthening governance arrangements

R2 We recommend that the trust takes steps to ensure that:

- its governance polices are applied in practice
- the very good practice evident in some of the trust's services are taken up by all services

- information about services is collected, collated and considered in a way which tells the trust about the volume and quality of its services and provides early warning of potential problems and that all these components of effective governance arrangements are connected together.

We recommend in particular that the trust:

Governance policy and practice

R2a Includes comparisons between governance policy and practice as part of its clinical and internal audit cycles.

R2b Designs and implements a system for reporting action taken in response to an adverse clinical event back to the person who made the report in the first place, and a similar system for ensuring that the outcome of an investigation into a complaint is reported to those involved in the care of the patient.

R2c Evaluates the way the complaints policy operates to ensure that complainants are satisfied with the way the trust investigates their concerns and that changes in practice follow justified complaints.

R2d Reviews its incident reporting processes (adverse clinical event report, serious untoward incident process and the whistleblowing procedure) to ensure they complement each other and that staff have easy access to guidance about what they should do if they have any concerns about care provided to a patient.

Effective governance practice across the trust

R2e Establishes and supports a multi-disciplinary team approach to care in all services.

R2f Ensures that all services have established clearly described clinical pathways for the care of the majority of their patients.

R2g Requires all services to collect, collate and report on outcome measures, and to include patient-reported outcome measures where that is appropriate.

R2h Improve the resources available for clinical audit so that more staff are engaged in audit work, and audits are completed.

R2i Distributes the resources available for clinical audit so that aspects of all services are subject to regular scrutiny.

R2j Invites clinical business units to report on the implementation of audit findings and their effect on services.

R2k Requires clinical business units to review the way that they identify and record risks, and monitor action designed to mitigate those risks.

Information about services

R2l Requires clinical business units to report on combinations of information about services (ie reported outcomes, complaints, activity, financial performance, performance against targets set without the trust) with other indicators (e.g. sickness absence, vacancies, content of exit interviews) so it can be sure that both 'strong' and 'weak' signals about performance are considered and acted upon.

Organisation development

R3 We recommend that the trust develops a comprehensive organisation development strategy and focuses in the meantime on three areas of its organisation development work:

- The new board committee arrangements and changes to board and executive team operations
- Achieving cultural change
- Increasing management capacity

We recommend in particular that the trust:

Board committee and operations

R3a Keeps the new committee arrangements under review to ensure that the governance and clinical assurance committee plays a major part in raising the level of reporting about clinical matters; the audit committee pursues the goal of integrated governance; and that finance, performance and business development committee sustains a strong focus in these areas.

Achieving cultural change

R3b Considers whether the clinical business unit arrangements will address the concerns about a gynaecology service delivered from several sites described in section 7 of this report, and acts accordingly. This includes concerns about the focus of responsibility for services at ACWH, and how far support systems and operational decisions are focused on the needs of the service as a whole.

R3c Addresses directly and resolves the "them and us" cultural divide between staff providing gynaecology services mainly or solely at ACWH and those working mainly or solely at Crown Street.

R3d Renews its work to support all members of staff with effective appraisal.

R3e Introduces a comprehensive medical workforce recruitment and development strategy to support its service development intentions

Increasing management capacity

R3f Boosts capacity by pursuing secondments into the organisation and joint appointments with partner organisation for critical management tasks.

R3g Clarifies where the responsibility lies for leading and managing work on risk management and governance, so that clinical business units have the necessary support for this work.

Operational management of gynaecology services at ACWH

R4 We recommend that urgent action is taken to address operational difficulties at ACWH. Work should continue to focus on three critical areas:

- the numerous operational problems both parties to the service level agreement with AUH perceive with the support for services at ACWH

- management of clinical records and the support for both inpatient and outpatient services

- ensuring that equipment is up to date and that contingency arrangements are in place which will sustain services in the event of an equipment failure

Appendix A

Terms of reference

This independent review (the review) is commissioned by the chief executive of Liverpool Women's NHS Foundation Trust.

The purpose of the review is threefold: to establish the exact circumstances and events that led to the initial investigation and to this review of governance; to consider the appropriateness of the current corporate and clinical governance arrangements for services at Aintree Centre for Women's Health; and to provide assurance to the trust about corporate and clinical governance across the trust.

The terms of reference of the three parts of this review are as follows:

- to consider the current clinical and corporate governance arrangements relating to services provided at Aintree Centre for Women's Health and, in this context, the safety of those services. A report will be made to the chief executive of the trust by the end of March 2009.
- to provide a comprehensive chronology of the circumstances and events that led to concerns within the trust about the performance of a consultant working within the urogynaecological services. This will also be completed by the end of March 2009.
- to review of the corporate and clinical governance arrangements across the trust as a whole. The scope and focus of most of this part of the review, and the completion date, are to be confirmed with the chief executive in the light of the part one report.

The detailed requirements within the terms of reference are:

Part one - Governance at Aintree Centre

- Review the documentation relating to current clinical and corporate governance structures, policies, and procedures in place for services at Aintree Centre for Women's Health, in the context of trust-wide documentation on governance.
- Take interview evidence and views from relevant staff about the governance arrangements at Aintree Centre for Women's Health and their application during the period since 2001.

- Establish the history of the management of clinical governance at the Aintree site since 2001.
- Consider the appropriateness of current structures, policies, and procedures in the context of accepted good governance practice.
- Consider the trust-wide clinical and corporate governance arrangements as they affect services at Aintree, including the linkages with services at the Crown Street site.
- Establish the extent to which the policies and procedures are and have been implemented and followed in practice within Aintree Centre for Women's Health, comparing the gynaecology service with other services.
- Consider any relevant external audits, reports or reviews on any aspects of clinical governance or risk, and the appropriateness of actions arising and the implementation of such actions.
- Review any relevant complaints and legal claims about services at Aintree Centre for Women's Health.
- Review the collection of data about services and the use within the trust of management and clinical information about services at Aintree.
- Provide a written report with recommendations about governance practice and governance assurance to the chief executive of Liverpool Women's NHS Foundation Trust.

Part two – Chronology of events

- Review documentary evidence of the circumstances and events concerning the urogynaecological practice of consultant X that led to concerns being expressed and to the exclusion of the consultant from the trust.
- Establish through interviews the views of appropriate members of staff about the above.
- Record a comprehensive chronology of these events.
- Identify any significant events within the chronology that relate to clinical or corporate governance practice and procedures.
- Provide a written report to the chief executive of Liverpool Women's NHS Foundation Trust, setting out the chronology and making comments and recommendations in relation to governance matters.

Part three – Governance of the trust

- Review the corporate and clinical governance documentation and arrangements in place across the Liverpool Women's NHS Foundation Trust.
- Consider the appropriateness of these arrangements in terms of current and future good practice and the future development objectives of the trust.
- Consider the application of the arrangements at board level and in each service provided by the trust. (The precise extent and focus of this work to be confirmed following the Aintree Centre review above).
- Include within the review the ways in which the trust handles and implements change resulting from untoward incidents.
- Include within the review the arrangements for medical staff recruitment, education, supervision and review, and development in terms of governance and risk.
- Provide a written report to the chief executive of Liverpool Women's NHS Foundation Trust.

After the review work commenced, further discussions took place with the chief executive and the director of nursing about the nature of part two of the review. It was agreed Verita's reviewers would focus on producing a chronology of governance and clinical governance events relating to services at Aintree Centre for Women's Health. Within this, they would include the chronology of events relating to the issues concerning consultant X, but would rely on the work of the clinical incident review group and the project manager established by the trust to handle the management of the issues raised by those events. Verita's reviewers have not interviewed consultant X.

Appendix B

List of those interviewed

Board members and corporate staff

Name	Role
Ken Morris	Chair
Roy Morris	Non-executive director
Yvonne Rankin	Non-executive director
Caroline Salden	Director of service development
Kim Doherty	HR director
Gill Core	Former director of nursing
Sue Lorimer	Former director of finance
Erica Saunders	Corporate services director
Cathy Umbers	Assistant director of clinical governance

Consultant medical staff

Name	Role
Paul Skaife	Colorectal surgeon AUH
Clare Howard	Director of anaesthesia AUH
David Richmond	Medical director
Karen Ward	Consultant urogynaecologist
Elizabeth Adams	Consultant urogynaecologist
Adel Soltan	Consultant gynaecologist
Jonathan Herod	Clinical director, gynaecology
Rob MacDonald	Clinical governance lead, gynaecology
Nabil Aziz	Clinical audit lead, gynaecology
Derek Parkinson	Consultant gynaecologist
Geoff Shaw	Consultant gynaecologist
Robert Kingston	Former clinical director, gynaecology
Roy Farquharson	Former clinical director, gynaecology
Dr Helen Scholefield	Clinical director, obstetrics
Dr Leanne Bricker	Clinical audit lead, obstetrics
Dr Devender Roberts	Training programme director

Service managers and support staff

Name	Role
Sheila Lloyd	Former directorate manager, gynaecology
Sue Brown	CBU manager, gynaecology and critical care
Nicky Bushell	Service development manager, gynaecology
Gill Murphy	Assistant directorate manager, gynaecology
Ann Bridson	Former matron at ACWH
Sharon Owens	Ward manager
Margaret Cuthbertson	Former administration manager ACWH
Gail Holding	PALS and family support manager
Sue Ledgerton	Theatre manager for gynaecology, AUH
Shirley Hill	Gynaecology matron ACWH

Others

Name	**Role**
Leonie Beavers	Director of strategy, Liverpool PCT
Karen Mercer	Practice education facilitator
Louise Shepherd	Chief executive, Alder Hey Children's NHS Foundation Trust and former Chief Executive, Liverpool Women's NHS Foundation Trust
Gareth Davies	Management consultant

Appendix C

Documents reviewed

Document
Section A: relating to the Aintree Centre for Women's Health
• Statements of strategy and/or purpose and/or objectives for the gynaecology service (current and since 2001) and for other trust services provided at the Aintree site
• Written service policies/care pathways for services at the Aintree site
• Budget for services at Aintree Centre; budget for each clinical directorate
• Staff numbers and grades/skill mix for each clinical directorate
• Structure chart showing management lines and responsibilities at Aintree Centre/ the trust's gynae services
• Statement about how the PALs service relates to the Aintree Centre
• Structure of clinical responsibilities and management (medical, nursing, midwifery, other)
• Medical/clinical committee structures involving Aintree Centre staff
• Schedule of complaints and /or incident reports applicable to the Aintree Centre since April 2001
• Complaints and serious untoward incident policies applicable to Aintree Centre
• All human resources policies that operate at Aintree Centre – including but not only, recruitment policy and processes, training and education policies, induction policies, black and ethnic minority policies, whistleblowing policy
• Staff appraisal and objectives processes, responsibilities and outcomes
• Documentary evidence of staff having individual KSFs and team development programmes

Document
• Risk register entries since April 2006
• Risk reporting responsibilities and risk and controls assurance policies
• Minutes and appropriate papers from directorate management meetings
Section B: relating to the trust
• Current trust constitution, standing orders, standing financial instructions, and scheme of delegation
• Trust's application for FT status
• Feedback reports from Monitor and external regulators on the trust's performance
• Terms of reference of the board, and its committees, and the management team
• Board structure charts, committee structure charts, and senior management structures
• Trust's current strategic statement and current organisational objectives
• Annual reports of the trust since 2001
• Trust board minutes parts one and two since April 2006
• Trust board agendas parts one and two since April 2006
• Agendas and minutes of the audit committee since April 2006
• Agendas and minutes of the remuneration, and any other formal standing committees since April 2006
• Agendas and minutes of the clinical governance/governance/risk committees since April 2006

Document
• Agendas and minutes of the risk and controls committees since April 2006
• Agendas and minutes of the control of infection committee since April 2006
• Agendas and minutes of trust executive team since April 2006
• Agendas and minutes of all FT governors meetings
• Current partnership agreements with other NHS organisations, and constitutions of any joint committees
• Names and appointment periods of trust chairs, non-executive directors and executive directors from April 2006 to the present
• Schedule of training or education days undergone by current NEDs, and the topics covered
• Schedule of training or education days undergone by trust FT governors, and the topics covered
• Current statements of purpose or objectives for each directorate of the trust
• Management and clinical leadership structure for each clinical service provided
• Current complaints and serious untoward incident policies and earlier versions
• Human resources policies – including but not only, recruitment policy and processes, training policies, induction policies, black and ethnic minority policies, whistleblowing policy.
• Staff appraisal and objectives processes, responsibilities and outcomes
• Development programmes for individual staff, and team development programmes
• Assurance and risk framework, and risk registers since April 2006

Document
• Risk and control policies and processes, and risk register entries for the last two years; and indication of risk reporting responsibilities
• Clinical governance policies and processes in place in the last two years
• Arrangements and responsibilities for integrated governance

Appendix D

Chronology of governance events and themes

(Abridged version: April 2009)

The chronology has been used to inform the sections of this report. It is in three colour-coded categories:

- corporate and clinical governance facts and events trust-wide (black)
- corporate and clinical governance facts and events in gynaecology services (green)
- corporate and clinical governance facts and events regarding Aintree Centre for Women's Health (red)

Month/Year	Event
1992	Liverpool Obstetrics and Gynaecology NHS Trust established
1993	Consultant X appointed at Fazakerley Hospital (now University Hospital Aintree)
March 1995	All services for women and babies from three former sites (Liverpool Maternity, Liverpool Women's, and Mill Road hospital) combined at new Liverpool Women's Hospital at Crown Street, Toxteth.
April 1995	Liverpool Women's Hospital NHS Trust formed
December 2000	Liverpool Women's Hospital Trust takes on responsibility for Aintree Centre for Women's Health (formerly part of the University Hospital Trust, Aintree) Trust becomes the largest specialist women's hospital service in Europe - one of only two such hospitals in England.
2001	Clinical governance lead role at ACWH performed by consultant X (until 2006 – when the lead was combined with Crown Street on a whole-trust basis)
2002	Annual report describes recent review of women's services and public consultation; outlines decision made to relocate inpatient obstetrics and special care baby services to Crown Street.

	Annual report: clinical governance structure described: 10 functions/activities shown as a flat structure all reporting to clinical lead. The functions described as research and development; complaints; clinical governance directorate leads (six); patient liaison; clinical governance and risk; public and patient involvement; legal services; infection control; medicines management; clinical audit.
January 2004	Board noted approval received for the trust to apply for FT status. Noted governance requirements for FT to be considered soon with a director from SHA supporting the process with the trust. Clinical governance quarterly report: CNST Level 2 had been attained in maternity standards; trust best performing specialist trust for infection control; new clinical audit committee – including patient representatives. PALS manager gave the quarterly report on key patient liaison issues and handling of particular cases. Noted that staff attitude has been a particular trend.
March 2004	Obstetrics and labour ward transferred from ACWH to Crown Street.
March 2004	Board meeting noted an option appraisal currently being carried out on the future provision of services at ACWH. ACWH project group had been set up. Performance report. "Doing well on those indicators we can measure". Agreed information governance strategy.
April 2004	Board meeting noted clinical governance problems, including – lack of time, implementation of policies, clinical ownership, links with ACWH, robust data collection.
April 2004	Appointment of new gynaecology directorate manager.
July 2004	Board agreed one of four options for the future of ACWH. The SLA with AUH, which was £5m per annum, needed to be resolved to enable the trust to move forward with developing services that can be sustained in the long term. Noted report on the long standing risk management strategy which had been commended by the assessors for RPST in terms of good practice.

July 2004	KPI meeting noted 22 week wait for follow up of consultant X patients. Six sessions cancelled ACWH due to leave and lack anaesthetic cover.
August 2004	KPI meeting noted five more sessions cancelled due to leave and lack anaesthetic cover. Noted significant increase in consultant X waiting list last six months. Of 10 patients awaiting dates, nine are for major surgery.
September 2004	Board noted agreement with Aintree Hospital to transfer general outpatient gynaecology into the ACWH from main clinics in AUH. Discussions around the theatre configuration however were more protracted. Clinical governance committee revised; medical director to become chair.
October 2004	Board noted the view of AUH that it would not be clinically appropriate to locate a theatre in ACWH. Corporate report noted a query regarding six patients at ACWH waiting more than six months and a reference in the auditor's management letter to undercounting at ACWH. Noted CE's statement that there had been concerns for some time regarding the quality of the information provided by AUH. However, ACWH will be consolidating onto the Meditech system and so it will only be theatre activity that will not be being recorded through the LWH system. Noted statement that there was a lot of work being undertaken to ensure the improvement of data quality, to which end a data quality group had been established.
November 2004	Board meeting noted the challenge of sustaining the six month target, particularly in urogynaecology, but plans were being put in place to address this.
November 2004	KPI noted the validation of consultant X patients being undertaken.
January 2005	Board discussion of waiting lists - work was underway to put on additional sessions to move patients from ACWH to LWH. Noted the updated assurance framework which "focuses more on the principal risks to the trust's corporate objectives. The process of refinement had been part of the work done with MIAA on the trust's governance review." The next stage will focus the directorate level assurance frameworks which will be based upon the detailed risk assessments of the operational plan. The final part will be the roll out of the risk register through the Ulysses system.

January 2005	KPI meeting noted consultant X to start sessions at Crown Street with DR and EA on 5 January. (subsequently changed to March)
February 2005	Service level agreements re-made with Aintree trust in respect of: - Critical care for gynaecology - Theatres and anaesthetics for gynaecology - various other clinical and support services (detailed specifications include service levels and arrangements to handle delays and disputes etc)
February 2005	Board meeting noted gynaecology activity and steps taken to achieve deadlines. There was a lot of work being carried out on the Aintree site. There had been 350 cases seen as outpatients instead of day cases. Underperformance in elective cases is masked by the numbers being seen as outpatients. Medical director referred to the major inpatient problem surrounding a particular consultant and particular sub-specialty (consultant X). However, the consultant concerned would now be doing clinics and operating at LWH resulting in a reduction in waiting time. (NB: no reaction/discussion of this report was minuted). Board noted achievement of CNST level 3 for whole trust
April 2005	Liverpool Women's NHS Foundation Trust formed. First meetings of membership council and of board of directors; formal and statutory conduct arrangements made; constitution approved.
May 2005	Board meeting noted risk assurance framework – live tool to help to understand the principal threats to the trust's business. It was noted that the process of embedding the assurance framework within the directorates was underway. The final part of the process was the implementation of Ulysses which will provide integrated risk registers.
May 2005	KPI meetings - information for ACWH now included in KPI meeting at Crown Street (but normally not waiting data). Waiting information for consultant X showing same pattern as before.
June 2005	Corporate assurance and standards committee (CASC): inaugural meeting - to support the principles of integrated governance. "The aim of the committee will be to move the trust to single risk sensitivity process covering all the trust's objectives, supported by coordinated collection and inspection of information".

July 2005	Board meeting noted options regarding the new Aintree care centre and the transfer of services from Walton Hospital. This would be out to public consultation from 12 July. Agreed that a briefing session for staff should be held.
	Gynaecology operational plan 2005/2006: 23 points - one to "maintain our 3 star status and comply with HCC standards" (risk rate 15); the other 22 operational and developmental. These included - finalise ACWH refurbishment and agree and implement a strategy for its development as an integrated gynae centre (risk rate 15). Action plan to review gynaecology services across the city and report to board September 2005.
August 2005	Appointment of trust chair. CASC meeting agreed the assurance framework with 16 key risks and noted the new integrated electronic risk register for clinical and non-clinical risks now operational in the trust via the Ulysses system and will report to CASC.
Sept 2005	KPI meeting considered questions raised about consultant X workload and conversion to surgery rates. Medical director and directorate manager to talk to consultant X. KPI notes choose and book system to go live: concern about impact on ACWH; concerns about lack of kit.
November 2005	Board meeting noted obstetrics operational plan and MD highlighted the issue of 24 hour consultant cover, which would be a requirement within the next five years. Discussion of work to improve IM&T infrastructure, and whether possible to achieve high clinical and operational standards without an appropriate IT infrastructure.
February 2006	CASC meeting noted performance indicators – in last 12 months significant reduction in inpatient waiting lists Aintree – work in hand to access whether less referrals or better case management. Obstetrics directorate to review against recommendations of the Northwick Park report about high maternal and neonatal deaths.
March 2006	Board meeting agreed operational plan and budgets 2006/7. Agreed integrated R&D strategy. Noted CGC minutes of December, and CE responded to a NED query

	about how board would know if there was a major clinical governance issue, saying the majors are to be asterisked in reports to board and "major clinical incidents would all be reported to the board as a matter of course".
April 2006	Gynaecology operational plan 2006/2007: contains 19 points, set out against the eight corporate objectives for the year. One point is "to maintain our three star status and comply with CHH standards" (risk rate 15); the other 18 points are developments in "our position" and operational.
April 2006	Board meeting discussed finance – action to ensure balance. Discussion financial pressures and £2m savings due by 2007/8. Noted that investment in last two years has been to tune of six consultants and 150 nurses/midwives. Operational plan and budget agreed 6/7. But a more full report on the gynae op plan to go to F&C committee. Staff survey results 2005. Reported as "generally positive". A list of actions was agreed. HCC standards declaration agreed – "full compliance". Medical director invited all board members to attend a CGC meeting. Chair would attend all committees to see how they work and how report up.
June 2006	CGC discussed policy on medical staff training in new techniques and policy on introduction of new procedures. Both responding to CNST and a new national circular. Discussion of a case referred to GMC and how the trust can trawl for similar events.
August 2006	Board meeting noted overspend reversed and under control. Noted on activity that all KPIs are green. Discussed issue in gynaecology about whether the aim is to achieve the financial target or the activity target.
August 2006	Board away day on strategy: discussed existing strategy; drivers for change; SWOT analysis
August 2006	CGC meeting discussed the being open policy – based on NPSA requirements; about explaining to patients when they've been involved in an incident.

	Incident reporting policy amended – it is now to cover both clinical and non-clinical.
August 2006	Audit committee discussed the risk register and assurance framework – noted work to be done on ensuring consistency since directorates scored risks differently. Noted a current review of directorate governance.
September 2006	Clinical annual report 2005/2006 - Gynaecology overview says "the directorate has continued to flourish in 2005 and 2006. The staff who transferred from the Aintree site in March 2004 settled in quickly." "A comprehensive range of high quality specialist ante natal care is now established in Aintree, which mirrors that provided at the Crown Street site."
September 2006	Trust's annual report for 2005/2006; the first published as an FT. Much bigger, more comprehensive, and more upbeat than formerly. Headlines included: • retained 3 star status • gained CNST 3 rating • dramatic reduction in waiting times for inpatients and outpatients • governance more engaged with the local community • planning being completed for trust to the north west gynae cancer centre for high risk patients. Nine objectives set out – including "to further enhance quality and safety of all services for patients". Risk: • the risk management strategy and processes were set out in detail • risk is handled by the clinical governance committee and the corporate assurance standards committee (which is the board meeting in alternate months) • "the board assurance framework is the main vehicle for managing key risks to the organisation. A tool for the board to assess regularly the level of risk for each goal within the corporate objectives against the controls in place, and to consider the adequacy of assurance." Clinical work described as 60 per cent Liverpool residents; 31 per cent Knowsley and Sefton; 9 per cent specialist cases from elsewhere.

September 2006	CGC noted gynaecology ACEs increased – discussion of whether due to staff problems.
October 2006	CGC noted clinical information to the board not substantial enough.
October 2006	CASC received a review of corporate governance by MIAA presented. Mainly positive but – some committees including CGC too operational; no induction committee members to roles; board papers average 230 pages against 120 most FTs and 19 items against seven (perhaps because they meet bi-monthly). Agreed that MIAA to do a directorate governance review too; CE and chair to meet to propose new board governance structure; review committee terms of reference; to continue to meet as board in private. Discussed clinical audit annual report 2005/6; discussion of need to put in more resource to this. Noted elective gynaecology numbers over-running. Weekly KPI work to evaluate. Discussed proposed citizenship committee to promote trust's services nationally and internationally.
October 2006	The mid-year update on operational plan 2006/7 describes a urogynaecology away day "to address changes in practice and service development opportunities".
December 2006	CGC discussed clinical governance leads needing to become more proactive.
December 2006	CASC noted outcome of directorate business review by MIAA: need to reassess role of management executive board to ensure issues affecting strategy objectives are communicated to directorates, and feedback made to trust board; directorates need to ensure corporate as well as clinical objectives are identified; directorates to take more ownership key business areas; directorates need to integrate their clinical meetings and their business meetings "to underline to clinicians that the trust is operating as a business. Noted "long record of corporate and business items not being addressed by directorates, resulting in lack of engagement by some clinicians". CE said that implementing these recommendations would take about two months to complete. Noted trust had pulled out of NHSLA level 3 assessment because they had prepared as per guidelines but the assessors had instead "looked at how the organisation demonstrated and assured themselves that controls

	were in place". Restart process for July. Complaint to Monitor. Aintree project board - to put a plan to March 2007 trust board. Trust meantime told AUH to drop four sessions. Possible arbitration by Monitor needed.
January 2007	Board agreed corporate objectives for 2007/8 (minutes don't record what they were). Discussion of trust underselling itself. Reference to proposed revised corporate strategy/ corporate aims "to be shared with staff. Concerns about sickness reporting "worrying" from a governance viewpoint.
January 2007	Membership Council discussed management consultant's recent work with directorates. Obstetrics' focus is review against NICE guidelines; clustering visits; triage; accommodation review first floor. Gynaecology focus is one-stop services to reduce number of visits; move some services to community; pain management. Marketing was stressed for all directorates, and "hallmarking the LWH brand".
February 2007	CGC meeting considered options for review of structure of reporting to CGC; includes all-embracing directorate reports to CGC at least twice a year. More work on ACEs to be done in standard directorate meetings, reporting to CGC. Discussion of policy on implementing best practice – including how clinicians decide what and when.
March 2007	First meeting of new risk management committee.
March 2007	Report to the executive team from a management consultant engaged (in January) to construct a trading account for the gynaecology service
March 2007	CGC considered risk register. Noted 346 risks quarter November to February (up 42 on last quarter) and put down to increase in reporting awareness. Discussed need for action plan for each of 23 high risk issues.

	Discussed directorate risk managers to form a peer group to share concerns.
April 2007	CGC noted increase in gynaecology ACEs – maybe related to "ACWH problems of last summer". Discussed how gynaecology to develop a clinical indicators report; had not produced one before.
May 2007	Board submitted to HCC full compliance with core elements of Standards for Better Health.
May 2007	CGC noted obstetric ACEs increasing; due to better reporting or more adverse outcomes? A NED asked how work on risk was progressing. Was told it is much better and the register is now a live document. Gynaecology directorate manager said gynaecology managers now meet weekly with staff "which has turned around their department".
June 2007	Board noted Liverpool PCT board has decided breast services to go to RL&BroadgreenUHT. Agreed Aintree project board to look at new service models now that breast cancer issue is decided. Internal audit report on directorate business – • gynaecology "needs a governance review". • overall conclusions about trust's operational planning in directorates: governance structure needs documenting; need better guidance on minutes and meetings; directorates need more guidance on objective setting and operational planning; need to agree how to embed assurance frameworks; need better ensure use of operational plans within directorates; need central store of minutes; focus meeting agendas more; management executive board to feedback to directorates better and vice versa.
July 2007	Medicines management committee considered a case about new process (TVM mesh) presented by consultant X. Case was agreed subject to financial sign-off.
July 2007	Management consultant presents sub-directorate trading account data to the urogynaecology team, including consultant X, and to other teams. One outcome was that all urogynaecology cases would be discussed through a multi-disciplinary team process.
	Management council noted trust is one of five FTs nationally with top finance and governance ratings: chair - "The trust can now present itself as a very successful organisation".

July 2007	Discussion of 18 week treatment target, and "by October ....an enormous amount of work to ensure compliance." Were advised that "clinical pathways for all gynae procedures have been agreed".
July 2007	CGC – new framework for consultant appraisals being developed. Now financial year based as are all other staff.
September 2007	Board meeting noted Maternity Matters project board between SHA/PCT/trusts. Item on collaboration with mid-Cheshire trust. Corporate report – in order to hit 18 weeks in gynaecology "an unprecedented number of patients to put through".
September 2007	CGC noted that in obstetrics – "clinical indicators remain difficult to collect".
October 2007	HCC ratings for 2006/7 published. Trust rated excellent for use of resources, and excellent for quality of services.
October 2007	Membership council discussion included working with Knowsley and Sefton PCTs on gynaecology outpatients being held in community clinics.
November 2007	Board meeting discussion of marketing strategy included recent staff research - Issues raised by staff during the research included: Their pride in Liverpool Women's, but; low morale in some areas; frustration with Agenda for Change pay and conditions; A need to know all in it for the long term; Is patient care the number 1 priority (raised by older staff)?
December 2007	Board part two - medical director gave first oral report "to apprise the board of concerns that had come to light" in clinical practice of consultant X. Board approved proposals that 400 cases from 2006 and 2007 be reviewed; to take three months. A NED queried why clinical audit didn't find the problem: agreed need to look at the rigour and resources of clinical audit.
? date 2007	Clinical annual report 2007 - Gynaecology section: "the pace of change within gynaecology is unrelenting". "The directorate is committed to ensuring effective use of resources and sustainable quality at Aintree". ACWH length of stay has been reduced and additional efficiencies with the 11 day ward. - Clinical director stated there has been more focus on clinical governance in the last year or so. - all statistics presented (such as mortality; complications from ops;

	readmission; length of stay; pressure sores; HDU usage etc) show marginally better than national average, except for haemorrhage and injury in day surgery.
January 2008	Board part two - medical director "apprised" board of developments; NCAS reported as "supportive". - Medical director to organise an occupational health review of consultant X. - Consultant X currently undertaking only cases approved by medical director.
January 2008	Agreed that the trust to host the north west FT network activities.
January 2008	CGC paper on evaluation of clinical governance reporting by directorates last six months: getting better but a few gaps to close.
February 2008	CGC – pre-op checking of consent "still a problem" at LWH. Policy on med staff assessment and supervision – needs urgent revision to pass CNST 3. Lack of sign off from doctors. R&D not included in directorate reports – "struggling with this".
February 2008	Transfer of breast services from trust to RLUBH, and 22 staff.
March 2008	Board debate about board assurance framework, and risks: include clinical outcome indicators as a risk; and concern about "loss of reputation" if lose CNST 3. CGC now reports to board direct, not via audit committee.
March 2008	Board part two discussion about consultant X (apparently – minutes not provided) Taking NCAS advice about seeking DH or Monitor advice on the issue of notifying patients.
April 2008	Board meeting approved 2008/9 operational plan and budgets - board asked execs to review the 19 high risks in board assurance framework - Noted auditors gave an 'A' rating for assurance but wanted to see "tightening of controls and real assurances" - KPI near miss on elective waiting time targets in gynaecology: concern

	about administration in gynaecology at Crown Street. – staff survey : concern at low response. – the committees of the board are listed as eight – CGC; finance and contracts; audit; trust risk committee; charitable funds; HR; marketing committee.
April 2008	Integrated operational plan 2008/9: - Six corporate aims listed: clinical excellence; strong finance performance; positive patient experience; provider of choice; promote status as teaching and research; skilled and effective staff. - core service developments for 2008/9 are: obstetric model of care; expansion of gynaecology out of hospital in partnership with PCT etc; expand assisted conception; explore links with other providers NHS and private. - service schemes listed in three categories: growth; productivity and efficiency; world class outcomes. (no maintenance, safety etc) - clinical priorities in gynaecology: deliver activity; reconfigure second floor and outpatients; implement nurse staffing review; develop consultant of the week model; increase market share through closer to home.
April 2008	Corporate objectives 2008/9 document: - lists five corporate aims (even though leaflet summary lists six) - lists 58 objectives against those five - only corporate objective that mentions gynaecology specifically is to provide purpose built private patient unit.
April 2008	Board part two - discussion about consultant X. Agreed an external review of cases needed. Discussion of possible future disciplinary processes.
April 2008	Medical director tells internal clinical case reviewer no more case reviews needed and consultant X needs retraining.
May 2008	Board part two – consultant X now on sick leave; will undergo retraining; RCOG visiting 19 June.
	Gynaecology operational plan 2008/9 - Introduction: the directorate has continued to demonstrate success in

May 2008	2007/8 and contributed to the trust gaining the highest Monitor rating for risk management. - cancer centre team has taken on all regional referrals - redesigned gynaecology patient pathways - pace of change in gynaecology is unrelenting - first consultations waiting down 11 weeks to five. - directorate committed to ensuring effective use of resources and sustainable quality at Aintree. - more robust clinical governance reporting has been achieved - weekly clinical quality meetings were established in the year - Objectives 2008/9 focus on the trust's five corporate aims for the year - 12 bullet point priorities – including: deliver quality patient-centred care; robust risk management; market share maintenance through closer to home; refurbish Aintree foyer and entrances, etc - Principal risks section just contains three financial ones and descriptions of assurance processes and dashboard work - lists 12 pages gynaecology assurance against 45 gynaecology objectives set out under the five corporate aims 2008/9: each of the 45 contains a risk and gap column but these are often very general and the action planned is vague. They are risks related to not delivering plans, not risks as such.
May 2008	CGC members asked for ideas to improve clinical audit – to take to executive group. Agreed to develop a clinical excellence strategy. New gynaecology risk manager appointed.
July 2008	Board part two - agreed two members to decide action on consultant X when RCOG external case review reports in August (no board meeting in Aug).
August 2008	Meeting on 20 August of board members delegated to receive the RCOG report and to discuss action flowing from it. RCOG report concluded there had been poor decision-making and it recommended: "training in interpretation of urodynamic tracings" and consultant X must attend MDT meetings and discuss all cases with them; management to audit consultant X's activities after six months of return; no clinical reason to recall any patients; urodynamics staff and equipment need upgrading at ACWH. The meeting noted the RCOG's recommendations and discussed the ethical and legal issues of actions arising from the report. Medical director would discuss the report further with RCOG; also to report to the board in September.
September 2008	Board part two – first ever written report on consultant X issues. The

	board noted the RCOG report of August and issues arising.
September 2008	Membership council/council of governors – agreed change of name.
September 2008	Meeting of the new chief executive with the medical director: who agree change of plan (from some of the RCOG recommendations) re consultant X – to refer his case to the GMC and SHA etc.
September 2008	Report from independent audit ltd – board performance review: - looking "at how board may need to evolve to meet future NHS landscape". - 73 points made about areas to work on. - says "board attention to internal risk appears robust".
October 2008	Board part two - detailed written report by director of nursing who had set in place a formal SUI review and incident review panel, board agreed - to complete 2006 case reviews and do a sample back to 2001 - a handling strategy to be developed - review of ACWH services to be undertaken (current adequacy)
November 2008	Board meeting discussed urogynaecology service pathway and primary care commissioning intentions for a city-wide service. Board meeting considered action taken since the HCC annual health check received in October – trust rated excellent for use of resources and good for quality (down from excellent). Board considered moving directorate structure from 6 to 4, following recent board time out session. Paper on clinical business units to follow. Discussed actions following independent external report on the board. Board concerned about improving relationships with Liverpool PCT and the city council; and use of NED time.
December 2008	Board commissioned internal audit to review committee structure. Board agreed proposed role and structure of CBUs. Letter from Monitor: the trust's quarter two 2008/9 FT monitoring results are a financial risk rating of five, a governance risk rating of Green, and a mandatory services risk rating of Green. Consultant X incident review group : medical director "stressed it (urogynae) was never unsafe at Aintree"
January 2009	Trust chief executive and executive directors meet with Verita to discuss consultant X case handling issues Trust chief executive and executive directors meet with PCT regarding

	consultant X issue handling - PCT to arrange GP input to review of patients. The incident review group role and membership was revised: to be chaired by the chief executive; appointed formal project manager.
January 2009	Council of governors meeting: - integrated operational plan 2009/2010 summary agreed. Includes – • **Obstetrics** – 98/168 hour cover on delivery suite. – 24/7 cover for obstetric theatres. – Approving business case for big push (and growth). – Development of community services – Fetal medicine joint working with Alder Hey. • **Gynaecology** – Consultant of the week in gynaecology. – Development of day case surgery. – Corrective surgery for female genital mutilation – Gynae chemotherapy for north of the river. – Commissioning of private patient unit.
March 2009	Board agree new committee structure for 2009/2010: down to five formal committees of board; new executive management arrangements; and CBU management arrangements. Work to be done in two phases to implement April to September, and October onwards – including some culture work and assurance. New clinical business unit for gynaecology and critical care planned to replace the gynaecology directorate in 2009/2010.

Appendix E

Benchmarks of good governance

Verita's reviewers conduct governance reviews against the following outlined benchmarks of good governance.

These take account of a number of governance requirements and guidelines to the NHS and to public services, including: the information provided to new chairs and non-executive directors by the NHS Appointments Commission, the Good Governance Standards for Public Services (2003), the NHS Integrated Governance Handbook (2005), the Intelligent Board (2006), the Audit Committee Handbook and the Department of Health's constitutional guidance for NHS trusts and foundation trusts. NHS foundation trusts (FTs) are established under an NHS Act of 2003 and have a more complex constitution and governance arrangements than other trusts, relating to their local membership arrangements, local governors' roles, and greater financial and operating independence. The constitution and performance of FTs is overseen by Monitor, an independent NHS regulator, who published the latest code of conduct for FTs in 2006 and the latest compliance framework and financial and reporting guidance in 2008.

Benchmarks

Benchmark one: organisational purpose, board roles and business structure

- agreed and published statements of organisational purpose and strategy; service strategies; annual objectives
- clear roles for all board members including coverage of all statutory aspects
- executive directors with roles and objectives agreed by the board, who also understand and contribute to collective corporate business
- non-executive directors who challenge the executives constructively, scrutinise management, ensure they have accurate and relevant information, act with collective responsibility, and act in the public interest
- clear, up-to-date, and statutorily compliant board-level structure, including: standing orders; standing financial instructions; scheme of delegation; committee structure; annual reviews of these; and an established corporate secretary and compliance role
- business control that includes: clear annual rolling business programme; clear individual and group roles at and below board level; integrated reporting and review of performance.

Benchmark two: performance analysis and assessment

- systems to enable the organisation to identify its actual achievement over a defined period against objectives and roles set for: the board; the corporate organisation; clinical governance; financial governance; information services; human resources; estate and facilities services
- systems to enable all clinical and professional staff to engage with the purpose and aims of the organisation, to contribute appropriately to their own disciplines and to the wider performance of the organisation
- systems to ensure that the organisation delivers safe and effective clinical services.

Benchmark three: assurance and risk

- a clear assurance framework, linking through: strategy; objectives; key control mechanisms; assurance against controls; reports to the board; planned actions
- an up-to-date and active risk register; clear plans to remove or accept identified risks; and realistic analysis of the ability to deliver plans
- an integrated approach to risk and controls assurance that includes all aspects of the organisation: corporate; clinical quality; service standards; financial; information; premises; human resources.

Benchmark four: organisational development

- agreed culture, behaviours and rules at board level
- appropriate induction for all board members
- team and individual development and training for all board members
- regular and effective appraisal of non-executives and the chief executive by the chairman and of executive directors by the chief executive
- clear board approval of senior appointments, directorate objectives, staff consultation arrangements, policies and procedures affecting staff and systems for involving and informing staff
- clear organisational culture, behaviours and rules understood and followed throughout the organisation
- effective induction, training, and appraisal systems for all clinical, professional, and other staff
- evidence of active board-level review of national and local staff surveys and opinion.

Benchmark five: partnership working

- active and appropriate whole-system working within the NHS
- good governance arrangements covering whole-system working
- active and appropriate joint working with other public agencies and local bodies
- effective relationship and systems with local authority formal overview and scrutiny.

Benchmark six: public accountability

- active and effective working relationships with regulators and the wider NHS including: Monitor; SHA; Department of Health; Healthcare Commission/Care Quality Commission; National Patient Safety Agency; others as applicable
- publicised and effective annual statutory meetings
- clear, timely, and well-disseminated annual reports
- allowance of public questions after board meetings
- existence of other means of keeping contact with local opinion and input
- working relationships with local MPs and councillors.

Benchmark seven: adapting to change

- analysis of in-year changes in external demands or regulations and adaptation to meet these
- regular forward look at likely new clinical or corporate demands or regulation; the likely governance issues; and the organisation's readiness.

Appendix F

Reviewers' biographies

Ed Marsden

Ed is a former NHS manager with many years' experience of leading complex organisations and managing sensitive political issues. He has worked for the National Audit Office and the Department of Health, and before founding Verita, he was director of performance management for West Kent Health Authority. Ed has a clinical background in general and psychiatric nursing.

Now the managing director of Verita, a management consultancy specialising in the conduct of investigations and inquiries in health and other public organisations, Ed has handled the political repercussions of high-profile mental health inquiries, including the Michael Stone case. Along with Professor Robert Tinston, Ed carried out the corporate governance review of the Royal United Hospitals Bath NHS Trust. He has also worked with Ruth Carnall on a financial management and governance review of Worthing and Southlands Hospitals NHS Trust. Ed co-wrote the board leadership review of the Maidstone and Tunbridge Wells NHS Trust. This follows the Healthcare Commission's report on the deaths of patients as a result of clostridium difficile. Ed is an associate of the Prime Minister's Delivery Unit and has carried out three assignments on immigration.

Hilary Scott

Hilary joined Verita as an associate in May 2008. She has over 20 years' experience working with the health service and public sector, including as deputy health service ombudsman from 1999 to 2003. For the past four years Hilary has operated as an independent development consultant. Among her recent assignments are leadership of a Department of Health programme for service reform, policy development work with the Healthcare Commission and the Home Office, and service development work with NHS trusts. Hilary chaired the UK charity Action on Elder Abuse between 2004 and 2008 and is an independent governor at the University of Westminster. She is also associate professor at Middlesex University Business School and a senior visiting fellow at Birmingham University's Health Service Management Centre.

Martin Hawkins

Martin brings to Verita 35 years experience in NHS corporate services, including organisational planning, coordination, control and inter-relationships. A recently retired health authority assistant chief executive, he is well versed both in the review of untoward incidents and in the analysis of governance issues. In addition to the core range of corporate services skills, he has also specialised at times in areas of planning, communications and human resources. Alongside his work with Verita, he is also a research fellow at the University of Kent health research unit.