BIRMINGHAM AND SOLIHULL JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

12th APRIL 2023

MINUTES

Present:	Solihull: Councillor's M McCarthy (Chairman), R Long, R Sexton, A Mackenzie
	Birmingham: Councillor's M Brown, R Pocock, D Harries
Witnesses:	Jonathan Brotherton, Chief Operating Officer, UHB David Melbourne, Chief Executive Officer, Birmingham and Solihull Integrated Care Board (B&SICB)
In Attendance:	Fiona Bottrill, Senior Overview and Scrutiny Officer (Birmingham City Council)
Support Officers:	Paul Rogers, Senior Democratic and Scrutiny Officer (Solihull Metropolitan Borough Council)

1. APOLOGIES

Apologies were submitted from Councillor Mrs G Sleigh (Solihull Metropolitan Borough Council), Councillor G Moore (Birmingham City Council).and Councillor K Kurt-Elli (Birmingham City Council).

2. DECLARATIONS OF PRECUNIARY / CONFLICTS OF INTEREST

There were no declarations of pecuniary or conflicts of interest.

3. QUESTIONS AND DEPUTATIONS

No questions or deputations were received.

4. MINUTES

The Committee considered the draft Minutes arising from the previous meeting held on 13th March 2023.

RESOLVED:

(i) That the minutes of the Joint Overview and Scrutiny Health Committee meeting held on 13th March 2023 be approved as an accurate record of the meeting.

5. UPDATE TO THE BIRMINGHAM AND SOLIHULL JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – INDEPENDENT REVIEWS AT UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST (UHB)

The Chief Executive (B&SICB) presented to the Committee an update to the Birmingham and Solihull Joint Health Overview and Scrutiny Committee addressing the independent reviews at University Hospitals Birmingham NHS Foundation Trust (UHB).

The Chief Executive (B&SICB) noted that the 'Phase 1 Review by IQ4U Clinical Safety Review' had presented a challenging read at times, which had highlighted some practices and behaviors at one of the Trusts major institutions which were not welcomed. The Trust's management did not underestimate the impact on those staff who had come forward to share their experiences of working at UHB during the period in question. However, in coming forward, staff had marked the beginning of the Trust addressing and fixing those issues identified.

Members were advised that it was clear to the Trust that more had to be done to understand the scale of what had happened at UHB to create the right culture. The report was hard hitting and taken extremely seriously by senior leaders within the Trust. Work had commenced within the Trust to address some of the highlighted issues within the report. However, it was also recognized that the report represented a specific point in time, with much work being progressed since the report's publication.

Finally, Members were informed that over 22,000 staff worked at UHB, with the care of thousands of people reliant upon them annually. It was recognized that those UHB staff would be impacted by the findings of the report. The Chief Executive (B&SICB) noted that some of the positives, as well as the negatives, arising through the report should also be recognized.

The Committee was appraised of the background to the review. The review was commissioned in December 2022 addressing patient safety, leadership, culture and governance, following the broadcasting of a Newsnight report in December 2022. Mr. Mike Bewick, an experienced, independent clinician and a former NHS Deputy Medical Director, led the review alongside a dedicated governance professional and clinician. Additionally, the NHS commissioned a Well Led Review of Leadership and Governance in the Trust in conjunction with NHS England. Thirdly, Dame Eve Buckland, Interim Chair UHB, has also commissioned a Culture Review. The review before the JHOSC was the 'Bewick Review', which addressed the allegations made in the Newsnight Programme broadcast in December 2022. Within the Bewick Review, it is stated that there are areas which require further scrutiny via the Well Led Review and the Culture Review respectively. UHB had agreed with Professor Bewick to continue to work together to complete all the reviews and produce a consolidated report by June 2023. The findings and recommendations arising from the Bewick Review would continue to be monitored and actioned during this period.

The Chief Executive (B&SICB) referenced his last attendance at the JHOSC, at which he stressed services at the Trust remained safe, and he reiterated this point. The review's view was that overall the Trust remained a safe place in which to receive care.

The Review Team detailed two concerns and seventeen recommendations, which ranged across clinical safety, governance and leadership. The Chief Executive (B&SICB) highlighted some specific recommendations. Following the Newsnight Programme, Dr. Nickolosis (who had worked in Haematology in the Trust) made a number of allegations about a Quality Review that had been undertaken in the Trust. Consequently, the Bewick Peer Team looked at what Dr Nickolosis had said, leading to a recommendation that an external, independent clinician in the field is appointed to review his assertions to ascertain whether they were relevant or not. The independent clinician would take a view whether there were any lessons to be learned arising from the review and secondly, to determine how the department had been integrated into the Trust since the merger in 2018.

Secondly, it had been determined that the prospective appointments of senior medical and nursing leadership ought to be reviewed. There was a feeling through the Bewick Review that there was not always a feeling of openness and transparency in the past appointments process for senior leaders in the Trust.

Thirdly, considering the tragic suicide of Dr. Kumar, a Junior Doctor at UHB, a review would be undertaken in conjunction with Health Education England of the processes to support those doctors in training who were concerned about their mental health and mental well-being.

Fourthly, the concerns of senior clinicians as expressed by the Medical Staff Committee in January 2023 were to be addressed explicitly as part of the Cultural Review i.e. regarding leadership and how leadership listens.

Fifthly, the Trust will commission a partner to deliver awareness training around identity issues, bullying, coercion and intimidation.

Finally, in the Newsnight programme, the appropriateness of GMC referrals was raised. Contrary to reports, the review found nothing contrary about the numbers, types or eventual outcomes of referrals. A total of seventeen referrals were reviewed.

In respect of a response to the review, the Chief Executive (B&SICB) advised Members that although the ICS commissioned services from the Trust, he was independent of UHB. Since the review had commenced, the Chief Executive (B&SICB) stated that the Trust had been working incredibly hard to address the issued identified. There has been full acceptance from the Trust in the findings and recommendations arising from the Bewick Review and of the need to act. It was also confirmed that the Cross-Party Reference Group would continue to work closely with Professor Bewick until the end of June 2023. All three reviews were scheduled to be brought back together, via a report in totality from Professor Bewick. The NHS was also due to complete its own independent review process i.e. oversight of all the actions undertaken by UHB to date.

In conclusion, the Chief Executive (B&SICB) stated that there was a genuine desire to improve Trust services, leading to a high performing team for which felt part of a good organisation to work.

Having received the report overview from the Chief Executive (B&SICB), the Chief Operating Officer (UHB) addressed the Committee. Members were informed that the Chief Operating Officer (UHB) fully accepted the reports recommendations and findings on behalf of the UHB Trust Board. It was further recognised the need to commit to learn from the reports findings, to identify and implement appropriate recommendations and to develop a new way of working in the organization. As UHB treated 2.2 million patients annually, developing public confidence in the Trust was incredibly important.

The requirement to do more to support UHB staff was fully recognized, as was the acceptance of the reports finding, recommendations, the need to make organisational changes and to maintain those changes.

Having received the report presentation and comment from the Chief Executive (B&SICB), the Chief Operating Officer (UHB), the Chairman invited Members of the Committee to submit questions pertaining to the report. In response to questions from Members, the Committee were informed that:

- Prior to the review commencing, enquiries were made to establish that Professor Bewick had no former ties to UHB before his formal appointment was confirmed.

- In terms of staff feeling that they could not come forward to provide evidence following the Town Hall event, the Town Hall event was arranged by the Reference Group. The reference Group was comprised of Members from Solihull Metropolitan Borough Council, Birmingham City Council, Patient and Clinician representatives. Professor Bewick had made his contact details available should anyone wish to contact him privately.

- Professor Bewick's report states that any whistleblower sources have remained private and kept in confidence.

- The issues the Parliamentary Health Services Ombudsman (PHSO) raised are addressed in the Well Led Report and the Culture Review, both of which were being resolved. The Chief Operating Officer (UHB) had met with the Chief Executive PHSO once, with a further meeting scheduled in April 2023.

- UHB was confident that it was addressing most operational issues raised across the range of reviews currently in progress. However, it was recognised that UHB was the largest health provider in Europe and that it could not be unequivocally stated that were no other issues yet to be identified across the Trust. However, safety and quality systems were in place and Professor Bewick had stated that overall the review team were confident in the safety at the Trust.

- The NHS was already talking with UHB regarding performance issues, prior to the broadcasting of the Newsnight programme, which included governance and culture. Improvement work was being taken forward as a system and service which had to be considered. The Newsnight report required a response, which led to the appointment of Professor Bewick.

- The report makes clear that the issues detailed within it had occurred over a long period of time. The ICB had been established since 1st July 2022 only and within a few months had commissioned the UHB Trust review. Furthermore, the NHS also had systems and processes in place to provide some oversight. Therefore, some thought should be given to how the Trust worked with the Joint Health Overview and Scrutiny Committee (JHOSC) to ensure that it was provided with the assurances required of it. It was important that the review processes were transparent and open to the JHOSC when addressing any future issues which may arise as part of the review process.

- The review report made clear that the ICB Review Committee was reviewing a number of issues identified in advance of the broadcasting of the Newsnight programme. The report also made clear in terms of the Freedom Speak Up Guardian arrangements at UHB and how they may be further strengthened and supported to allow people to come forward to express concerns. A great deal of work has been undertaken by the Trust over the past 4 to 5 months in this area, involving engaging with staff both individually and in groups to have in many cases difficult conversations.

- It was recognized there needed to be a change in culture within the Trust, which would not take place overnight. It also needed to be acknowledged that a culture change would take some time to implement, but the Trust was in a better place than was the case 4 to 5 months ago.

- Following the broadcasting of the Newsnight Programme, the Chief Operating Officer UHB has continued to engage with UHB staff across the organization and intended to continue to do so into the future. Extensive staff feedback and information had been received through the thousands of conversations and engagement undertaken, which has been used to start to address some of the issues that underpin the reasons UHB staff feel as they do about working in the Trust where they have cause to feel unhappy, have concerns, under values, not respected or not listened to.

- The Trust had commenced a Culture Review in April 2023, which had a series of interventions designed to be anonymised /confidential according to the individual's preferences, designed to further increase the scale and pace of engagement with Trust employees. The issues raised were hugely complex and multi-factorial. Feedback had been received from Doctors, Nurses, Clinicians, allied health care professionals, health care scientists, management and secretarial staff, porters, housekeepers and support staff.

- The Trust had adopted three recognised organisational values 12 months ago: 'To be Kind, To be Connected and To be Bold', all of which were in the best interests of patients. The Trust believed this included the recognition of those staff who were performing well and in line with the Trust's values, which would in turn generate more of those desired behaviors. Also in place were staff recognition awards, long service awards and unprompted senior leaders visits to clinical areas, all of which were in place to recognize the excellent award Trust staff were delivering.

- Further follow up work was being progressed specifically against some of the recommendations relating to Oncology Services, 'never events' around blood-based products and the newer surgical service would all be reported on via the oversight arrangements in place with NHS England, the ICB and JHOSC. Any other issues identified or arising through the other reviews will also be subject to oversight arrangements. However, there were other extensive procedures in place to review and address areas such as clinical safety / harm incidents, which involved appropriate prioritization and categorization. These processes also entailed root cause analysis, identifying themes and linking back to quality improvement programmes. The oversight for these areas links back to the UHB Trust Board.

- A new Sub Committee structure was to be implemented supporting the Trust's Board of Directors, which would focus on key areas including the quality and safety agenda and culture review, which would support in the early identification of any new issues going forward.

- From an ICB system perspective, a significant change had been observed in the direction of travel at UHB in the last 4 months, supported by the appointment of Dame Yve Buckland as Chair of UHB and the interim appointment of Jonathan Brotherton as Chief Operating Officer, UHB, leading to greater transparency and openness not previously seen. Early signs of performance improvement in services had also been evidenced, such as for cancer waiting lists and across emergency and urgent care pathways.

- Pressure on the UHB workforce was significant pre, during and post Covid pandemic. Post pandemic vacancy levels had increased, largely due to the experience of working through the pandemic period, as well as the underlying issues identified within the review relating to working in the organization. Those staff unhappy with the organisational culture chose to leave for other Trusts and hospitals in the region, which were also having to manage vacancy levels.

- Qualified, registered nursing vacancies were experiencing the highest vacancy levels at ward level. Vacancy levels were running at 14% during the summer 2022, with the latest vacancy figures for the end of February 2023 running at just under 11%. This equated to an upward trajectory in the appointment of nursing staff across areas such as hospital wards, surgical theatres and ICU. In turn this leads to less stress placed on existing staff, which can lead to reduced staff sickness days and supporting improved patient care. It was also highlighted that the entire NHS was challenged with high vacancy rates. Tackling Trust vacancy rates was a key priority, as was staff retention which was dependent on addressing the organizational cultural issues which had been identified to date. A Director from Public Health Education England had also been appointed to undertake a review of vacancy rates across the entire local health system.

- It was recognised that creating a value-based culture across the

organisation would take time, with their being gaps within the Trust organisation currently in this regard. Work was currently on-going to target resource and efforts to address culture. A new organisational operating model was to be introduced after Board-to-Board discussions held between the UHB Trust, NHS England and the ICB on 30th November 2022. The new operating model would provide new, local senior leadership for each of the hospitals, leading to de-centralisation and devolvement. It was viewed that this would provide staff with greater involvement and influence over key decisions about health service provision and patient care.

- Since the Trust's merger, the wider organisation has been working in a very centralised manner, which was validated via the feedback being received from staff through the engagement processes. Although the organization would retain the benefits of being a £2BN organization and the economies of scale that brought, further benefits with the proposed revised operating model were expected to include reducing unwarranted clinical variation and outcomes.

- Improved local ownership and leadership was also required, which the new arrangements would address. For example, there would be hospital based Chief Executives and Leadership Teams, which would form part of a wider Trust based executive team network. It was expected these arrangements would support greater shared corporate responsibility and lead to greater impact on positive organisational culture. It was envisaged that the introduction of the new organizational operating model in hand with the on-going Cultural Review would have a significant positive impact on the feel of the Trust in the coming months.

- It was confirmed that future recruitment would be in accordance and in the spirit of the recommendation made within the report for the senior appointments process.

- The Chair and Chief Executive of Healthwatch were members of the Reference Group and it was reported that they were of the opinion the four ground rules proposed by Healthwatch had been met. Further follow up work had been commissioned through the Reference Group for Professor Bewick to deliver. This also included further meetings and engagement work with Trust staff who had yet to come forward to discuss their experiences and issues arising from working in the organization.

- The Committee highlighted the *Standardised Hospital Mortality Ratio* (SHMR) being detailed as 110 in the report (in statistical terms above 2 standard deviations above the mean), which equated to 10% above other health organisations, and questioned what work had been undertaken to analyse the reasons for that and what evidence was in place to support the analysis. The Committee was informed the ICS commissioned an independent data analyst to review the figures to draw a conclusion whether this was an area which was of special concern. It was concluded that an explanation for the figures was required, but it was not an area of special concern per se. This was due to the other relevant measure being within the standard range of deviations. However, it was noted that

Professor Bewick had stated that this was an issue which should have been reviewed by a Quality Committee at UHB to undertake a detailed deep dive of the underlying causes for the statistics.

- Independently, the ICS had consequently undertaken an analysis of the SHMR figures for the Trust.

- The Committee questioned the standard of findings /benchmark data established for the conclusions arising from the review of the SHMR data, especially where conclusions were drawn against varying amounts of data, some of which was circumstantial evidence, being available for review and analysis. The variation in establishing the standard of proof was questioned by the Committee.

- Members were informed that Professor Bewick was clear in his conclusion within the report that the population should be confident that UHB was a safe place to be treated. He further stated that culture had an impact on outcomes within health care, which in turn has led to the Trust's Culture Review. Although emerging outcomes were not expected overnight, they were expected to emerge over the course of the next 12 months.

- The Committee was advised that UHB had accepted the reports finds and recommendations in their totality, including for any specific references towards patient safety. The Committee was also informed that the Trust had a range of measures in place to measure patient safety, as did the Care Quality Commission (CQC), the ICB and NHS England. The Trust worked with all these regulators and systems in place. The CQC had undertaken some inspection of the organization during December 2022, with a report scheduled for release in April 2023, which was expected to point to a deterioration in safety in certain domains in some departments around patient safety. As such, a range of measures and monitoring systems were already in place to measure the Trust around patient safety outcomes. However, the review by IQ4U was quite clear in its finds and recommendations, which UHB fully accepted and were addressing.

- It was confirmed that in conjunction with other health organisations across the Birmingham and Solihull ICS geography there was a very active, dedicated international recruitment team and programme in place to attract nurses and other health professionals from abroad. UHB had historically recruited qualified nursing staff from overseas, many of whom continued to serve in the organisation for many years. UHB was currently seeking to recruit internationally 200-250 nurses annually and had made concerted efforts to do so over the past 18 months. Benefits arising from the successful recruitment process included the opening of more operating theatres post covid, increased diagnostic services available than was previously the case immediately post covid, increased ITU beds opened and improved staffing ratios in certain specialist nursing areas. Feedback on the internationally recruited nurses had been very positive, both from the nurses themselves and the teams in which they were located.

- It was confirmed that UHB was reviewing its systemic processes to eradicate error leading to improved performance. The Trusts Chief Medical Officer was developing an approach to quality improvement based on proven methodologies across a range of industries and sectors. The attention and focus on reviewing complaints was now directed towards underlying themes rather than the individuals involved in any one incident. It had been established that although the organisation was one with a very high incidence of reporting, it transpired that the proportion of incidents leading to any kind of harm was very low. This gave staff the means to report incidents or 'near misses', whilst giving the organization the opportunity to put solutions in place to prevent them from becoming matters of harm. However, it did also remain the case as detailed in the report and via the Public Trust Board that there remained a lot of incidents of harm, which the Quality Improvement methodology is addressing.

- It was confirmed that the Committee's comments from the meeting would be noted and addressed through the Trusts remaining reviews.

- The Committee was assured that the UHB Trust Executive Leadership and Management Team recognised and understood the difference between robust management and leadership and bullying. Some further developmental work as part of a wider development package was required in the best interests of the organisation to ensure that safe and efficient patient care was delivered without the negative organizational behaviors as explored through the review report. This work would be addressed through a distinct piece of work and via the wider Cultural Review.

Having considered the report, the Committee:

RESOLVED:

(i) To note the report;

(ii) To receive a copy of the ICS analysis of the UHB Trust's *Standardised Hospital Mortality Ratio* (SHMR);

(iii) To receive an annual summary of the learning that had taken place over the course of the year across UHB be brought forward and submitted to the JHOSC in future; and,

(iv) To receive a roadmap for the remaining reviews in terms of how they will report, expected dates/timescales/milestones.

6. DATE OF NEXT MEETING

The date of the next meeting was to be confirmed. It would be hosted by

Birmingham City Council.

The Birmingham and Solihull Joint Health Overview and Scrutiny Committee (JHOSC) meeting closed at 7:48 p.m.