University Hospitals Birmingham NHS FT (UHB)

Phase 1 Review by IQ4U
Clinical Safety

Preface:

This report was commissioned by Birmingham and Solihull ICB, rapidly in response to growing public disquiet over the culture and potential clinical safety at the Trust. We had only 6 weeks to produce a first report; we conducted numerous interviews, received written submissions, conducted a documentary review and attended a number of reference groups, and a public meeting. Our conclusions and recommendations are, therefore, limited at this point and time is needed to investigate many issues in more detail.

As a result, we make clear in this report those areas we feel are of concern, where we cannot fully establish the facts yet, but which are sufficiently serious to merit further detailed scrutiny to either confirm them or disprove them. UHB is on a journey with new leadership and needs to be assessed in the context of the progress that it is making, and to demonstrate that it has incorporated learning from other planned reviews and from the work that is to come next.

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About us

1. iQ4U Consultants Ltd was set up in 2015 by Professor Mike Bewick (MB) focusing on health, education and health related sciences. Since then, MB has worked in collaboration with several senior consultants including Dr Rebecca Mann (RM) and Mr Giles Peel (GP), who are currently assisting him in this review. MB was the former National Deputy Medical director at NHSE England until 2015. Dr Mann is a consultant paediatric neonatologist and Giles Peel a chartered secretary and governance expert. Between them they have conducted over 30 reviews including:

   - Clinical service reviews of maternity, cardiology, cardiac surgery, neonatal and emergency care
   - Mortality reviews in general medicine, cardiac surgery, accident and emergency, and neonatal medicine.
   - Well-Led reviews into larger Tertiary centres, district general hospitals, community and mental health trusts.
2. MB trained in both hospital medicine and general practice prior to becoming a medical director in Cumbria and then for the North of England, ultimately taking up the national deputy post. He has never worked in Birmingham nor carried out any previous reviews there. Any contact with the previous senior leadership at UHB was by chance at national meetings and none are known to him personally. This is true for GP and RM also.

Why this review?

3. On Thursday 1 December 2022, UHB was informed by Healthwatch Birmingham that their Chair, Richard Burden, would be featuring on BBC Newsnight later that evening, having contributed to the programme some days previously. The programme featured interviews and statements from current or former staff from University Hospitals Birmingham (UHB) relating to a range of concerns around leadership, governance, and culture at UHB impacting on patient care.

4. In the days before this, an inquest into the suicide of a junior doctor who was working at UHB at the time of her death had concluded. Whilst the coroner apportioned no blame to UHB, understandably the inquest attracted significant media discussion. In the immediate aftermath of the Newsnight programme, further media coverage discussed other cases and Newsnight subsequently ran an interview with Professor Bion, the Trust's Freedom to Speak Up (FTSU) Guardian, on Friday 9 December. The Chair of Healthwatch Birmingham released a further statement raising concerns over bullying and patient safety at the Trust. Since then, the trade union Unison has published its own review of concerns of bullying and poor behaviours at UHB raised by its membership. This was sent to the CQC but not seen by the Trust until last month.

5. Preet Gill, the MP for Edgbaston, whose constituency includes the Queen Elizabeth Hospital site of UHB, has written to the Secretary of State (SoS), Rt Hon Steve Barclay MP, raising issues relating to the culture at UHB and further concerns over safety at the Trust. In response, the Integrated Care Board (ICB), in conjunction with NHS England, confirmed an approach to addressing these through a series of rapid independently-led reviews of the Trust, addressing three areas:

   I. Aspects of patient safety raised in the Newsnight programme and other recent media activity commissioned by NHS Birmingham and Solihull ICB. The findings from this will link to two following reviews.
   II. The Governance processes at UHB, commissioned through an independent Well-Led Review (WLR), using established NHS WLR methodology, and undertaken by NHS England. This will provide the Trust with the information to focus further work on an independent culture review.
   III. Culture at UHB commissioned by the Interim Chairman at the Trust.

6. Our review focuses on the first of these but as with all such reviews it will report on cross cutting themes that will assist in all 3 reviews. The review has been commissioned by Birmingham and Solihull ICB. It is envisaged that MB with his two colleagues will oversee the 3 reviews on behalf of the ICB. Separately, a reference group has been set up by Preet Gill MP, to include politicians from adjacent constituencies, local councillors and patient representatives. The review team has agreed to feed back its findings to this group and attend their meetings.

Background

7. Our initial narrative focuses on the composition of the organisation, its leadership, the professional allegations made against it and wider impact that such a significant Trust with a deteriorating reputation could have on the wider community and region. UHB is one of the largest health providers in the UK and Europe. It employs over 22,400 people across 4 sites. These are:

   - Queen Elizabeth Hospital (QE) Birmingham (UHB)
   - Birmingham Heartlands Hospital (formerly Heart of England NHS FT[HEFT])
   - Good Hope Hospital (formerly HEFT)
   - Solihull Hospital (formerly HEFT)

Sources of information referenced in this report include:

i. Members of staff listed in the document and others who have contacted us independently
ii. 18 of the 44 participants at the Town Hall events who contributed during the broadcast
iii. 6 members of the Medical Staff Committee
iv. A senior consultant haematologist from UHB
v. A member of the neurosurgery team (independently made contact)
vi. Two senior managers at the QEH site
vii. A site manager from UHB
viii. A former senior haematologist from UHB
ix. A former senior consultant physician at UHB
x. Written submissions as follows:
   a. A former neurosurgeon at UHB
   b. A former member of the corporate affairs department
   c. A former plastic surgeon at UHB and also a member of his staff
   d. A member of UNISON and the evidence submitted by his members
   e. Two anonymised statements from former members of clinical staff
   f. A statement from a current member of staff witnessing bullying
   g. A statement from a site manager
   h. A former senior transplant surgeon at UHB

Overall, this constitutes 39 direct contacts in addition to the list of interviewees listed within the report.

8. The merger, by acquisition, of the Heart of England NHS Foundation Trust (HEFT) with UHB was completed in April 2018. All 4 sites provide acute, specialist and elective care for the citizens of the Greater Birmingham area and the QEH site acts as a regional centre for specialised and highly specialised services.

9. The most recent Care Quality Committee inspections (October 2021) documented concerns:

   - Good Hope; rated as 'requires improvement' for urgent and emergency services, and medical (including older people's) care.
   - Heartlands; rated as 'requires improvement' for medical (including older people's) care, maternity, and surgery; inadequate for urgent and emergency services.
   - Queen Elizabeth; rated as requires improvement for urgent and emergency care. However, cancer services, HIV and sexual health, surgery, palliative care, outpatients, and medical (including older people's) care were all rated good.

   In addition, the CQC made Trust-wide recommendations that are of direct relevance to this review:

   - *"The trust should ensure recruitment processes are open and transparent and are able to evidence recruitment processes for senior positions.*
   - *The trust should ensure action is taken regarding identified themes to resolve concerns.*
   - *The trust should ensure all risks are escalated as appropriate and documented on the relevant risk register.*
   - *The trust should consider the way in which it communicates with staff when discussing issues raised.*
   - *The trust should consider the way in which lessons learnt are shared.*
   - *The trust should consider the way in which the council of governors are utilised to ensure the chair and non-executive team are held to account.*
   - *The trust should consider the mixed views of staff with regards to culture and take appropriate action.*

   Furthermore: "There was a mixed perspective from staff regarding feeling respected, supported and valued. Staff were focused on the needs of patients receiving care. The Trust was at the start of its equality and diversity agenda in daily work and provided opportunities for career development. The Trust promoted an open culture where patients, their families and staff could raise concerns without fear, however not all staff felt comfortable raising issues".

   - *Trust leaders spoke clearly about compassion for the wellbeing of staff and the need to be inclusive, empathic and compassionate.* ***We heard about historic leadership being control and demand and executives recognised the need to change****."*

10. Like most acute hospitals in the UK there is a significant delay in accessing acute, cancer and elective services post pandemic. The last Health Watch report noted the disappointing position that UHB was achieving in the cancer wait times, being in the national lower quartile for performance. This review's scope is not to assess overall Trust performance but to explore how areas of concern have been addressed and to look at the wider Trust role in caring for both its patients and staff. Issues over the Trust's own responsiveness to concerns have been identified in various internal reports (UHB's Quality Report 21/22 as an example) and from Health Watch. The "Unison review" of July 2021 was similarly critical. It is a credit to UHB that the Freedom to Speak Up (FTSU) system was identified as a key priority in successive years from 2020. That said, the 4-year look back by the FTSU guardian showed there was still significant progress to be made. We were told by several people that whilst more were using the FTSU facility, many staff felt that speaking up would either result in no action, or for some, retribution.

11. Preet Gill MP, and the Chair of Healthwatch Birmingham, Richard Burden told us that both had received extensive complaints about the organisation's conduct. Many were concerned about the "toxic atmosphere and bullying at all levels of management." Indeed, several staff members have left and then spoken out. This was reflected at the listening event that we attended on 23 January and in subsequent approaches made to the review team. The listening event was initiated by Preet Gill MP and was by invitation extended to individuals who had independently contacted her and Health Watch in the past to express concerns about their experiences at UHB. Approaches made to the iQ4U team were by independently initiated contacts from a range of concerned current or past employees.

12. Birmingham and Solihull ICB oversees healthcare for a diverse community with a population of 1.3M people, with wide disparities in health outcomes reflecting significant areas of deprivation and poverty. There are considerable differences between the local populations surrounding the 4 component hospital sites at UHB. Their demands and population health profiles are different. The staff at the various sites have inevitably developed their own culture and management styles. The merger of HEFT with UHB was the single most important event with complex sequalae as different cultures collided. This was as true for clinicians as managers. As is typical in mergers, some services were able to adapt and assimilate more easily than others - Stroke services being a good example. At the other extreme, Haematology has not been able to do so, or at least not fully.

13. Historically, the style of leadership, clinical and managerial was widely thought of as robust at the UHB QE site. The senior leadership comprised a formidable team with strong national reputations who raised the standards of care and profile of the Trust. The leadership style was widely described as forthright and decisive. For some this was charismatic and inspirational and for others, the culture was felt to be oppressive.

14. In April 2018, the then Medical Director of both UHB and HEFT, Dr David Rosser (DR) was appointed as Executive medical Director and Deputy CEO for the newly merged University Hospitals Birmingham Foundation Trusts (UHB). He was subsequently appointed Chief executive of UHB on 1st September 2018. The culture of UHB appeared to evolve further, characterised by a no-nonsense approach to failure, and resulted in decisions on service change, disciplinary issues and performance. Feedback from a specific diaspora of those who felt aggrieved described the newly emergent senior management style as dictatorial and overzealous. More generally from our other interviews, the style was seen as robust and often lacking kindness and empathy.

15. We received substantial evidence of how these behaviours affected significant numbers of staff included in the review and how certain specialities deteriorated as a result. These are reflected later in in this report. There were also examples of high performing specialties and the picture of performance across all departments is complex.

16. The role of such a large organisation, is not just to deliver healthcare. As a major stakeholder in Birmingham's wider environs, it is seen as the fulcrum for the development of the region itself, and as a locus for employment, research and education. It is entirely in Birmingham and Solihull's interest to look for a renaissance at the Trust, as it will a have much wider social and economic benefit.

Methodology and TORs

17. The terms of reference are detailed in Appendix 1. Our review collated its evidence from:

    - Interviews/discursive with key personnel and individuals who have contacted MB either directly or through the offices of Preet Gill MP, Health Watch or as part of an online webinar hosted by Preet Gill on 23 January 2023
    - A documentary review: the documents reviewed are listed in Appendix 2
    - Site visits to all 4 hospital sites that comprise UHB

18. In the short time we have had to conduct this phase of the review we have concentrated on some key lines of enquiry. These include:

    - Professional standards and disciplinary processes including GMC referrals
    - Clinical safety at the Trust with specific focus on
        - Haemato-oncology
        - Never Events
    - Reports of inappropriate behaviours including coercion, bullying and inconsistencies in applying professional standards when incidents arise
    - A brief review of the current clinical governance systems in response to Serious Incidents and Quality, up to and including the Board
    - Processes that improve staff wellbeing and how well these were implemented for staff at risk of self-harm
    - The Trust's response to the suicide of a member of staff (a Doctor in the final part of her training, Dr Kumar)

Findings from interviews, reports and listening event on 23 January 2023

19. We have received several key documents highlighting concerns raised by both individuals and representative organisations. These include:

- A letter from Preet Gill (PG) to SoS dated 14th December 2022; this expansive letter highlighted PG's concerns over the 'toxic' culture at the Trust, poor management and potential unsafe practices. The letter also called for a Francis style inquiry into the issues she had identified
- The Newsnight programmes themselves; whistle-blowers, the chair of the local Health Watch and the Trusts' Freedom to Speak Up Guardian were all interviewed. The claims of an unhealthy culture and the bullying of staff were consistent themes from all contributors. Issues about specific actions of individuals and lack of concern over patient safety were also raised, and this review will go some way to address these concerns.
- A summary email from the senior medical staff committee (representing Consultants within the Trust)
- The report from Unison 'Patient Care Concerns at University Hospitals Birmingham 21 July 2021'; this report detailed evidence which highlighted issues in 2 key clinical areas, haematology and cardiac surgery. The latter is somewhat historical, the former forms part of the current review. The paper also reports evidence from the workforce at UHB of a counterproductive culture whereby raising concerns were often 'air brushed' away and that the focus on the QE site was one of a ruthless pursuit of excellence. It is understood that this report was sent directly to the CQC and the first sight the Trust had of this was not until January 2023.

20. We have interviewed local community leaders, several members of staff and leadership at UHB/ICB. These included:
    - The current Chief Medical Officer at UHB
    - The clinical service lead for haematology at UHB
    - The current CMO at Birmingham and Solihull ICB
    - Deputy Medical directors at Heartlands and Queen Elizabeth sites
    - Clinical service lead for Emergency care at heartlands Hospital.
    - Preet Gill MP
    - Chair of Health Watch Birmingham
    - Chief Nursing Officer (CNO) at UHB
    - Chief Nursing Officer at Birmingham and Solihull ICB
    - Deputy Director of Patient Experience at UHB's QE site
    - Freedom to Speak Up Guardian at UHB
    - Interim Chief Executive Officer at UHB
    - Clinical service lead Neurological services UHB
    - Two trainee doctors in ENT
    - A trainee doctor in Cardiothoracic surgery.
    - A consultant haematologist at UHB
    - Video call with Senior Medical Consultant Committee (6 members)
    - A consultant haematologist QEH
    - A member of nursing staff Neurosurgery Unit
    - Members of corporate affairs staff
    - A senior member nursing operational staff
    - The previous CEO UHB until December 2022
    - Dr Nikolousis (MN), a former consultant haematologist QEH
    - A former Clinical Service Lead, haematology UHB (until Jan 2020)

21. MB attended and spoke at a webinar event on 23 January 2023, chaired by Preet Gill, where we heard from 18 attendees, part of an audience of 42. We have also received several written submissions via MB's personal email. These included:
    - A former senior academic at UHB who is now working successfully in a significant academic unit.
    - An anonymous former senior Trust manager with specific allegations against the former CEO/CMO Dr David Rosser
    - A retired surgeon at UHB
    - A Clinical Nurse Specialist from UHB (in practice).
    - A former senior transplant surgeon at UHB
    - A former senior urological surgeon UHB

    Attendees at this webinar were part of a group who had previously contacted PG and seems likely to include individuals who might be more likely to have a negative perception of the Trust than a randomly selected staff or patient group. Nonetheless, the comments made and the concerns expressed showed a strong degree of concordance with wider feedback from many other corroborated external evidence sources and cannot be disregarded.

22. The Newsnight article concentrated on specific allegations of bullying, a toxic environment and allegations of unprofessional and incompetent leadership at the Trust. Our findings from the interviews have led to several themes coming from both current and past employees of UHB, which we now address.

Merger Issues

23. Many of those who contributed to the review feel that the merger by acquisition in April 2018 between HEFT and the QE was not an unqualified success. HEFT had moved into a state of financial failure with a deficit of £90m and there were additional clinical safety concerns with some high-profile governance cases, not least the case of Ian Paterson. Monitor, the then regulator of foundation trusts, instructed the senior management at UHB to intervene at HEFT. The management team under the leadership of the CEO/CMO and other executives formed a new board at HEFT in late 2015. While the issue of finance was significant driver for the change, the evidence supplied by UHB's then CMO, reports significant clinical safety issues at HEFT. The merger took place in the aftermath of the Paterson Inquiry and this legacy along with significant numbers of clinical incidents led to, in our view an understandable focus on improving clinical governance processes at HEFT. What evolved was a process where the expected engagement under the Competition and Mergers Authority's (CMA) oversight of two organisations, centred on a 'Chinese wall' between two management teams (with some individuals common to both). This separation is not uncommon practice for failing Trusts in the NHS, and in this case, it was somewhat compromised by the more pressing clinical safety issues. From the point of view of staff at HEFT it might have appeared that the merger was one sided and several senior staff present at the time have stated that they were being 'done to'; this must be balanced by the evidence of some cases of significant clinical concern being discovered by the incoming clinical leadership.

24. The Haematology service, where former clinical rivalry between UHB and HEFT led to worse dysfunction, was the prime example of an inadequate merger process for many, but it was not alone. This commentary is not a criticism of the decision to consolidate the haematology in-patient service on the QE site (indeed this was recommended by the service's clinicians), but rather reflects concerns we heard that the decision was not as effectively implemented as it could have been. The absence of feedback from other services involved in the merger seems likely to be an indication that things have gone well for some. It seems likely that despite the significant challenges of a pressurised merger that integration of most services was achieved successfully - but our initial feedback received is that there remains a difference of approach across the 4 sites and any solution to the current problems besetting UHB needs a site-based approach to adequately reflect their different characters and nuances, as well as to facilitate change across an organisation of the sheer scale of UHB.

25. The Trust had already recognised challenges within the Neurosurgery service at UHB, which were longstanding ("at least 8 years") in nature - indeed they have recently sought an independent review of neurosurgery services from the Royal College of Surgeons (RCS). This identified several areas of concern including unprofessional behaviours, a lack of leadership and a confrontational attitude between colleagues. It is understood that an action plan has been put in place. That aside, concerns about a deterioration in service around the time of the merger were additionally highlighted. The evidence from both the current Clinical Service Lead (CSL) and that received from a senior neurosurgeon, also recorded serious concerns. These themes were common in many of the conversations we heard. We were told that specific problems have arisen due to an increase in referrals to the neurosurgery team at QE from the former HEFT sites. This is because historical referral pathways which determined access to these highly specialist tertiary services were now able to be bypassed by the former HEFT sites; they were no longer assessed in the same way as other external Trusts, and so enjoyed greater, and sometimes inappropriate access. The Deep Brain Stimulation service was suspended in 2019, with follow up services only now being offered by the Trust. It is important to recognise that the problems within neurosurgery at the trust are longstanding and significant and the

effectiveness of any action plans which have been put in place still needs close monitoring. The merger was a pivotal issue for UHB, and while many departments have embraced the changes, as evidenced at the site visits (below), there are individuals who have not, and this is having a persistent impact on the development of the Trust. It should also be remembered that covid had a major impact, with many of the senior management team being pulled in multiple directions by new responsibilities, including externally during a prolonged period of disruption. The disappearance of HEFT, acquired by its neighbour, where for many years there had previously been a healthy rivalry, was difficult to take for many staff. Some left - as an example 6 haematologists (2 from the QEH site and 4 from HEFT) as well as many specialist nurses. The number of people leaving from both sites from this speciality was felt to be unusual. At the Townhall event, contributors were explicit that many left due to the working environment and not necessarily, for example, because of workload related issues.

Conversely, we have found evidence of improved relationships especially since the onset of the pandemic in 2020. The Trust was one of the hardest hit organisations during the pandemic and like many other parts of the NHS, staff came together to confront this unique challenge. Also, like many other Trusts, the recovery phase has been challenging with some services having to be prioritised over others. This has led in some quarters to a resentment of centralised control, and the reorganisation has rekindled memories of what was seen by many as a very heavy- handed merger. This was reflected in CQC feedback: "We heard about historic leadership being control and demand and executives recognised the need to change". It is not clear that this change in approach has yet been delivered, or at least felt by staff members. We understand that an organisational review, led by external experts, is underway and actively considering a change to site-based leadership.

Culture

26. We heard repeated reports of a long standing 'bullying and toxic' environment. UHB has rapidly enlarged to include all 4 Birmingham acute hospitals. Whilst its approach was initially thought of as 'firm and fair' it is now more commonly reported as 'overzealous and coercive'. Even current Trust employees in senior positions recognise that the previous senior management, whilst well-meaning and with the aim of improving care, could come across as very robust and severe in their approach. Most of those who gave evidence at the webinar on 23 January were more forthright, as were many of the correspondents who have contacted us separately. It is important to recognise again that staff who come forward will usually be those who hold strongly held concerns – but again to note that there was a concordance between the opinions expressed at the webinar and statements made in face to face /online interviews as well as through other external assessments such as CQC. It should also be noted that we spoke to staff members who are perfectly content in their current roles but simply wanted to make the culture at UHB better and were therefore happy to speak up.

27. As part of the interview process staff were assured that all comments would be non-attributable – this is a core part of ensuring that current employees feel able to openly describe their opinions and feelings relating to being a trust employee. Particularly with regard to the current employees who were interviewed directly, it should be said that many were happy in their posts and were not seeking any grievance against the Trust, and yet they were still able to be objective and describe very negative behaviours in some parts of the organisation. We heard many examples of concerning comments covering a range of topics including issues over promotion processes, bullying of staff (including junior doctors), and a fear of retribution if concerns were raised. All of these issues will be the subject of further investigation in the Phase 2 Culture Review.

Professionalism

28. One of the major concerns that has been raised was the style of governance within UHB for medical disciplinary processes, with accusations that the previous CEO Dr David Rosser (DR) had an overzealous approach. The case of Mr Tristan Reuser (TR), an ophthalmologist at the Trust whose case was reported on the Newsnight programme and used as an exemplar case in this regard. TR was dismissed from the Trust in June 2017 following referral to the GMC in which DR stated that TR had not been involved in a whistleblowing event, when he had in fact reported concerns about safety in January of that year. There were separate employment tribunal and GMC hearings dating from October 2018 to May 2020 for the employment tribunals and a final GMC hearing relating to DR in July 2021. We understand that the reasons this took so long was that the Trust appealed against employment tribunal findings and DR sought a hearing from the GMC. We do not comment on the disciplinary case itself but are interested in the handling of the case relating to TR's whistleblowing (it must be noted that the Employment Tribunal found that he was not dismissed as a result of whistleblowing) and the comments made by the Tribunal Judge about DR's conduct. DR was given a warning by the GMC for his actions when he was Executive Medical Director of UHB as well as Deputy CEO and Executive Medical Director at HEFT, but a review (that we have not been party to and that was undertaken prior to DR's GMC hearing) concluded that he was able to continue in a senior leadership role.

29. We have received a written update from the Trust relating to this GMC referral stating that a Fit & Proper Persons investigation was undertaken prior to the GMC hearing at the behest of the CQC. This review addressed the issue of the misleading statement made to the GMC made as part of the referral. We have been told that "The FPP investigator could not find any evidence that would suggest the then CMO had deliberately misled the GMC. It would appear a genuine oversight as the disclosure letter had played no part in the disciplinary hearing." From the GMC's point of view, DR was told that the regulator proposed to issue him with a formal warning after an investigation. He refused to accept it, exercising his right to a hearing before the investigation committee. At the hearing which took place on 22nd July 2021, the GMC investigation committee accepted that the inaccurate statement regarding DRs statement about whistleblowing was unintentional, however the GMC considered that DR had been "reckless" in failing to check that his statement was true. A warning was placed on his record on the medical register for two years, stating that his conduct "*risks bringing the profession into disrepute and must not be repeated*". Further statements in the GMC summary included "***You failed to take reasonable steps to ensure your above declaration to the GMC was correct. Had you done so, you would have been reminded that you had very recently become aware that Dr A and a colleague had made a public interest disclosure in a letter to their Divisional Director, dated 9 January 2017. Their letter had been written, in their words, to highlight a problem they had previously highlighted to middle managers and had now occurred on too many occasions***". This whistleblowing event would separately be consistent with reports of others who also perceived that concerns of clinical safety were not taken seriously within the organisation. In a further written response from DR made after sight of the initial draft of this report, he stated that: *"He was willing to accept a warning in principle but had concerns about the wording of the warning, so exercised his right to a hearing before the GMC investigation Committee. At the hearing the GMC's opening position was clear that they were not alleging that the misleading statement was made deliberately."*

30. Whilst we have not seen or requested a copy of the internal UHB FPP review (and this was beyond the original scope of our work), we understand that this predated the GMC hearing result

and we believe that this should have led to a decision by the Trust to review in detail all the issues leading to the TR dismissal once the Trust's CEO and former CMO had received a GMC warning for bringing the profession into disrepute. There were wider concerns described in the GMC documentation of this case review:

"The date of your referral was important, occurring shortly after the disciplinary hearing, of which you were the chair. You did not correct this until the employment tribunal was progressing over a year later. Your assertion that the letter had no immediate material affect to the proceedings shows a lack of insight on your part. The Committee determined you have developing insight, but that this appears to be limited by the qualified apologies in your solicitor's letters in 2020 and 2021. It also had regard of the positive testimonials, however the Committee noted that there had been no material remediation other than the apology given and testimonials provided. "

31. In our opinion, statements made by the GMC and the Employment Tribunal were extremely serious and brought into question DR's suitability for senior leadership roles. The Tribunal Judge commented *"Dr Rosser made the referral (of TR) to the GMC Fitness to Practice Team later on 5 June 2017. That referral contained a number of material inaccuracies that suggest that either Dr Rosser was deliberately misleading the GMC, or at best, that he had failed to give the matter anything like the level of care and attention required."*[Tribunal Judgement Case Number 1303554/2017 dated 8 October 2018 paragraph 11.121] The GMC response might reasonably have been expected to trigger an effort to seek wider assurance about the overall management of the case and whether there had been any apparent learning from the GMC's assessment of DR's professional behaviour. Particularly in his role as Medical Director and responsible officer DR had a primary responsibility to monitor conduct and performance and to evaluate fitness to practise. DR, we noted, subsequently relinquished his name from the medical register.

32. Seeing how the internal review was conducted will be important. We have been told that the specific assessment of the GMC was later considered by the NEDs, who concluded that the issue had already been adequately investigated and no further action was required. We want to explore this further, and to understand how and why the Trust, and in particular the Board, judged that DR's continuation in post was suitable or desirable.

33. The Newsnight programme also reported that it requested and received a Freedom of Information (FoI) request on GMC referrals. The correspondence stated that of 26 referrals over a 10-year period, none resulted in GMC action. The accuracy of these numbers is currently being confirmed with the GMC. Our investigation has seen reports of 17 cases which refute this claim. For example, 2 resulted in a criminal conviction and removal from the Medical Register, one was struck-off for unprofessional behaviour, and some were the inevitable consequence of a lack of engagement with the revalidation process. Others resulted in internal disciplinary actions or limitations to the doctor's clinical scope of practice. In our view, there was nothing exceptional about the numbers or types of referrals or their eventual outcomes in these 17 cases. It should be noted that there is no accurate benchmark for GMC referrals, but medical staff who spoke to the review team clearly expressed a perception that there was a rather rapid process to escalate to a GMC referral and other possible routes for resolution were not always explored fully.

34. Also of concern was the view expressed to us by some senior doctors that the decision-making process as to when and if a doctor should be reviewed under the higher professional standards procedures seemed erratic and unpredictable. Other clinicians stated that this process was used as a coercive tactic to silence dissent. Those who gave feedback to the review were concerned that individuals 'who were favoured' would not be held to account. This perception of the

environment that they worked in filled many with the fear of speaking up. This was reflected in the concerns Health Watch raised in response to the Trust's Quality report in 2020/21. Our impression is that there is supportive soft intelligence and a current belief that higher professional standards enforcement processes have been misused, and that this should now be formally addressed and actively managed. It is one of a number of cultural aspects of UHB that seems to provoke a response amongst some staff – at least those who have been prepared to speak up – and this should now be fully examined. A theme of an inequitable and inconsistent approach to both disciplinary processes and reward systems undermines legitimate attempts to both actively manage underperformance and reward excellence and merits an active review of the transparency and equity of both processes.

35. iQ4u recognises and agrees that reaching an appropriate middle ground between simultaneously addressing poor performance (notoriously poorly undertaken in the NHS) and drifting to overzealous disciplinary measures is difficult – but the key issue that staff were concerned about was inconsistencies in both disciplinary responses and rewards systems- cronyism for both positive and negative HR interventions. At a most basic level the TR case exemplifies this - the employment tribunal finding: "This……..suggested a level of **bias and collusion** at a senior management level against the Claimant". The current concerns of staff relate to inequity and lack of transparency in the Trust's approach to be reward and sanctions that seem to be based on individual personnel factors rather than critical and transparent decision-making process. Offering assurance in this regard should enhance the processes and improve effectiveness of managing aspects of management of staff at both ends of the performance spectrum.

Dr Vaishnavi Kumar's death

36. Dr Kumar was a respected senior doctor in training approximately one year from qualifying as a consultant diabetologist. She took her life on 22 June 2022. It is not appropriate to comment on the causation of her death as there has already been a Coroner's inquest, but some of the comments made during the coroner's hearing support others' statements about the working environment at QEH. In a newspaper reporting the coroner's inquest, the following were stated:

"Much-loved and talented doctor took own life after feeling 'belittled' at work

Dr Vaishnavi Kumar 'cried most nights' after returning home from working in a 'hypercritical' environment

Dr Vaishnavi Kumar, who worked at Birmingham Queen Elizabeth Hospital, had felt 'belittled' at work and regularly returned home in tears, an inquest was told. Still conscious when the ambulance arrived, the doctor told the crew "under no circumstances" to take her to the QE Hospital. She was taken to City Hospital where she was already critically ill by the time she arrived. Her Father, Ravi Kumar, who is also a doctor, told Birmingham Coroner's Court that his daughter felt the QE was a "hypercritical environment to work in." Giving evidence, he said: "She used to say it was a very hypercritical place. They used to pick up small little things, belittle and be a bit condescending in the way they used to behave there….Most of the time she used to come back home and cry a little bit…..He told the hearing his daughter had said she did not make any complaints about any colleague's behaviour and 'got on with her job'….."

37. We were told of considerable unrest and indeed anger at the Trust's response to this tragic event, from both Dr Kumar's family (who we have not met) and from staff who worked with her and

the wider junior Doctor community. This was not the first death by suicide of a doctor at UHB. There are established processes whereby staff can access help when they develop various degrees of mental health problems within the Trust. These were recirculated on 28 July 2022 and included accessing help via 2 tools:

- Time To Talk
- Mental Health Workshop

In the aftermath of Dr Kumar's death, and in light of the media attention following the inquest on 20 January 2023, the Trust (postgraduate team) wrote to all staff in light of the increased media attention following the inquest, on 20 January 2023. This communication pointed out the help available as well as providing a more general message on how to access confidential help from colleagues. A previous email on 13 January was directed at junior doctors but without any context. It was short and somewhat superficial given the recent tragedy. The Trust issued a communication release on 20 January, explaining the increased media attention and how the organisation would learn from the tragedy. The email also directed employees to the various agencies who would be able to help individuals affected by the news. Other documents were available to staff including a document 'looking after your mental health and well-being'. This document highlights several other points of access for help including a confidential counselling service, the chaplaincy team, occupational health, advisers on coercive control and domestic abuse and staff wellness clinic. It is reassuring to know that a senior medical colleague (the Divisional Medical Director) visited Dr Kumar's Mother very shortly after her death, but we understand that this was not a formal visit from senior leadership at the Trust. The Trust did formally write to the family 2months later. Our review also heard from several employees at the Trust who expressed their disappointment and anger at the lack of senior representation at Dr Kumar's funeral. While the Trust did agree to livestream the ceremony to staff on the day, other responses were seen as hard hearted, lacking empathy and representative of 'callous' senior leaders. Setting the tone at a senior level is vital, we believe that this opportunity was lost, and many felt that the Trust had kept itself at arm's length from the Kumar family.

38. The family's reflections are consistent with the statements we heard from staff and reflect poorly on the Trust and HEE. Comments included:

    a. No opportunity for a face-to-face meeting with the trust was offered
    b. Despite informing trainees that the trust had been in touch with the family, no-one from the senior management team had contacted Dr Kumar's family
    c. A senior member of staff within medical staffing was unaware of Dr Kumar's death – and indeed emailed her personally 26 days after her death, asking her why she was removed from her post by HEE and if she is still being paid.

    The family presumed a HEE investigation was underway but had heard nothing about this. They felt they had several unanswered questions and that they could meaningfully contribute to the review. They emphasised to the Trust that as her employing body they had a duty of care to Dr Kumar. If possible, we will reproduce the letter Dr Kumar's father sent to the Trust as her employer. His dignified complaint in the face of the loss of his daughter emphasises the gap between his perception of the Trust as his daughter's employer and their perception of their response and management of this tragedy.

39. We recognise that the current Interim Chair has made very considerable progress in reaching out and working with Dr Kumar's father to both make amends for the previous insensitive handling of this tragic event and also to engage with him in terms of developing constructive ways forward

in terms of learning. It is also important to understand that the response to an event like this can only partly be met by updated guidelines and policies -for example about managing death in service - but more significantly needs a fundamental shift in the way an organisation demonstrably cares about its staff as people. It does not need a policy to inform senior and experienced staff how to offer humane and personal responses to rare catastrophic event.

The Board's oversight of these issues

40. In 2020, KPMG undertook a review of governance at UHB. They commented on an unusual governance structure, especially concerning clinical governance, and referred to the relative few numbers of meetings of the Trust Board and its Committee for Clinical Quality. It was made more unusual still by the fact that this committee comprised nearly the full Board in terms of its membership; Non-Executive Directors (NEDs) were members but were not the only members (there were 6 NEDs and 5 Executives as members), unlike very many other board-level Clinical Quality Committees across the NHS. The more usual model is for a Board Committee to be chaired and populated by independent NEDs, with executives only attending as non-members to brief the NEDs and respond to their scrutiny. Studying the Committee's terms of reference in force at the time, this committee was quorate with "a minimum of three members" present. In other words, there was no stipulation that any NEDs had to be present for the meeting to be properly constituted (although we have been told by the previous UHB Chair that this never happened in practice). This is important because these clinical quality committees should be fora where NEDs, as committee members, can scrutinise attending executives and develop their own independent views on quality and patient safety without being "led" by management. It is also unusual that the Chair of the Trust was also the Chair of this Committee.

41. KPMG also made a statement: ***"The Trust places heavy reliance on its operational groups, led by Executive Directors, to identify and escalate issues appropriately."*** This is an important observation; in conventional governance models, the NEDs would expect to scrutinise the appropriateness of escalation of incidents from the lower-level management groups at the Board Quality Committee. In our opinion, because the Quality Committee at UHB was much larger and included Executives as equal members, we believe this ran the risk of the NEDs being overly influenced by these other voices in a committee that should be theirs to run. This area should be examined further to form a more detailed view of what picture was being presented to the NEDs and ultimately the Board on clinical governance.

42. KPMG then returned in January 2022 to review Incident Reporting processes. They rated the Trust as providing "*Significant assurance with minor improvement opportunities*". All in all, a very positive outcome, and yet there was almost no reference to the earlier concerns about Board oversight and the Committee structures responsible for Quality. Whilst it seems not to have been included in scope, this seems to have been a missed opportunity for the Trust to demonstrate and externally validate effective clinical reporting all the way up to the Board. We should state here that the CQC in their June 2021 inspection, stated that "Trust leaders operated effective governance processes", although there was no specific reference to the construct of the Board's Quality Committee. The composition and purpose of this Committee has since been changed by the Trust.

43. In terms of FTSU, the report to the Board on 27 October 2022 stated that 34.7% of all allegations raised related to harassment and bullying. Another striking statistic from this report was that only 53.8% of staff respondents had stated that they felt safe in raising concerns at UHB – a number that was declining. One comparator here is that the National Guardian's Office most recent statistic, published in March last year, is that 62.8% of respondents felt that their organisation

had a positive culture of speaking up. It is to the Trust's credit that this has been one of their areas for improvement in the most recent 2 years, but it is important to reflect on these statistics and how staff came to feel like this – we would wish to see more evidence of improving performance in this area.

44. We have not interviewed any NEDs as part of this review. In interviews with the interim Chair and interim CEO we were told that the Trust has now revised its committee structures in the light of earlier criticism, and this will no doubt be examined as part of a future Well-Led Review. Nevertheless, we would like to understand in more detail how NED oversight worked then (and does now in the light of the changes quoted to us) in terms of their assessment of how executive management was going about its work. At the risk of making a petty point, we noted that the current UHB website (in its "About Us" pages in early February at the time of this review), only references board sub-committees covering Audit and Executive Appointment/Remuneration. There was no reference to any Board Committee covering Patient Safety or Quality.

45. Before the commencement of this Review, a new interim Chair and interim Chief Executive were appointed at UHB. We have been told by the ICB that these appointments had been made with the support of the ICB and NHS England.

Never Events

46. Data was provided on 26 Never Event (NE) reports submitted between 8th January 2020 and 5th November 2022. Reviews of the most recent 5 cases, reported since 13th May 2022 have not yet been concluded or signed off so detailed information. is not yet available on those cases. There are some differences in the total numbers finally reported by the trust and other data sources (i.e. Newsnight) possibly due to differing reporting periods (calendar rather than financial year) and the fact that some apparent NEs are downgraded to SIs after investigation. The Trust has reported the following numbers of Never Events (information from the NHSE website: https://www.england.nhs.uk/patient-safety/never-events-data/):

- 2020: 12 cases
- 2021: 6 cases
- 2022: 8 cases (5 of these NEs not yet fully assessed so very limited information)

47. These cases are summarised below (please note: the Trust supplied a report using NRLS codes rather than the NE categories used by NHSE in their National reporting system. To allow the data provided to be benchmarked to the National NE data we have amended the classification to fit with NHSE classifications of NE from the description of the primary event. This does not materially change the assessment)

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Never event classification	Description
Surgical	
Wrong site surgery	2 (Wrong site anaesthetic and Botox)
Wrong implant/prosthesis	2 (lens in ophthalmology, IUD)
Retained foreign object post procedure	8 (4 guidewire, 2 swab, 1 NOS, 1 part of a drain)
Incorrect operation or procedure	7
Medication	
Mis-selection of a strong potassium solution	0
Administration of medication by the wrong route	0
Overdose of insulin due to abbreviations or incorrect device	0
Overdose of methotrexate for non-cancer treatment	0
Mis-selection of high strength midazolam during conscious sedation	0
General	
Falls from poorly restricted windows	0
Chest or neck entrapment in bed rails	0
Transfusion / transplantation of ABO-incompatible blood components or organs	5+1 (1= incorrect plasma, further detail re: transfusion errors included below)
Misplaced naso- or oro-gastric tubes	0
Scalding of patients	0
Unintentional connection of a patient requiring oxygen to an air flowmeter	0
Undetected oesophageal intubation	0
Other	
Local classification of wrong method of preparation	1 – Not otherwise specified/ investigation not complete, details not known

48. There was no evidence of clustering by department or division other than the concerns identified within transfusion practise (see below). There is inconsistency in the Trust's current classification system – for example, there were 2 retained swabs, one was classified as a "retained object", the other as "swab count incorrect". Similarly, a patient who was wrongly administered group O plasma (instead of group A) was recorded as a serious adverse reaction rather than as transfusion of ABO incompatible blood.

49. Assessment of the findings demonstrate a clear and structured approach, with evidence of good quality root cause analysis in each of the cases. There were no obvious omissions or concerns about the detail of the overall findings in each case.

50. In several cases the recommendations were devolved to the appropriate division to develop in response to the findings of the Never Event RCA. This seems appropriate, but the tone of some of the recommendations tended to focus on individual staff responsibilities rather than considering systems based or human factors contributory factors. Comments included:

    - "That the findings of this investigation as regards to the actions and omissions of the staff be reviewed by the Divisional Management Team."
    - "This is bad surgical practise by the surgeon"
    - "Team communication fell below the expected standard"
    - "Human error as arose in this case"
    - "The guidewire was retained as a result of human error by the radiology registrar"

51. Similarly in a paper submitted to the ICB to discuss UHB Never Events in February 2021, the ICB sought further assurance about how the Trust was "building and accessing expertise in Human factors" and the Trust responded that it utilises "a systems approach and ergonomics consideration in response to *human error*". Recommendations included escalation to relevant external agencies (e.g., MHRA devices) as well as recommendations for relevant local educational programmes and audit.

52. In general, the recommended actions seemed appropriate and involved dissemination of learning by a range of measures - email to relevant individuals and departments, inclusion in departmental teaching programmes, and alterations in guidelines / Standard Operating Procedures (SOPs). There was a relative paucity of systems-based interventions - but the nature of Never Events is that one would expect existing standard practise to be sufficient to prevent occurrence. Therefore, many of the actions might reasonably be expected to be enhancing awareness of and adherence to current best practise.

    Patient notification was mentioned in 7/19 of the completed action plans but it is not clear that full duty of candour was completed - the action was described as "An offer of feedback letter will be sent to the patient and a copy of the investigation report will be provided following this if desired" in 3 cases. Examples of Duty of Candour (DoC) letters were not seen as part of this review, but one would hope that "an offer of feedback" in fact extended to a full explanation of events and an apology in line with DoC requirements rather than just a letter offering to provide further information. We have been informed that a full DoC process has been completed in all relevant NEs

Benchmarking reporting and Blood Transfusion Never Events

53. As stated earlier, several areas of concern were outlined in a series of Newsnight broadcasts about the safety culture at UHB, but with regard to Never Events there was a specific allegation of 20 never events occurring in the year from April 2020 and that the Trust was responsible for half of the total number of transfusion- related errors in England during that year. A provisional report from NHSE for the year April 2020 to March 2021 (note: slightly different time period) details the following results:

	Administration of medication by the wrong route	Chest or neck entrapment in bedrails	Failure to install functional collapsible shower or curtain rails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during conscious sedation	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	Retained foreign object post procedure	Scalding of patients	Transfusion or transplantation of ABO incompatible blood components or organs	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
University Hospitals Birmingham NHS Foundation Trust								3		4		2	3	**12**

In this time period, the number of National NHSE Never Events reported was 364, of which 8 were transfusion of ABO incompatible blood products.

54. These data suggest that there were 12 never events reported to NHSE - the highest number for a single organisation included in the NHSE report of that year and 3.5% of all Never events reported that year. 4 of these related to transfusion of incompatible blood products or organs, and this is 50% of the NHSE total for the year. The gap between 20 reported cases on Newsnight and the 12 cases reported via NHSE may reflect the fact that several cases initial reported as potential Never Events could (after investigation) be downgraded to SIs.

55. The number of reported NEs relating to Transfusion of ABO incompatible blood components has clearly been of concern internally as well as being publicised by Newsnight and the Trust has recently completed a review of 7 Never Events re ABO incompatible transfusion. Summary data provided from each of those cases reveals the following:

    In 2 of 7 cases the incompatible blood was administered because of bedside errors (patient details not checked against the blood bag) - i.e., ward-based errors. In 5 of 7 the wrong blood was issued by the transfusion laboratory - in 2 cases the Laboratory Information Management system (LIMS) had not been updated after patients had undergone 'blood group incompatible haematopoietic stem cell transplantation (which alters the transfusion requirements, with different blood groups required for different transfusion products post HSCT). In 3 cases involving 'blood group incompatible haematopoietic stem cell transplant' recipients, the LIMS was correct but the wrong blood was issued from the transfusion laboratory. Transfusion errors seem to be a particular issue in patients who have undergone haematopoietic stem cell transplantation, where both the patients original blood group and the transplanted blood group needs to be considered and where differing blood group products are most suitable depending on the blood product being transfused.

56. The Trust's review of this issue refers to a national database of transfusion reactions (the Serious Hazards of Transfusion [SHOT] report) and reports that here are between 17 and 19 transfusion errors in blood group incompatible HSCT recipients reported each year between 2018 and 2021. UHB undertakes approximately 11% of allogeneic transplants in the BSBMT annual reports. It is suggested that UHB's apparent high rates of transfusion errors might reflect a different approach to reporting from other organisations. This does not offer full assurance - the data still shows a high number of transfusion errors, and in 5 of the 7 cases the root cause seems to be unrelated to the HSCT status of the patient (wrong blood issued by the lab or bedside error). Whether other trusts have low reporting rates or not is a separate issue that should not be used to offset a signal that suggests concerns with regard to transfusion practise within the Trust. The internal review noted a cluster of 3 cases in late 2020 coincided with a rapid move of the in-patient haematology service from Heartlands Hospital to QEH and this possible confounding factor looks to be consistent with the data available from NHSE which offers a reassuring picture:

Time period	Organisation	Transfusion related NEs: number (%of total)	Total NEs: Number (% of total)
Apr 18-Mar '19	UHB England total	0 (0%) 4	9 (2%) 496
Apr 19 -Mar '20	UHB England total	1 (20%) 5	8 (2%) 472
Apr 20- Mar '21	UHB England total	4 (50%) 8	12 (3%) 364
Apr 21-Mar '22	UHB England total	1 (14%) 7	4 (1%) 407

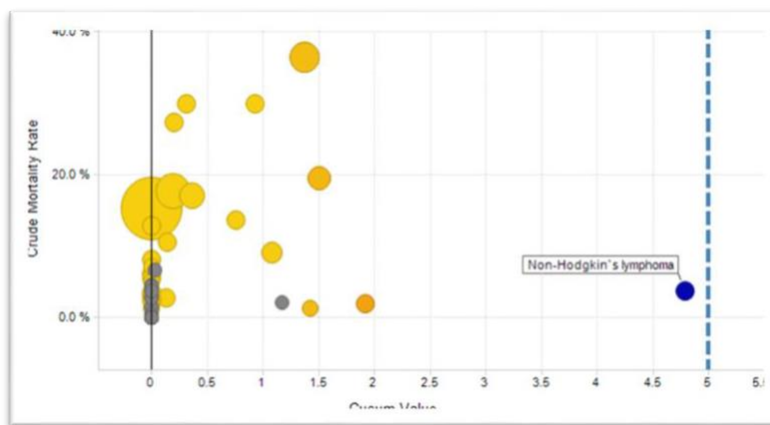
It will be important to ensure that UHB has not adjusted its reporting advice or thresholds for blood group incompatible HSCT patients who get issued with the wrong blood products and that the recent apparent reduction in reported NEs is as a result of genuine improvements in transfusion safety within the Trust.

Although it was factually correct to state that the number of never events is the highest reported by a single organisation, the numbers are too low on an annual basis to draw any meaningful conclusion. It seems that other than the outlying year of April 20 to March 2021, the UHB NE data fits within the range that one might expect to see offering a complex regional and supra regional service in some fields.

57. In summary, the language used in the NE assessments seemed to suggest that there was a focus on "human error" rather than human factors or systems-based interventions. There is an obvious concern around blood transfusion NEs and this merits further review. Whilst individual action plans seemed appropriate it has not been possible to ascertain whether these have been fully implemented. There is a specific outstanding query around a proposal that the Trust might alter the reporting of Never events relating to transfusion errors in HSCT patients and this does need clarification as a matter of urgency.

Haematology

58. An incident at QE on 3 March 2017, resulted in an SI investigation (W118127) which was supported by Dr Brian Pouchet. The report related to a patient who had undergone haematopoietic stem cell transplant (HSCT) and was finalised on 17 August 2017 with an agreed action plan. At the same time DR (as CMO) asked through one of his colleagues Dr Ryder, that MN review a case series of 10 Haematology patients who had died as in-patients. MN was the clinical Director for clinical Haematology and oncology at HEFT. The index case involved a patient who was a HSCT recipient with lymphoma. The initial departmental response was to undertake a review of the 10 most recent deaths in haemato-oncology, this was later adapted to focus on lymphoma patients. It is thought that the later focus on patients with lymphoma arose partly because the index case suffered with lymphoma, and then at a CQMG meeting soon after it was noted that the mortality for non-Hodgkin's lymphoma was approaching the CUSUM trigger (see Table below), but the precise rationale behind the initial 10 case selection and then the move to lymphoma patients are not clearly documented.



MN's reports were submitted to the Trust in July 2017. There is a lack of clarity about actions that arose from MN's initial reports, but it seems that it was decided that no further actions were required. We learned that, in December 2022 (following disclosure by Newsnight) the current CMO and Haematology clinical service lead became aware of MN's report. This was reviewed and responded to on a case by case basis by the current Clinical Service lead (CSL), who provided an opinion on the quality of MN's reports as well as an assessment of the level of concern for each individual case. It therefore seems that MN was initially invited to provide an external (and therefore independent) review of Haematology cases and his review, although critical of care in a number of cases, resulted in no formal response or action plan.

MN undertook his review in 2 phases:

- 12 patient deaths within Haematology between October 2016 to January 2017
- 7 patient deaths with lymphoma diagnosis Between September 2016 to January 2017

59. In December 2022 the reports returned by MN were reviewed in detail by the Clinical Service Lead. He provided his expert opinion on both the content and the quality of the reports. He considered that "there are no cases in which any of the possible concerns identified by MN relate to patient harm".
60. We have summarised the differences in the comments by MN and PF in two tables below. The first shows findings relating to 12 patient deaths within haematology between October 2016 to January 2017. This report outlined major concerns in the care of three patients, moderate in three cases and low-level concerns in one. No commentary was provided about the cases where no concerns were identified.

Case number	Dr Nikoulosis' comments	Current CSL's counter comments
Major concerns		
1	Not clerked for nearly 48hrs No clear ownership of patient No GCSF prophylaxis	Patient stable throughout Confusion over this lasted 5 minutes GCSF prophylaxis not routine
2	Commenced on VTD, usually for autologous BMT pts DNAR not done Patient low resp rate, delayed review Antibiotics started late Never assessed by ITU	VTD entirely appropriate DNAR completely inappropriate This is incorrect Disagree Ward based care appropriate
3	Insufficient obs overnight Delayed stem cell infusion, no incident form Given vanc when stated to be allergic Inadequate frequency of obs despite elevated SEWS ITU not involved early enough	Pt stable so no issue Problem investigated at the time Action taken incl DoC Patient stable ITU and outreach appropriate "very complex, received excellent care"
Moderate concerns		
4	Not reviewed by consultant for 1w Hb 60g/L, blood prescribed but not given	Reviewed daily by Spr and D/W Consultant Not commented on
5	Delay in ED/ haematology handover (8h) Delay in antibiotics	No comments made
6	Intensive chemo regime? appropriate for this patient Wrong choice of initial antibiotic	MDT decision, seems entirely appropriate Changed after 1 dose, pt not harmed
Mild concerns		
7	Changing diagnosis, ALL ->AML, concerns re: accuracy	Rare event but recognised

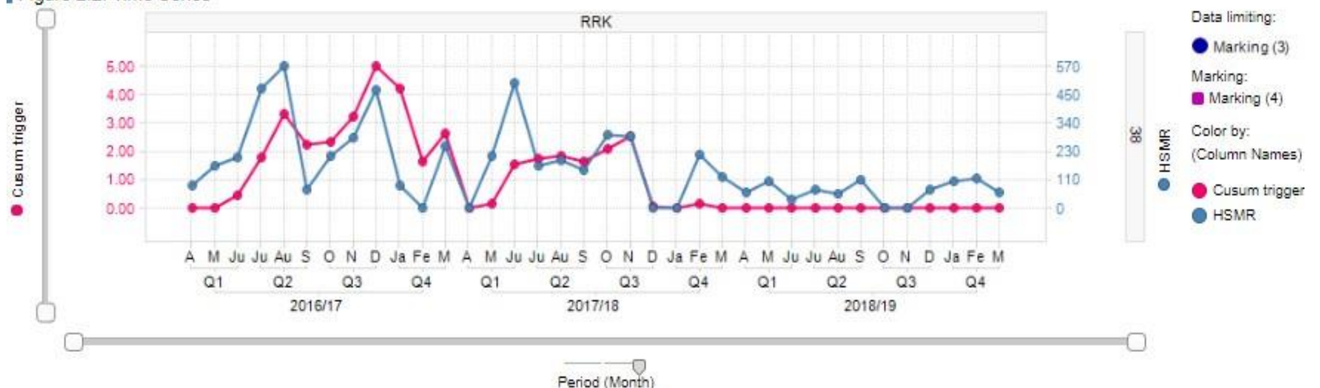
The second table shows findings relating to 7 patient deaths with lymphoma diagnosis between September 2016 to January 2017 (report 22/6/2017):

Case number	Dr Nikoulosis' comment	Current Clinical service lead's (CSL's) comments
Major concerns		
1	Brain lesion? malignancy from RHH	This wasn't the case. Clearly referred by GP
	5-day delay in MRI	
	No medical input for 4 days	That's because it was the weekend
	Lack of senior haem input	Looks like case was discussed
	12 days prior to death no Rx other than steroids	Agree no senior input, died of pneumonia, no treatment as was awaiting transfer
2	2-week delay until haem SpR review	6-day delay
	First seen by Cons haem 32d post admission	Seen after 25days
	Delay in antibiotics	Agreed
	Couldn't find ECHO	Patient had ECHO
	PCP Rx should have been started earlier	I do not see how the patient's treatment could have been any better
3	Limited haem Cons input	Outlines input from haematology Cons
	Passed away after 26days without Rx	Patient not fit enough for biopsy, so no Dx made so no appropriate treatment
4	Concerned that biopsy needed	This is not the case - only a possible dx of Tcell lymphoma
	No senior haem input	No need for senior haem input
	Pt died 30 days after admission, no Rx	Could not be treated as unwell with sepsis
	Concerns re: delay CT reporting	Need to check whether dating error
Moderate concerns		
5	SEWS score 7, obs not repeated for 5h	Obs stable albeit on oxygen, medical entries in notes throughout the afternoon
6	SEWS of 4, no obs for 4hrs	No comment made
	Patient hypothermic and no notes entry	Patient was reviewed on day in question
7	Changing diagnosis, ALL ->AML, concerns re: accuracy	Rare event but recognised

61. Although we have not referenced source materials, it seems the report contained several factual errors. It seems that that after receipt in July 2017 the Dr MN's reports sat with the Divisional management team who felt that there were no further actions required. For his part, MN's perception is likely to have been that his report was "shelved" – as indeed it was - but it is not possible to understand why he did not take forward the governance concerns he had identified during his time in management in the newly merged Trust. Having completed his report and referred it to the divisional team it was not his primary responsibility to take it forward again.

62. At a later stage the ICB completed a Summary of events leading to the two reports made by MN as part of an ICB report/ rapid review of patient safety (undated) and this report states that there seems to have been a failure of feedback to MN and of clear documentation of completion of the evaluation of those reports. It seems that the review sat out with the Trust's own defined standard reporting procedures and no clear plan for management of the reports was identified when it was first commissioned. Certainly the response to the report was inadequate given the nature of the concerns raised and the lack of any apparent formal response or documented action arising from the findings. There was no evidence of escalation within Trust governance reporting procedures. Both the quality of the report and the clinical opinions contained within it were criticised by the QE clinical lead and combined with a return to baseline CUSUM, the divisional team felt that no further action was required. It seems that the review process was not well enough thought through at its inception, and that it was poorly executed. Importantly, it seems that as no definitive assessment or conclusion with regard to MN's concerns at the time of the report, that the potential need for DoC for patients' relatives was never considered either. This statutory DoC was brought into law in 2014 for NHS Trusts and is now seen as a crucial, underpinning aspect of a safe, open and transparent culture. It is not clear that relatives were informed about the review or its (negative) findings. Once MNs initial critical report was received an immediate response should have been to seek a definitive opinion on each patient's care as part of the legal responsibility to ensure that DoC was completed. It is not at all clear that this duty was considered as part of the initial divisional response to the report. It is not clear that the December 2022 was sufficiently robust to fully lay to rest all clinical concerns about this important patient cohort. It is not clear that DoC has been fulfilled for the cohort of patients reviewed by MN.

63. The CUSUM of 4.86 in Dec 2016 is followed by a gradual reduction over time:



64. Whilst CUSUM returned to expected / below expected by 2019, it would be worth ensuring this improvement in mortality has been sustained. Despite concerns about the accuracy of some of the factual content of MN's reports, to the non- haematological eye some themes emerged that may be worthy of further consideration- specifically the frequency of input from consultant haematologists, and possibly whether there were delays in initiating treatment in some cases.

65. One final comment from the previous CSL for Haematology, who was in post during the pandemic, was that the first knowledge she had of the reviews by MN, was when she watched the Newsnight programmes in December 2022. The reviews identified significant areas of concern, which should have been considered much more closely by the Haematology team. We are interested to know why the reviews were not shown to the team?

66. We believe that the Trust still needs to consider whether they are now in the position of having two opposing assessments from 2 individual Consultants, with no definitive opinion about quality of care within haematology. Furthermore, now this issue has assumed such a high public profile, it may add impetus to the need to consider a single, well designed, externally undertaken review of quality haematology services within UHB.

UHB performance indicators (clinical including staffing)

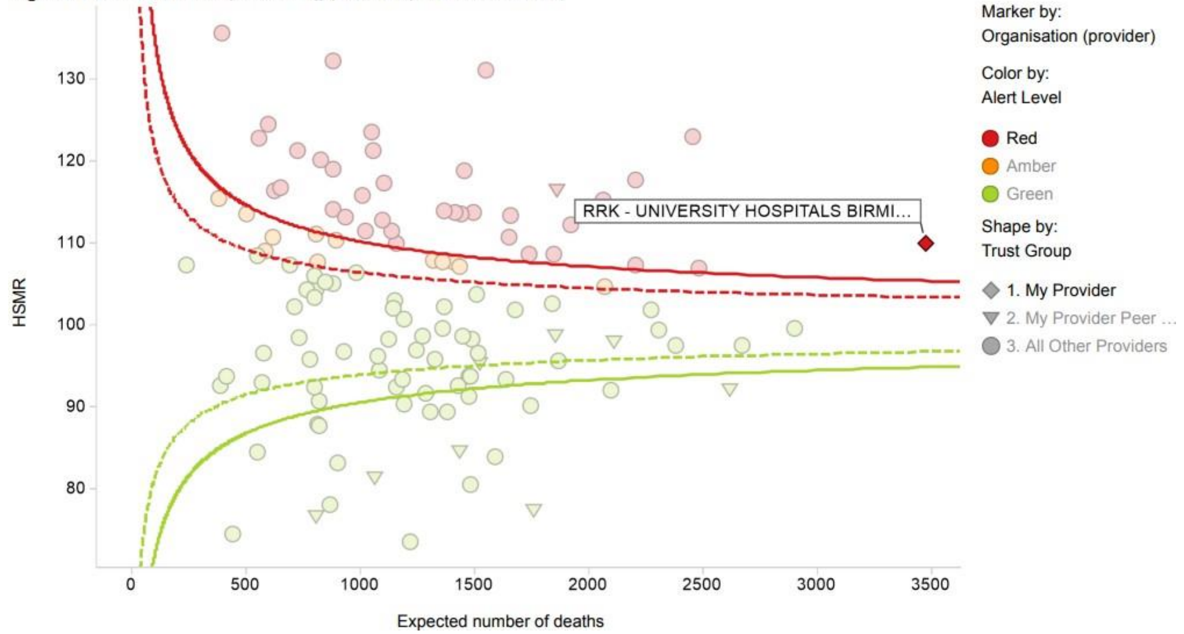
67. Our review has looked extensively at the various internal documents and specifically the Trust's Integrated Quality Reports (IQR) and minutes of the Clinical and Professional Review of Incidents Group (CaPRI), held regularly at the Trust. We have also viewed evidence of staffing levels Trust wide and at a site level.

Mortality at the Trust

68. The most recent hospital standardised mortality ratio (HSMR) at 110 is statistically significantly higher compared to other organisations (in statistical terms it sits above the two standard deviation variation). HSMR is an indicator of healthcare quality that measures whether the number of deaths is higher or lower than expected. It is a nationally benchmarked indicator, released on a monthly basis. Like all statistical indicators it is not perfect, but can be both a measure of safe, high-quality care, and a warning sign that things are going wrong. We acknowledge that there are a wide variety of professional opinions about the relatively strengths of HSMR reporting. Nevertheless, it remains an NHS-wide benchmark that is used in every Trust. The other widely used metric is the Summary Hospital-level Mortality Indicator (SHMI, which for UHB is within the accepted range at just over 100. (SHMI is an NHS-produced metric designed after a review of HSMR which was felt by many to be inconsistent and a poor indicator of performance. The principal differences are that SHMI takes into account more variables particularly co-morbidities and the emergency/elective split of admissions) and measures deaths including those in-patients who die within 30 days of discharge. The 'funnel plots' below illustrate this, extracted from the January 2023 IQR.

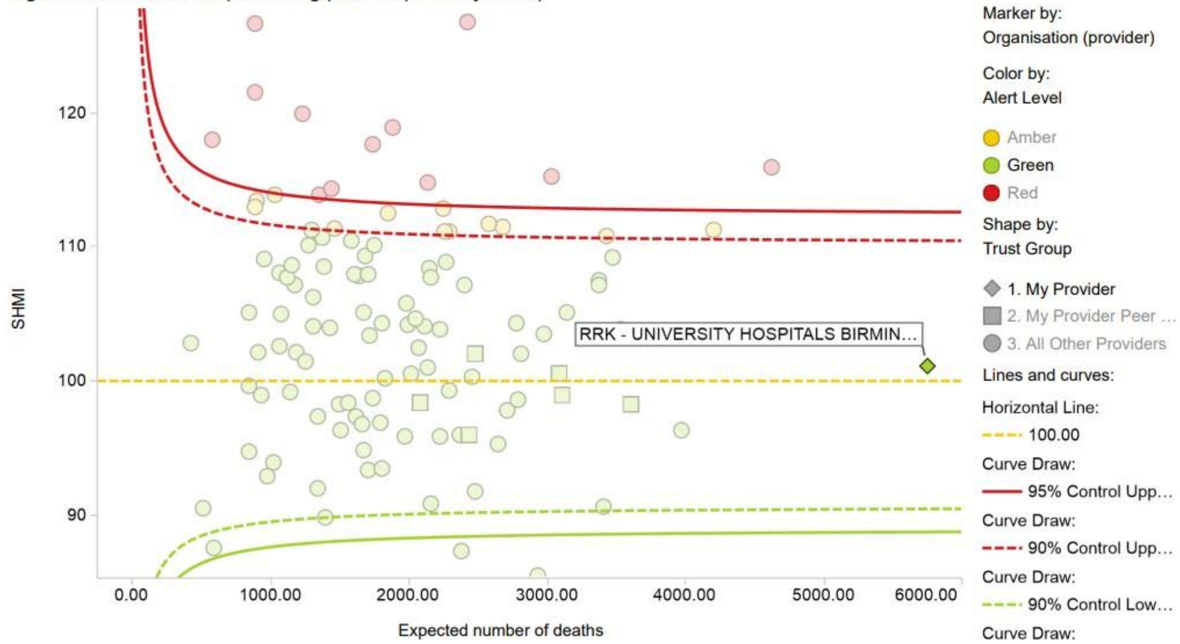
1 | Activity Overview (HSMR)

Figure 1b: Funnel Plot (Rebasing period up to October-22)



1 | Activity Overview (SHMI)

Figure 1b: Funnel Plot (Rebasing period up to July 2022)



69. The scope of this review does not extend to a detailed analysis of why the Trust remains an outlier for the HSMR measure of mortality. Data has been made available to us by the current CMO, that indicates a disparity in how data from patients in a palliative care phase of their care may be distorting the figures. In the post-Francis era, following the failures in care at the Mid Staffordshire Hospitals, UHB, like all hospitals is keen to understand and act on the factors which impact on mortality. The Trust has a very active process in responding to alerts, especially when rates of death are raised in specific clinical areas, such as fractured neck of femur. The IQR reports indicate the level of inquiry required to address these issues, and the review process of such data through the CMO's leadership is clear and thorough. How this is reported and acted on by the Board is less well defined.

70. A raised HSMR could be explained, as the Trust suggests, by coding issues. But, when the issue in hand relates to a mortality rate which is – on the face of it - 10% higher than other providers it is vital that the organisations response is robust and self-critical and includes definitive assessment of confounding factors rather than assumptions based around differences in coding. What is known about the interrelationship between the working environment and staffing and mortality additionally suggests that if the cultural environment at UHB has not already affected mortality it is likely to be affecting the patient experience and morbidity. Effective team working leads to higher levels of innovation and a culture of openness has been shown to reduce mortality. Lower recruitment levels (both medical and nursing) are associated with increased mortality and worse patient outcome, and if the staffs' current concerns about the working environment have not already translated to less good treatment and outcome every shred of evidence suggests that they will do in time. The single biggest long-term crisis facing the health care sector in the UK at the moment is staff recruitment and retention, and UHB needs to ensure that the current experience of working within the Trust does not in any way compromise a long-term staffing strategy in an increasingly competitive market. If that is the only reason to more actively engage in a programme of improving the working culture and environment in the trust, then it remains a powerful driver.

71. The IQR reflects an effective active reporting process covering all areas where clinical harm may arise. We report elsewhere on Never Events, and the IQR reports on these extensively. The latest report from January 2023 is a representative example of such a report.

Workforce

72. The NHS is currently subject to a significant shortfall in its workforce. This is multifactorial and beyond the scope of this review. UHB actively manages the shortfalls in key clinical areas and has a proactive recruitment policy within the UK and internationally.

Nursing

73. The most recent data on nurse vacancies shows a figure of 13.35% (England average of 10%), representing a shortfall against plan (financed) of 870 nurses in November 2022. Individual sites and wards are analysed in the CNO-led Care Quality Group meeting, held monthly. The situation is RAG rated and particular focus is kept on wards with vacancy rates of over 30%. This is managed daily, with staffing updates at ward level reported 3 times a day.

74. Although all sites have difficulties maintaining staffing levels currently, Good Hope Hospital is the only one with a CQC regulatory notice at present (section 29a for quality of healthcare requiring

significant improvement, issued in Dec 2022). To mitigate this and maintain safe staffing levels across the Trust, each ward has a budgetary allocation for additional staff to act as 'floats' who form a flexible workforce. This allows for an immediate response when staff report in sick, a common occurrence. In overall terms, recruitment is otherwise improving with an expected surge in January from the most recent cohort of qualified nurses and from international recruitment.

Medical staffing/ Senior Medical Staff Committee

75. An experienced medical director and surgeon leads on the Trust workforce plan for medical staff. Since the pandemic, illness and sickness absence and restrictions in workplace activity (through work with occupational health), have led to significant challenges with junior doctors' rotas. The current model builds-in excess capacity, using junior specialist doctors (JSD's) to reduce the impact of the gaps. With a sickness rate of 4.5 % (average for Doctors in England 1.8%) and restrictions on some doctors working at nights and on prolonged shifts (on the advice of occupational health), this is an essential supplementary workforce.
76. From our interviews with consultants at all 4 sites, there is a general confidence in the current recruitment of clinical staff to consultant posts. This was not reflected from their academic counterparts who contributed feedback, who reported genuine concern about an increasingly negative view of the Trust. This was also reflected in the GMC survey of doctors in training.

77. Very significant concerns have been raised by the most senior group of Doctors within the QE site - the Senior Medical Staff Committee (SMSC). As recently as January 2023, these Doctors raised concerns that were sent to us as part of this review. Some have been raised historically and all have been escalated to the current management team. Comments included:
    - The failure to support a high class integrated clinical academic campus
    - Lack of competency in running the organisation and the impact on basic clinical care
    - Cronyism at every level of medical management appointment up to executive level
    - A lack of confidence in the executive team compounded by:
        - Lack of Hospital based clinical leadership – multiple representations to senior level
        - Services compromised through reconfiguration and questionable leadership
        - Failure of the divisional model
        - Lack of professional structures in terms of planning
        - Dysfunctional processes for maintaining higher professional standards
    - Poor communication at both organisational and individual level
    - Bullying – multiple colleagues from multiple services have reporting overt bullying and micro-aggressions

    iQ4U are not able to independently corroborate the substance behind these comments within a project of this timescale, but these concerns cross reference / are entirely consistent with comments received from a number of other internal and external reference sources including the feedback given by individuals to the reviewing team. The fact that the SMSC have felt strongly enough to put these concerns in writing to the current executive team should be taken as a major "red flag" in managerial and governance terms. Taking many individual factors into account, the SMSC concerns hold a central and independent place in supporting the conclusions of this external review.

GMC Survey Feedback

78. GMC junior doctor surveys offer Doctors in training a chance to give anonymous feedback about their experience of working within a Trust across a range of fields, including (but not exclusively) overall satisfaction, workload, reporting systems, and teamwork. The value of the data is that

the survey has a high response rate, it is performed annually so can offer the opportunity to analyse changes in experience with time, and the results are benchmarked against all other NHS trusts. The data are expressed by training sub-specialty at trust but not individual hospital site level. So, the data summarised here have been analysed for all the trainees working in UHB across all four sites and show the following:

- Comparison of the results from 2018 to 2022 reveals a clear deterioration in the trainee assessment of working within UHB. During this period, the number of scores allocated in the bottom quartile compared to national comparators increased from 45 to 93. More concerningly, the number of posts ranked in the worst 5th centile nationally increased from 19 to 58.

- The data are benchmarked against all other training environments, so this deterioration represents a significant decline in the quality of the working environment for a key part of the UHB workforce over the last 4 years.

- It is likely to have significant long term adverse effects on recruitment to training rotations within the Deanery, as well as to long term medical staffing recruitment at consultant level. At a time when recruitment is probably the single largest issues facing the NHS, this is a position that the Trust cannot afford to be in and a serious focus on junior doctor working conditions and support is needed to reverse this trend.

Site Visits

79. MB visited all 4 sites at UHB. He was escorted between sites by a member of the CMO's office (who was not present for any of the meetings) and introduced to various personnel at each site. We mention this as it was of interest to visualise the geography of the various localities where the 4 hospitals are based and to gain some insight into the travel times between them. This was instructive as several rotas for staff are across these sites. An example being maternity cover by obstetricians for Good Hope and Heartlands. Visits to the QEH and Heartlands sites took place on 25 January, Good Hope and Solihull on 2 February.

The following personnel were interviewed:

- QEH
  - CSL for Neurology/Neurosurgery
  - CSL for Haematology
  - Deputy CMO for the QEH site
  - ST8 Trainee
  - ST4 trainee
- Heartlands
  - Deputy Medical Director (DMD) for the Heartlands site
  - ED consultant
- Good Hope
  - Deputy CMO for Quality improvement
  - CSL for older people
  - Consultant physician and SRO
- Solihull
  - Medical Director of operations and consultant surgeon
  - Critical Care consultant and DMD of Division 1.
  - CSL Anaesthetics
  - Chief Registrar.

80. The 4 sites all have their own character and distinct populations. Good Hope is a traditional DGH style hospital with most acute services on site. Rotas are generally internal to each site but some such as obstetrics are delivered across 2 sites. Solihull Hospital and Community services delivers predominantly outpatient and diagnostic services as well as a birthing unit. Clinical services delivered include cardiac catheterisation, haemato-oncology, dialysis, ophthalmology, rheumatology and dermatology services. From our limited visits all staff that we met were in general happy with their roles and working conditions. The QEH is very much seen as an 'ivory tower' and somewhat different to the other sites. It is a modern, well equipped and staffed hospital with regional specialist as well as acute hospital services. Heartlands is a large hospital within a very deprived area of the city. It is exceptionally busy and has a high demand population. Its buildings are old, and the site is cramped and in need of regeneration, with the notable exception of the Heartlands Treatment Centre, a significant capital development on that site, opened in Jan 2023. The comparison of the QEH and the other sites in terms of a working environment is stark. We found most staff we interviewed had come to terms with this when they applied for posts at any site within UHB - concerns were more about how the organisation is managed rather than the physical environment. UHB has an active upgrade of premises at the Heartlands site to redress the imbalance.
81. The concerns raised about UHB predominantly relate to the culture and environment for staff, with the unavoidable negative effects on patient experience and ultimately outcomes not yet apparent. But the silence of the patient voice - particularly for example from the Council of Governors – during this tumultuous time has been striking, and any future review must consider ways to ensure the Council of Governors develop a more active role in holding senior leaders to account. This has also been referenced by the CQC who recommended "The Trust should consider the way in which the council of governors are utilised to ensure the chair and non-executive team are held to account."

Areas of concern:

82. We will continue to hold an oversight role as part of the forthcoming Culture Review and Well-Led Reviews take place at UHB. We have agreed with the ICB that all the issues raised in this report will be looked at more thoroughly in the course of these two further pieces of work. At the end we will produce a covering report to summarise our views on all the external work that has been undertaken. We feel that it is important to achieve some form of closure by the end of this process, and we will propose an "Organisational Duty of Candour" response that could help to deliver effective reconciliation for staff.

83. As a result, we only wish to highlight three areas of concern specifically at this stage:

a. There are several areas where clinical safety concerns exist. We highlight the raised HSMR (which should not be assumed to be due to inaccurate coding) and some areas of concern in levels of staffing, particularly nursing at GHH. This said, our overall view is that the Trust is a safe place to receive care, but any continuance of a culture that is corrosively affecting morale and in particular threatens long term staff recruitment and retention will put at risk the care of patients across the organisation – particularly in the current nationwide NHS staffing crisis.
b. The views of the QE site SMSC are highly significant. They represent clear evidence that the cultural problems at the Trust most likely persist, apparently remain entrenched and require serious attention. Because these concerns cover such a wide range of issues, from management organization through to leadership and confidence, we believe there is much more work to be done in the next phases of review to assist the Trust on its journey to recovery.
c. During our short review we have received significant co-operation from the Trust in terms of

access to individuals and documentation. However, as our work has progressed, we have found that this goodwill has dissipated, and we have seen an organisation that is culturally very reluctant to accept criticism or to acknowledge the adverse views expressed by us and other significant external bodies. We do not direct this at the Trust's interim leadership team, but others seem to be, or have been, far less open to any suggestion that there are problems at UHB.

Recommendations

These recommendations can be made now with confidence, but as stated above we note that wider areas of concern will still need to be investigated in greater detail than has been possible to date and may yet generate further enquiry:

A. Clinical Safety

As a result of our initial review, we believe further assurance is required into several aspects of clinical care:

1. **Haemato-oncology:**
    - **A specific review of mortality should be conducted by an external specialist in this field with support from a governance lead. The terms of reference should include:**
        i. **An independent retrospective review of all the deaths first analysed by Dr Nikolousis to establish any lessons learned**
        ii. **Consideration as to whether there an outstanding DoC responsibility relating to this patient cohort**
        iii. **All deaths in the year 2021/22**
        iv. **An assessment of how integrated the department is following the merger in 2018 with a focus on how leadership and accountability of the service currently functions**

2. **Given the Never Events associated with transfusions, an external review into these, and laboratory protocols should be conducted and should include the views of an independent biomedical scientist**

3. **Neurosurgery: this review primarily focuses on the leadership and culture of the department this should include an assessment of the effectiveness and progress of the current neurosurgery development plan. To develop a fully effective recovery plan it seems likely to require significant ongoing external senior neurosurgical support.**

4. **We suggest the close monitoring of future mortality statistics and if these are persistently and significantly raised a further external review is commissioned.**

B. Governance and leadership

We understand that under the interim leadership of the Trust Board that the committee structure is being reviewed. To assist in this process and to support the next phases of review (a Phase 2 Cultural Review and a Phase 3 Well-Led review) we propose that the following areas are examined:

1. **For Board committee and accountability structures:**

    a. **How the board historically has evaluated risk and particularly clinical risk, and what has now been changed**

b. An appraisal of the current board leadership's perception of clinical risk, highlighting areas which require immediate action

c. Testing that the primacy of independent NEDs in Board committee roles (especially in Quality and Patient Safety), with appropriate scrutiny of executive performance, is now enshrined in the current governance arrangements. This should include that NED members of board committees must be present to make them quorate.

d. A refresh of the FTSU Guardian role and how the board interacts with this system

2. **That the escalation process for clinical incidents and other areas of clinical risk is fully analysed from specialty up to Board level**
3. **That prospective appointments of senior medical, nursing, and managerial leadership are reviewed with a focus on developing core skills, including those required for leadership, collaborative working methods, professional interaction, and disciplinary processes.**
4. **That UHB does have an objective approach to succession planning at senior level, including executive level key appointments in medical, nursing and managerial leadership and uses appropriate, transparent and robust selection processes for these appointments.**

C. Staff welfare

In light of the tragic death by suicide of Dr Kumar, and from all we have been made aware of through this review this is a significant area of concern which requires several priority recommendations for the board to enact:

a. **Together with HEE, a review of the processes to support doctors in training who are concerned about their mental health, ability to speak up freely about concerns with colleagues and a clear message that they will be listened to**
b. **The Director of Medical Education to consider actions to counter the growing dissatisfaction of junior doctors in training with their working environment with the Trust Board to monitor the effectiveness of outcomes**

D. Culture

The culture of UHB will be addressed more extensively in phase 2 of the review. In this phase 1 study it was impossible to ignore the consistency of feedback from almost everyone we spoke with or heard from, albeit with caveats about self-selection. We have listed some of these in our findings and this early intelligence, should help describe the remit and the terms of reference of phase 2. The review team felt strongly that some areas of concern required more urgent attention by the Trust prior to the completion of the next stages of the process. We recommend:

a. **That the concerns of senior clinicians, expressed to us in by the Medical Staff Committee in January 2023, are addressed specifically as part of the Phase 2 cultural review**
b. **That the Trust commissions a partner to deliver awareness training on how to identify issues of bullying, coercion, intimidation and misogyny.**
c. **That the Trust reviews the role of the FTSU Guardian and offers all staff confidential and secure environments to report any past or current issues from which they have felt reluctant to come forward about**
d. **Before publication of any report from the culture review, the Trust develops a reconciliation unit with the aim of improving relationships within the organisation and preparing for the recovery phase which is necessary to allow staff and patients to feel secure.**
e. **That a 'no blame' culture is adopted and, when necessary, reinforced when whistle-blowers report concerns**

f. **A Non-Executive Director at UHB is tasked with supervising this change working with the Director of People.**
g. **The Trust board must consider ways to ensure the Council of governors develop a more active role in holding senior leaders to account**

Final comments:

The review team recognises that whilst there have been changes within the senior leadership team, many of the concerns raised in our report and by other external agencies and independent sources over recent years still resonate with staff throughout the Trust. A new start is now possible under the leadership of the recently appointed interim chair and NEDs and with a focus on reconciliation and recovery. The next stages of this review will confront the persisting underlying cultural and organisational issues. For many, these will undoubtedly be painful, but it is necessary to confront the past as the first stage of recovery. It is important that the next few months offer an opportunity to reconcile with the past and progress. The recovery of this large important landmark organisation, centred within the UK's second most populated conurbation can set the tone for a wider economic stimulation of the area.

Professor Mike Bewick
Dr Rebecca Mann
Mr Giles Peel.

iQ4U
18 March 2023

Appendix 1 – Terms of Reference

Independent review of governance procedures at University Hospitals Birmingham NHS Foundation Trust (UHB), in response to concerns raised by 2 consultants at the Trust publicly during a BBC Newsnight programme on the 1st of December and the subsequent press enquiries about the safety and culture at the trust.

Background

On Thursday 1 December 2022, UHB was informed by Healthwatch Birmingham that their Chair, Richard Burden, would be featuring on BBC Newsnight later that evening. The programme featured interviews and statements from staff from UHB currently or previously employed at the Trust.

In the few days prior to this, there was negative coverage of the Trust in respect of an inquest into the suicide of a junior doctor who was working at UHB at the time of her death. While the inquest was very balanced and the coroner apportioned no blame to the Trust, the media chose to use a quote from the doctor's father as their headline/angle into the report.

In the immediate aftermath of the Newsnight programme further media activity was expressing interest in other cases and an interview with Professor Bion, the Trust's Freedom to Speak Up Guardian, was aired on Newsnight on Friday 9th December along with a further interview with the Chair of Healthwatch Birmingham, who has also released a statement raising concerns over bullying and patient safety at the Trust.

As a result of these concerns the Trust, along with Birmingham and Solihull Integrated Care Board (BSOL ICB) wish to put in progress a 3-phase independent review.

1. Aspects of patient safety raised in the Newsnight programme and other recent media activity
2. Culture at UHB
3. Governance processes at the Trust commissioned through a well led review

The Trust recognises the immediacy of the situation both to reassure the public and its Board of the quality of care at the Trust, and if any immediate remedial actions are required to improve safety at the organisation.

The 3 reviews will require different timelines. There is an immediate need for a safety review to be carried out by a credible external investigator. This should be completed in weeks and will be commissioned by BSOL ICB. The review team will report to the Chief Executive Officer of the ICB. It is proposed that this review reports to the ICB by the mid-January with an interim report indicating immediate actions required to assure the health system of the safety of clinical services (with specific reference to the areas of concern raised by staff in the Newsnight broadcast as priorities) and what immediate actions, if any, are required

The current terms of reference concentrate on Phase 1 of the review.

The second and third phases of the review, covering culture and governance, will be undertaken in early 2023 with an estimated commencement date of the completion date of February 2023, with a completion of all phases by the end of June.

Rapid review of patient safety at UHB.

The review will ascertain the safety of the current service(s) and appraise the system of current reporting and governance processes and if they are fit for purpose. The review will be independent and without limits but will include.

1. Rapid review of the report into concerns over the care of patients with haematological conditions to include
    a. Background to report referenced: why and how commissioned.
    b. Review of report itself; to look at, with UHB haematologists, to establish if further expert review is required
    c. How and who to, did the original review report and with what actions were taken?
2. A review of the governance processes invoked into the referral of doctors to the GMC, including an overview of TR case highlighted on Newsnight, as well as benchmarking the Trust referral pattern to the GMC.
3. A rapid overview of the Trust's response to deaths through suicide, of staff in their employment, and an overview of the incidence and prevalence of such cases. The review would include an appraisal of the Trust's response to such tragic events.
4. A rapid appraisal of emails sent by key members of staff within the context of the allegations (nurse email)
5. A rapid review of 12 never events at UHB in 2021/22 with a further look back at events since 1st April 2022
6. A rapid review of the current governance processes to include.
    a. Incident reporting and evaluation
    b. Quality of reporting
    c. Responsiveness of UHB senior team to serious incidents.
    d. Transparency and the functionality of the Freedom to Speak Up process and whistleblowing policies.
    e. Governance review of how all these processes is appraised and acted on by the Trust Board.

Essential information which would support the independent external review would include.

- Latest CQC evaluation of the Trust and specific performance matrices of the past well led review
- Performance indicators to include
    - Key performance indicators for elective, acute and cancer care
    - Any recent independent reviews into haematology
    - Details of the 12 never events during 2020/21
    - Staffing including vacancies, churn and retention/recruitment data
    - GMC feedback from doctors in training
    - Letters of referral of the ophthalmologist to the GMC and any subsequent relevant correspondence.
    - Quality reports 2021/22
    - Staff survey 2021/22
    - Transcripts of the Newsnight programmes and any email or other communication with the BBC or other intermediate.
    - Disciplinary processes within the Trust for senior medical staff
    - Last 4 quarterly reports of the Trust's Quality Committee (or similar)

Methodology

This will be a desk top review supplemented by focused interviews to include

1. The Trust's Chief Medical Officer and RO if different from the CMO
2. Chief Nursing Officer
3. Non-Executive Director responsible for quality and safety
4. Head of Quality / Chief Legal Officer?
5. FTSU chair
6. Senior member of patient liaison personnel
7. Quality lead at the ICB
8. Clinical director of haematology and relevant medical director for the division
9. Further personnel identified by the review team when necessary.

The rapid review will concentrate on the above 6 essential areas of concern and should also provide an initial evaluation that will provide baseline information for phases 2 (culture) and 3 (well led) of the review.

Assumptions

The independent review team will have access to

- A secure repository for documents available online
- A central point of contact at UHB to arrange interview appointments via a Teams video link
- Contact details with key members of the executive teams at both the ICB and UHB
- Access to the ICB/UHB communications team when required for any external communication issues that may arise.

It is not envisaged at this stage that on site visits will be required.

Timelines

Phase 1 of the review will commence as soon as possible once contractual agreements have been finalised early in the week beginning 12th December 2022.

The review team will report verbally to the ICB Chief Executive Officer by the 12th of January with a draft report agreed by the 23rd of January, subsequently extended to the **7th of February**. The review team will be available to give written statements on the progress of their report to support UHB/ICB's communication teams during the intervening period.

Phases 2 and 3 of the review will require more detailed planning but are expected to report by 31st June 2023.

Appendix 2 - List of documents received excluding personal emails to MB which were received in confidence.

ICB Investigation Overview v2.1
1. abc Haematological conditions report with appendices anon
1.1 CaPRI review report 18 May Second Case Review
1.2 CaPRI review report 22 June Second Case Review
2.1 GMC Consultant referrals v2 ANON.
3.1 Occupational Health – _Bereavement Guide
3.2a. Email from Head of PGME 29th June re Dr Kumar's funeral
3.2b. Order of service
3.2c. FW Dr. VE Kumar email to HEE
3.2d Email from MD-Education to Dr Kumar's father
3.2e. Emails btwn MD-Education and family friend of Dr Kumar
3.2f Mental Health workshops UHB In the Loop comms 28 July 2022
3.2g Email re Book of Condolences for Dr Vaishnavi Kumar Facebook and In the Loop.msg
3.2hi Staff notice further media coverage.msg
3.2hii appendix UHB Wellbeing
3.2I Junior doctors Reminder of welfare Support.msg
3.2j Support for you
bereavement support, counselling, and mental health services Chaplaincy Team
urgent mental health issue.
5. Rapid review of Never Events.
6.a1 UHB Incident Management Policy
6.a2 UHB Incident Management Procedure.
https://www.england.nhs.uk/patient-safety/a-just-culture-guide https://www.england.nhs.uk/patient-safety/organisation-patient-safety-incident- reports/organisation-patient-safety-incident-reports-13-october-2022/ https://www.england.nhs.uk/publication/organisation-patient-safety-incident-report-up-to- march-2022
6.b.i. QIP Appendix 1 Reporting Structure Diagram
http://uhbhome/quality-improvement.htm
6.b.ii QIP Appendix 2 New and Supportive Peer Review Process - Phase 3 6b. ii. QIP Appendix 3 CQMG - Cancer MDM SOP
6.b.ii QIP Appendix 4 Diabetes QI project Final
6.b.ii QIP Appendix 5 Safer Swallow PICS
6.b.ii QIP Appendix 6 LocSSIPs Consultant Induction Presentation
https://doi.org/10.1186/s12911-022-01865-y
6.b.iii QIP Appendix 7 Corporate QIP Leadership
6.b.iv QIP Appendix 8 Corporate QI Steering Group ToR
6.b.iv QIP Appendix 9 JCQAG ToR 202103
6.c1 2021 Terms of Reference for CaPRI v1.2
6.c2 CQMG ToR
6.c3 CQMG agenda items 2018 – _2022
6.c4 KPMG_UHB_Incident Reporting_Final Report_Jan 2022.
6.d.1 UHB FTSUG Report to Trust Board 2018-2022 DRAFT CONFIDENTIAL 38

Additional supplied by ICB (Birmingham and Solihull)
7.1 Review of SHMI by Dr Richard Wilson 14th February 2023

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