Birmingham and Solihull Integrated Care System
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NHS
Birmingham and Solihull

Terms of Reference

Independent review of governance procedures at University Hospitals Birmingham NHS Foundation Trust (UHB), in response to concerns raised during a BBC Newsnight programme on the 1st December 2022 and the subsequent discussion and feedback 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, having contributed to the programme some days previous. The programme featured interviews and statements from staff from University Hospitals Birmingham (UHB) currently or previously employed at the Trust relating to a range of concerns around leadership, governance and culture at UHB impacting on patient care.

In the few days prior to 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 Guardian, on Friday 9th December. The Chair of Healthwatch Birmingham, released a further 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 place three independent reviews that complement the overall picture.

1. Aspects of patient safety raised in the Newsnight programme and other recent media activity commissioned by NHS Birmingham and Solihull Integrated Care Board. The findings from this will link to two following reviews.
2. Governance processes at UHB commissioned through an independent well led review (using the established well led methodology) undertaken by NHS England which will provide the Trust with the information to further focus work on an independent culture review.
3. Culture at UHB commissioned by the Interim Chairman and Interim Chief Executive.

BSOL ICB recognises the immediacy of the situation both to reassure the public of the quality of care at UHB and if any immediate remedial actions are required to improve safety.

The three 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 BSOL ICB. It is proposed that this review reports to the ICB by the end of 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 governance and culture, will be undertaken in early 2023 with an estimated commencement date of the 9th of January and a completion date of March 2023.

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 appropriateness of the report (referenced in Newsnight ('the report') into concerns over the care of patients with haematological conditions to include
    a. Background to report including why and how it was commissioned
    b. Who wrote the report, under what governance structure, what methodology was adopted, what were the recommendations and conclusions and what actions were taken by the Trust in response.
    c. Review of the findings of the report, with UHB haematologists, to determine whether further expert review should be recommended.

2. A review of the appropriateness of the governance processes which apply when determining whether or not to make a referral to a professional regulator, such as the GMC, including an overview of the TR case highlighted on Newsnight and benchmarking of the Trust's referral pattern to the regulators such as the GMC.

3. A rapid overview of the Trust's response to staff deaths, including the tragic suicide recently concluded by the coroner, to include:
    a. overview of the incidence and prevalence of such cases
    b. an appraisal of appropriateness of UHB policies
    c. a review of whether appropriate support and training is available to staff in the context of a death from suicide by a staff member, including support for staff with psychological distress from a suicide and action taken to prevent similar deaths by suicide.

4. A review of Newsnight referenced nurse e-mail ('the e-mail) to establish:
    a. Context of the e-mail; from whom and what specialty area.
    b. Response by the Trust to its contents.

5. A rapid review of twelve never events at UHB in 2021/22 to include the original Trust led reviews and with a further look back at events since 1st April 2022. To determine whether actions appropriate lessons learned and assurance of relevant change in practice.

6. A rapid review of the appropriateness of 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 whistle-blowing policies.
e. Governance review, including defined executive responsibility, of how processes are 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 twelve 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 organisations.
    - Disciplinary processes within the Trust for senior medical staff
    - Last four quarterly reports of the Trust's Quality Committee (or similar)

Methodology

This will be a desk top review supplemented by focused interviews to include (but not limited to) discussion with individuals listed. The reviewing team may wish to hold discussion with others if felt necessary.

1. Preet Kaur Gill MP and Richard Burden (Chair of Healthwatch)
2. The Trust's Chief Medical Officer and RO if different from the CMO
3. Chief Nursing Officer
4. Non-Executive Director responsible for quality and safety
5. Head of Quality / Chief Legal Officer
6. FTSU chair
7. Senior member of patient liaison personnel
8. Non-Executive Director for Quality at the ICB
9. Clinical director of haematology and relevant medical director for the division

The rapid review will concentrate on the above six essential areas of concern as listed above. In addition, the reviewers should:

1. Indicate any cultural issues that they have become aware of during this review which should be investigated further during the culture review.

2. Set out, based on this review, any specific issues in respect of how the Trust is being led that should be included in the well-led review.

It is important that the review is open and transparent. As well as oversight arrangements through the BSol ICB and NHS England oversight group, it is essential that the review remains accountable to those who have raised concerns and provides assurance to the public and local partners. As such, Preet Kaur Gill, MP for Edgbaston, will chair a cross party reference group made up of local representatives. Reference group members will input into the review as well as bringing together local voices and organisations to steer its broader direction. The reference group will hold the oversight group and review lead to account and ensure the review's independence and that its findings are published.

The reference group will act as the conduit through which concerns raised with MPs, Healthwatch, unions and others can be shared with the review lead confidentially. Patients and family members will also be able to share concerns and feedback via this group and then onto the review lead. In this way, the reference group will ensure that the final review captures and reflects as many voices as possible and that patients are at the heart of any recommendations it makes.

Assumptions

The independent review team will have access to

1. A secure repository for documents available online
2. A central point of contact at UHB to arrange interview appointments via a Teams video link
3. Contact details with key members of the executive teams at both the ICB and UHB
4. 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 and reporting

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 19th January with a draft report agreed by the 30th January. 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.

Factual accuracy checks will be undertaken with participants in the review. The final draft report will be reported to the UHB January Board and through the ICB Quality Committee in January.

Oversight of the whole programme of work across the three phases will be overseen by a co-chaired NHS England and NHS Birmingham and Solihull group.

The findings of the review will be made public following the findings being presented at the respective NHS Boards.

An engagement plan will be developed with key stakeholders to ensure information continues to flow this will include (but not limited to):

- Meeting with local MPs on the 21st of December
- Presentation to the Joint Health Overview and Scrutiny Committee of Birmingham City Council and Solihull MBC during January.

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