None

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
TRUST BOARD OF DIRECTORS
FRIDAY 30 JUNE 2023

Title:	**Summary of actions and progress – December 2022 to June 2023**
Responsible Director:	**Dame Yve Buckland, Chair/Jonathan Brotherton, Interim CEO**

Purpose:	It has been an extremely challenging six months for UHB, due to significant operational performance pressures and serious concerns regarding patient safety, governance, leadership and culture. This report details the progress and actions that have been taken since December 2022 to June 2023.
Confidentiality Level & Reason:	None
Board Assurance Framework Ref: / Strategy Implementation Plan Ref:	SIP - #5 Assuring the highest quality of care and experience to our patients, carers, families and visitors SIP - #1 Creating a healthy and fair place to work SIP - #3 Developing, valuing and supporting our people at all levels as leaders and enablers SIP - #5 Assuring the highest quality of care and experience to our patients, carers, families and visitors BAF - SR1/22 - Inability to improve the health, wellbeing and fairness offer to staff. BAF - SR6/22 - Material breach of clinical and other legal standards leading to regulatory action BAF - SR5/22 - Inability to maintain a co-ordinated, structured and collaborative approach to achieve quality improvement priorities
Key Issues Summary:	
Recommendations:	The BOARD OF DIRECTORS is asked to: Note the NHSE Well-Led developmental review Receive the action plans Approve the approach to aligning these action plans into a Trust Improvement Plan.

Signed: Dame Yve Buckland	**Date:** 30 JUNE 2023

None

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TRUST BOARD OF DIRECTORS
PRESENTED BY CHAIR/INTERIM CHIEF EXECUTIVE
FRIDAY 30 JUNE 2023

1) Background

It has been an extremely challenging six months for UHB, due to significant operational performance pressures and serious concerns raised through the media, other stakeholders and regulators regarding patient safety, governance, leadership and culture.

We have taken these concerns incredibly seriously; under our new Chair and Interim CEO we have reflected, reviewed and reset; openly acknowledging and accepting our failings. We are listening, learning and welcome the additional assurance and support that has been provided through independent oversight.

The internal and external scrutiny on the organisation is intense; three independent reviews – safety, leadership and culture - numerous regulatory clinical quality inspections and forensic focus on operational performance.

Not wishing to wait solely for the findings and recommendations from the external interventions, the Interim Chair and Interim CEO, despite not being in substantive roles, took the decision to proactively make a series of bold – but necessary and fundamental – changes to put one of the largest trusts in the country back on a positive path, ensuring patients are confident and assured that the care provided at our hospitals is safe and that our 24,000 staff all feel proud of the quality of care that they are giving.

These changes – being actioned concurrently – have addressed and are addressing: Board composition and governance, Executive leadership and devolvement from a central to a hospital-based leadership model, commissioning of a wide-reaching cultural review and ensuring the key operational standards, with patients seen and treated in as timely and as safe service as possible, are delivered.

Implementing and embedding just one of these changes is a monumental challenge; to implement them at the same, is a reflection of the desire and direction set by the new leadership.

While we want to be able to fix things as quickly as possible, change of this scale will take time to be felt by those that need to feel the change most; the changes at Board level, will not yet be felt by colleagues on the ward; however, we are committed to ensuring this happens.

Our unstinting focus is on providing the best possible patient care, building a values-led culture and supporting our incredible colleagues.

Compliance with the terms of our license to operate, as regulated by NHS England

(NHSE), is imperative. The key areas of compliance that we are working to provide full assurance on are: operational performance; culture and organisational development; quality; governance and board oversight.

The progress and actions taken to date, against these key areas of compliance, are summarised in the following report.

2) Reviews

We are currently engaged in three independent reviews; patient safety, culture and leadership.

The first of these reviews, the patient safety review, was commissioned by the Birmingham and Solihull Integrated Care Board (ICB) and undertaken by Professor Mike Bewick, following allegations made in the media and concerns raised with other external stakeholders.

It was published in March 2023 and made very difficult reading. Its 17 recommendations were welcomed and accepted in full, and it highlighted significant concerns that UHB needed to, and has started to, address and to continue to learn from, as we move forward. Publication of the second phase is due to be published (today) 30 June 2023.

An action plan addressing the recommendations has been developed, implemented and is being monitored through NHSE/ICB oversight meetings, as well as through our own revised internal governance processes (please see Appendix A for the patient safety review action plan).

A well-led developmental review (Appendix B) was undertaken by NHSE between January and March 2023; a multistage review process was conducted, which included an online self-assessment for Board Directors, well-led interviews for all Executive and Non-Executive Directors and senior leaders, reviews of key documentation. In addition, in-person and virtual focus groups took place with approximately 229 staff across the four main sites and drew on data from a survey link sent to all staff, which was completed by 371 participants.

A Board Development session, led by NHSE, was held in May, where the key findings were discussed, recommendations accepted, and an action plan developed and immediately implemented.

Since receipt of the report, an action plan to respond to the recommendations has been developed in conjunction with Board members (please see Appendix C for the patient NHSE well-led review action plan).

The third review; the culture review, was proactively commissioned in March 2023 by the Interim Chair; recognising the strength of internal and external concern that had arisen before and after the series of events since December 2022.

The review is focusing on listening to and engaging with as many staff as possible and then taking positive action to improve how it feels to work and thrive at UHB. It will also

None

identify any systemic issues, practices or processes, organisational development and other gaps that need urgently addressing and a framework to address them.

To date nearly 4,000 colleagues have completed a confidential online survey and over 350 have attended face-to-face confidential listening groups.

Ensuring psychological safety for colleagues is paramount and has been written to the terms of reference for the culture review; a board development session on psychological safety is scheduled with Roger Kline, independent Chair of the Culture Review Reference Group, for September to follow up on these issues arising out of the findings of the culture review.

The review will make recommendations on how to make positive changes to move forward, whilst acknowledging the failings/learnings from the past.

The review, being carried out by an independent provider, following a competitive appointment process, is being overseen by a Culture Review Reference Group.

The outputs and recommendations from this review will be shared and acted upon following publication, later in the year.

3) **Leadership changes**

In January 2023, there was a change in leadership, with the appointment of a new Interim Chair Dame, Yve Buckland and Interim Chief Executive, Jonathan Brotherton.

Both Dame Yve Buckland and Jonathan Brotherton are fully committed to and are actively investigating, and understanding, all the issues raised and working tirelessly with staff and external experts to address them.

In May, the Council of Governors requested that the Interim Chair became substantive to provide stability to the organisation, which was accepted.

4) **Revised Board arrangements**

The Chair has implemented a revised approach to unitary board governance, designed to create a culture and conditions for continuous improvement, as well as resetting the tone and reputation of the organisation.

This is being achieved through using appropriate diagnostic tools and oversight; capitalising on the experience of non-executive directors – new and established; understanding and using patient and staff data more effectively; as well as improving key partnerships and using these relationships more effectively.

There are additional committees for Finance and Performance; Clinical Quality and Safety; Workforce and Culture Committee, supported by a clear reporting structure.

A Board Development programme has been devised, shared and discussed with the Board and been implemented, reflecting key findings of the well-led review and other key strategic drivers for the organisation.

None

The Interim CEO started a review of the Trust strategy with the executive team, on commencing in post. Since April 2023, the refreshed Board has already held two sessions to input into the strategy and has produced the top lines of the new direction to share with the organisation. This work is also consistent the new ICB strategy.

All Board meetings now have a strategy session on the agenda. The Trust Board and its new People and Culture Committee now receives a patient or staff story at the start of its meetings.

An active procurement process to engage external experts (Office for Modern Governance) to provide additional resources to support the committees in developing new assurance systems, is progressing. Two of the new committees have already introduced statistical process control models to support the committees. The NHSE national team, leading on Making Data Count, will be running the session for the Board, as part of its development plan in August.

5) New Non-Executive Directors

A number of new Non-Executive Directors (NEDs) have been recruited, who have not only added new skills and a fresh perspective, but much-welcomed diversity.

Professor John Atherton and Dr Peter Williams commenced their appointments as NEDs in March, filling the two existing vacancies. They have both been appointed to the Clinical Quality and Patient Safety Committee. Professor Atherton has also been appointed to the Audit Committee and Dr Williams to the Finance and Performance Committee.

Saleh Saeed and Stuart Cain both commenced as Associate Non-Executive Directors in March. Mr Saeed became a full NED on 1 June 2023 and Stuart will join on 1 July 2023. Both will be joining the People and Culture Committee and Stuart will also join the Finance and Performance Committee.

Ranjit Sondhi took up appointment as an Associate Non-Executive Director in March. He will sit on the People and Culture Committee in an advisory role. Philip Gayle has also joined the Trust as an Associate Non-Executive Directors, initially joining the Audit Committee.

6) Council of Governors

Voting is taking place to elect 11 new UHB governors in parts of Birmingham and Solihull; a third of the organisation's Council of Governors. The poll opened on 9 June and closed on 29 June, with UHB Foundation Trust members able to vote. The new Governors will add fresh perspective and diversity and as a whole, the Council of Governors will have the opportunity to build more effective and positive relationships with the Board, their constituents, our staff and patients.

The Council of Governors have held a session with NHS Providers (May) to establish better ways of working. Further follow-up sessions are planned with the NEDs, which will commence as soon as the new Governors are elected (July).

None

7) New leadership and operating model for UHB

One of the first actions taken by the Interim Chief Executive was recognising and driving forward a different way of working for the benefit of our patients and colleagues. In January 2023, he commissioned an external organisation to support the design and implementation of a new operating model for the Trust which will ensure leadership is strengthened at all levels, particularly at individual hospital level.

Whilst there are many benefits to the size and scale of UHB, there are also some drawbacks. Many colleagues have shared that they affiliate most closely with their hospital or service and do not feel as valued or empowered as they should do, given its centralised approach and limited hospital leadership arrangements.

A new group operating model is going through its final stages of development, the first phase of which will be implemented in October 2023. The new model will: create local leadership at hospital/site level; retain the best parts of working at-scale, by working as a group of hospitals and services; build a stronger values-led culture; prioritise staff welfare and well-being.

The following have been actioned:

- The Chair has started the national recruitment process to appoint a substantive Group CEO, with interviews taking place the week commencing 10 July 2023.

- The re-structure of the Group Executive Team and their portfolios have been finalised; the current structure of 14 executives, will be replaced by seven voting executives and five Board attending executives, which will include the four new positions of Hospital Executive Directors, who will have responsibility for each of their hospitals. The new structure will be implemented in July 2023.

- The external recruitment process of the new executive roles, four Hospital Executive Directors and Chief Strategy and Digital Officer has started, with interviews, week commencing 17 July 2023.

- The final design of the new operating model, steered by the Clinical Reference Group, jointly chaired by the Chief Medical Officer and Chief Nurse, is being further tested at speciality level and will be locked down by the first week in July.

- The management structures to support the hospital senior management teams and clinical speciality groupings are being worked through and will be ready in early July.

8) Culture

8.1 Staff and stakeholder engagement and action

The Interim CEO and executive team have met face-to-face with hundreds of staff and, virtually, with thousands. All-staff CEO-led webinar briefings happen weekly, with real-time questions and answers, and an average attendance of

None

between 450 and 500. There have been a series of regular face-to-face meetings with junior doctors and the consultant body to understand and action their key areas of concerns.

The new monthly values-based *Kind, Connected and Bold Awards* are evaluating very positively with all staff.

The Interim CEO is also very visible within the Trust and has visited particularly challenged specialties to meet with consultant groups, and listen to their concerns. The Chair meets regularly with the QEHB Senior Medical Committee (SMC), is now holding similar sessions with the SMC of Heartlands, Good Hope and Solihull.

In addition, both the Interim CEO and Chair have an open-door policy and speak each week with any individuals who want to make their voice heard directly, or who have brought particular concerns from their area of working.

There are regular monthly and bi-monthly engagement meetings with a range of key stakeholders for Birmingham and Solihull such as local MPs, health overview and scrutiny committees, health and wellbeing boards, council leaders, mayors, Healthwatch, local authorities, professional bodies and regulators, including NHS England, Integrated Care Board, Parliamentary Health Service Ombudsman and Care Quality Commission. These are meetings proactively arranged by the Chair and Interim CEO as they work hard to re-establish and build positive relationships with key partners.

UHB has particularly strong working relationships with the statutory health overview and scrutiny committees and regularly engages with them on ad-hoc issues and matters, including regular attendances at formal public meetings.

The Board recently received a report from Health Education England (HEE) on the key hotspots where there were problems being raised by doctors in training. An action plan has been developed to deal with these hotspots, bringing in additional resources from HEE and others. One of the NEDs is now part of the steering group for the sessions. Additionally, a broader action plan has been drawn up to deal with the wider concerns being raised by trainees.

The Freedom to Speak Up Service (FTSU) is being reviewed and the Guardian has produced a model in discussion with the Chair, which is designed to better reflect the new site-based operating model and also increase resources and access to freedom to speak up services. This will be referred to the next public Board in July.

8.2 Values-led leadership and staff experience

The Interim CEO has recently launched a long-term values-based leadership programme, which is aimed at, and relevant to all leaders in the organisation, whether you are a team leader or an executive director. ‘Welcome to Leadership’ (WTL) supports newly-appointed and established managers with the fundamentals they need to lead and manage their team effectively. It bridges the gap that managers often experience between their first day in a new

None

leadership role and any formal centralised training and development that might be available more broadly.

This is just one element of a comprehensive and evolving programme of work which includes: the development of a culture blueprint, new starter 100-day programme; implementation of a Talent Framework; new flexible working approach; reward and benefits review; 'stay' conversations; targeted hotspot interventions, well-being webinars, disability masterclasses and Fairness and Staff Networks.

9) NHS priority standards update

We continue to make good progress against recovering our services, following the devastating impact of the COVID-19 pandemic in the NHS's priority performance areas.

9.1 Ambulance handover delays: the number of patients conveyed to hospital and waiting more than 30 and 60 minutes, had been reducing month-on-month. In April, May and June ambulance handover delays have continued to reduce, which is really positive and testament to the hard work of our teams.

9.2 Urgent and emergency care: NHS England's two year plan aims to stabilise services to meet the NHS's two major recovery ambitions – one of which is to achieve 76% A&E four-hour performance by March 2024. We are currently not meeting this standard, with our performance averaging in the region of 55%. Plans are in place to address this new standard, support teams and ensure that patients are seen and treated in a timely way.

9.3 Cancer: there has been a phenomenal improvement in the position from August 2022 up until end of March; with the agreed plan being delivered (no more than 480 patients waiting 62 days). While this is, of course, more patients than we would like, this is again another remarkable team effort, with numbers of patients waiting 62 days now less than it was before the pandemic. The backlog has unfortunately increased during May; this is due to the impact of the industrial action, bank holidays and also the referral demand which is significantly higher. Our new 62-day cancer target is that no more than 330 patients will be waiting longer than 62 days by March 2024.

9.4 Faster diagnostic cancer standard: there is a requirement to confirm or exclude cancer diagnosis within 28 days of a suspected cancer referral being received, with a target of 75%, by the end of 2023/24. We are currently ahead of our plan, with notable improvements over the past 2-3 months, which is very positive.

9.5 Referral to treatment (RTT) long waits: we are seeing a much-improved position for patients and there has been considerable effort to limit any additional delays to patients; this focus remains, with 200 patients waiting over 78 weeks at the end of May.

9.6 New national key milestone for the 2023/24: there is a new milestone for this financial year that no patients should be waiting more than 65 weeks by

None

March 2024. Plans are in place to address this new standard, support teams and ensure that patients are seen and treated in a timely way.

10) Improvement plan

Undertakings have been given to NHSE about how we will improve; we are in the process of developing an organisational-wide improvement plan, which will ensure that the undertakings will be effectively delivered.

It has been agreed that multiple, separate action plans may mean it is more challenging to ensure sufficient oversight of the completion of actions, and whether the action have made the necessary changes. Therefore, the plan will pull together various action plans throughout the organisation, which are contributing to the Trust completing the undertakings agreed with NHSE.

Once the relevant actions have been agreed, metrics will be identified that are capable of demonstrating progress and improvement. These metrics will show the current position, and the expected position to provide ongoing assurance and forward look. There will also need to be testing and triangulation to provide assurance that the plan is making positive changes. This may include reports, clinical reviews, and patient and staff feedback. There will also be clear parameters set for when an action can be moved to 'business as usual'.

A dedicated oversight group will be set up to manage the plan. However, the accountability for the completion and effectiveness of actions will not be the responsibility of this group. The accountability for the key actions will remain with the Board of Directors, and the relevant Board committees. For example, actions related to patient safety will remain the responsibility of the Clinical Quality and Patient Safety Committee.

11) Recommendations

The Board of Directors is asked to:

11.1 Receive the updates provided on progress and actions from December 2022 to June 2023;

11.2 Note the NHSE Well-Led developmental review

11.2 Receive and note the action plans in the appendices; and

11.3 Note the approach to aligning these action plans into a Trust-wide improvement plan.

Patient Safety Review (Prof. Mike Bewick and team – phase 1) recommendations implementation plan April 2023 - draft

Ser	Recommendation	Action	Responsibility	Deadline	Progress	Evidence Required	Oversight
A.	**Clinical safety**						
1.	**Haemato-oncology:** 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: a) An independent retrospective review of all the deaths first analysed by Dr Nikolousis to establish any lessons learned. b) Consideration as to whether there is an outstanding Duty of Candour responsibility relating to this patient cohort. c) All deaths in the year 2021/22	ICB to commission a report from RCP – using RCP Independent Review methodology.	CMO	Timeframe to be agreed as part of ToR with ICB and RCP	a. ICB has commissioned a review by RCP. Terms of Reference are currently being agreed between ICB and RCP b. Duty of Candour will be considered if the external review considers that there was harm identified and the duty of candour requirements are met. c. Following discussion with Prof Bewick, the ICB will request that the 20 most recent deaths prior to 31 March 2023 are to be reviewed.	Completed review by RCP for haemato-oncology and any required DoC	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting and at the ICB Quality Committee **Trust Oversight:** Trust Committee for Clinical Quality and Patient Safety and

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	d) 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.	To commission external review	CPO	June 2023 to identify external provider September 2023 to commission following procurement exercise	d. The Trust has identified a number of providers and will run a mini competition exercise through June/July to assess merits of external procurement versus resourcing review internally. Terms of reference for the review have been developed. Assessment will take place July/August - for outcome September. The Culture Review will also feed through discoveries on integration to inform assessment.	Completed external review of department with focus on leadership.	the Trust Board

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2.	**Never Events:** 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.	ICB to commission external review with support of NHSBT.	CMO	As per action 1 above	The ICB has commissioned the RCP to complete the review. The terms of reference are currently being agreed between the ICB and RCP. Chair of National Blood Transfusion Committee will support. This will include review of laboratory protocols.	Complete review by RCP into never events associated with transfusion	As Above
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.	• Assessment to be carried out by Division 5 working with Chief People Officer (CPO). • May also need to feed into the Culture Review, depending on outcomes.	CPO/CMO	12 May 2023 to commission review	A scoping exercise has been undertaken, to inform programme of external mediation and support, with terms of reference for the review now prepared and a provider identified. The area has also been identified for specific inclusion in the Culture Review, and we will feed through discoveries in to support programme.	Complete external mediation and assessment of the neurosurgery development plan.	As Above
	To develop a fully effective recovery plan it seems likely to require significant ongoing senior neurosurgical support.	The Trust has had external senior neurosurgical support. To clarify with the ICB what further support is required	CMO/CPO	12 May 2023 to commission review	Following clarification from the ICB the support required for neurosurgery will be provided by the provider identified in A3 above.	Complete external mediation and assessment of the neurosurgery development plan.	As Above

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4.	We suggest the close **monitoring of future mortality statistics** and if these are persistently and significantly raised a further external review is commissioned.	Trust to continue monitoring mortality statistics and take appropriate action as and when required.	CMO	Complete	• Mortality statistics continue to be monitored monthly along with internal reviews of mortality indicators alongside the learning from deaths programme. The outcome is reported to the Clinical Quality Monitoring Group. Clinical Quality and Patient Safety Committee, UHB Board and ICB Quality Committee • ICB Quality and Safety Committee and /or UHB Committee for Clinical Quality and Patient Safety to continue to review the mortality statistics and determine if an external review is required within the context of regular reporting	Monthly mortality and learning from deaths report to CQMG Quarterly Learning from Deaths Report to Committee for Clinical Quality and Patient Safety, Trust Board and ICB Quality Committee	**External Oversight:** ICB Quality Committee **Trust Oversight:** Trust Committee for Clinical Quality and Patient Safety and the Trust Board

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B.	**Governance and leadership**						
1.	For Board committee and accountability structures: a. How the Board historically has evaluated risk and particularly clinical risk and what now been changed.	Assessment to be prepared for Board seminar to identify actions for oversight by CQ&PS Cttee.	CLO	July 2023	Assessment is underway, to be presented at the Trust Board Seminar in July 2023. This will include the work associated with the risk appetite statements.	Report from Board Seminar Updated Risk appetite statements	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting and at the ICB Quality Committee **Trust Oversight:** Trust Committee for Clinical Quality and Patient Safety and the Trust Board
	b. An appraisal of the current Board leadership's perception of clinical risk, highlighting areas which require immediate action.	• Areas of highest risk to be identified and agreed with Board, with details of actions being taken. • Risk appetite statements to be reviewed	CMO & CNO	September 2023	Risk appetite statements are to be finalised following the Board Seminar		

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	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.	Terms of Reference have been amended to ensure majority NED membership and quorum of Committees.	CLO	N/A	Complete- all terms of reference have been amended.	Board Committee Terms of Reference	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** Trust Board

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	d. A refresh of the FTSUG Guardian role and how the board interacts with this system.	• Refresh - See below – D 3 • Include oversight of FTSU in ToR of People and Culture Committee • Patient safety issues will be reported to CQ&PS Cttee.	CPO	Complete 30 June 2023	Terms of Reference for People & Culture Committee include bi-annual FTSU reporting. Report 1 of 2 in-year has been completed. Patient safety issues arising from the FTSU will be included in the newly devised Patient Safety Culture Report to the CQ&PS. The FTSU Guardian and Head of Clinical Governance and Patient Safety have met to agree on what information will be included. The first patient safety culture report is being presented to the Committee for Clinical Governance and Patient Safety on 22 June 2023.	• People and Culture Committee Terms of Reference • FTSU bi-annual report • Patient Safety Culture Report	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** Committee for Clinical Quality and Patient Safety, People and Culture Committee and the Trust Board

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2.	That the **escalation process for clinical incidents** and other areas of clinical risk is fully analysed from speciality up to Board level.	• The escalation process for clinical incidents has previously been reviewed by KPMG in 2021/22. The review found significant assurance. For the Chair of the Clinical Quality and Patient Safety Committee to review this repot to see if a further review is required. • Escalation process for areas of clinical risk to be analysed by Head of Clinical Governance and Patient Safety as part of the governance structures that are to being put in place for the Trusts new operating model	CLO	July 2023 October 2023	• Previous KPMG report is being reviewed by the NED Chair of the Clinical Quality and Patient Safety Committee. • As set out in a Board seminar in March 2021, areas of clinical risk are escalated from the speciality meetings, to the Divisional Quality and Safety meetings, to the Divisional Board and in turn to the respective Executive Level Committee. In light of the new operating model that is coming into effect from 1 October 2023 and the new Board Sub-Committee structures that have been	Report to Board Seminar	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting and at the ICB Quality Committee **Trust Oversight:** Trust Committee for Clinical Quality and Patient Safety and the Trust Board

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3 and 4	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. That UHB does have an **objective approach to succession planning senior level**, including executive level key appointments in medical, nursing and managerial leadership and uses appropriate, transparent and robust selection processes for these appointments.	• A new programme is being launched regarding values led leadership and behaviour in recruitment and appraisal processes. • Programme to be informed by Culture Review • Commission internal audit to undertake assessment of Trust succession planning and appointments at a senior level	CPO & CCO	June 2023 ToR to be returned by 26.05 - and field work to be undertaken and reported on by 30.08.2023 Evaluation will take place in real time on upcoming recruitment	Leadership programme launched in June, relevant for all line managers from Band 3s to Executives NHS Board Recruitment Compact – confirmed we will be part of the pilot programme, lead has been contacted and will support in any arising new Exec appointments – compact designed to ensure process adheres to best practice, finding the right people with right values, and championing diversity. KPMG have agreed to undertake internal audit on succession planning and appointments at senior level – Terms of Reference have been approved. Field work to commence in June, and reporting in July/August through Audit Committee but also in to People & Culture Committee. Current senior level appointments are being overseen by CPO with new approach to recruitment, to be used to test approach and evaluate effectiveness from panel and candidate perspective	Progress update reports on implementation of leadership programme and pilot programme with NHS Board Recruitment Compact KPMG Internal Audit Report on succession planning and appointments at senior level	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** People and Culture Committee and the Trust Board

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C.	**Staff welfare: in light of the tragic death of Dr Kumar, and from all we have been made aware of through this review is a significant area of concern which requires several priority recommendations for the Board to enact:**						
1.	Together with HEE, a review of processes to support doctors in training who are concerned about their mental health, ability to speak freely about concerns with colleagues and a clear message that they will be listened to.	Medical Academy – joint working group with HEE and ICB to determine a strategy and implementation plan.	Chair CEO CMO	12 May 2023 initial meeting with Andy Wallett	Meeting took place with Dr Whallett HEE on 12 May 2023. Enclosed below is a summary of what is both in place or being put in place. Wellbeing and Experience June 202	Report on actions and assurance on work completed presented to the People and Culture Committee Outcomes from junior doctor surveys	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** People and Culture Committee and the Trust Board
2.	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.	• Work with HEE, as above • Report to Board through People & Culture Cttee	Director of Medical Education				
D.	**Culture**						

Ser	Recommendation	Action	Responsibility	Deadline	Progress	Evidence Required	Oversight
1.	That **concerns of senior clinicians, expressed to us by the Medical Staff Committee** in January 2023, are addressed specifically as part of Phase 2 cultural review.	• This has been included in Terms of Reference of the Cultural Review to be undertaken by Value Circle. • ValueCircle meeting with Prof. Bewick	CPO	N/A	Complete	Outcome of the Culture Review by ValueCircle	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** People and Culture Committee and the Trust Board

Ser	Recommendation	Action	Responsibility	Deadline	Progress	Evidence Required	Oversight
2.	**That the Trust commissions a partner** to deliver awareness training on how to identify issues of bullying, coercion, intimidation and misogyny.	• Ensure action taken when issues of bullying, coercion, intimidation and misogyny are identified • Appropriate partner to be identified and commissioned • Incorporate outcomes of Culture Review work by the ValueCircle and will be included in follow-up action.	Chair CPO	Partner identified 31.05.2023 Programme implementation by 08.2023	Potential suppliers identified – effectiveness of training delivered explored in terms of sustained impact in organisations where it has been delivered. Procurement exercise to be undertaken June/July with draft programme of work to be delivered, but programme will be finalised with input from the procured provider and also input from the discoveries of the Culture Review so that the training responds to early indicator findings. The CPO has got Board agreement to deliver an End Sexism in UHB culture change programme, incorporating the BMA End Sexism in Medicine pledge. The Chairs of JNCC and JLNC have agreed to form a joint steering group to take forward, to be launched w/c 03 July, with support from BMA.	Training programme and progress updates on implementation Outcome of Culture Review by ValueCircle	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** People and Culture Committee and the Trust Board

Ser	Recommendation	Action	Responsibility	Deadline	Progress	Evidence Required	Oversight
3.	That the **Trust reviews the role of the FTSUG** 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.	• Identify best practice and good implementation - Expert advice to be sought • Take into account site-based structure.	CPO FTSUG SID	July 2023	Also see B1d above. Expert insight on some FTSU cases has been sought from external legal advisor.. Has highlighted some areas to address in terms of patient safety reporting escalations which will be addressed through patient safety reporting to CQ&PS (see actions below). Reference materials accessed via NGO. New Trust policy on Speaking Up has been produced and signed off by Board, and FTSU leads have been undertaking promotional work on sites to ensure visibility of service and improved understanding of access. FtSUG and SID have reviewed approach to service against new operating model and are devising plan for service.	Outcome of review and associated actions implemented	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** People and Culture Committee and the Trust Board

Ser	Recommendation	Action	Responsibility	Deadline	Progress	Evidence Required	Oversight
4.	Before the 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.	• Process for reconciliation to be developed • Approach to be reviewed by the Culture Review Independent Reference Group.	CPO	Phase 1 June 2023	Resolution Framework phase 1 report commissioned and received. Phase 2 being scoped. Alternative also being scoped as Resolution Framework training will take longer to put in place and embed – therefore will be mobilising network of internal resources around reconciliation – including Confidential Contacts, trained mediators, trained psychological first aiders and Wellbeing Officers Reconciliation on a case by case basis has been underway to review past cases including feedback to individuals where organisational learning has taken place or will be implemented.	Resolution Framework reports and associated actions	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** People and Culture Committee and the Trust Board

Ser	Recommendation	Action	Responsibility	Deadline	Progress	Evidence Required	Oversight
5.	That a **'no blame' culture is adopted** and, when necessary, reinforced when whistle-blowers report concerns.	• Behaviours framework, review of processes, meetings and structures • To be included as part of Culture Review implementation plan • To ensure the 'just culture guidance is embedded as part of the Trusts implementation of PSIRF	CPO CLO	June 2023 September 2023	Resolution Framework phase 1 report commissioned and received. Phase 2 being scoped – business case in development to progress phase 2. As part of the Trust's implementation of PSIRF an assessment on its application of Just Culture has been carried out and actions identified to ensure the just culture guidance is embedded within the Trusts processes. All Trust Incident investigation officers have attended training on the application of a just culture	As above PSIRF Project implementation plan and reports to Clinical Quality and Patient Safety Committee	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** People and Culture Committee, Clinical Quality and Patient Safety Committee and the Trust Board

Ser	Recommendation	Action	Responsibility	Deadline	Progress	Evidence Required	Oversight
6.	**A non-executive director at UHB is tasked** with supervising this change working with the Director of People	The NED Chair of the P&C Cttee, supported by committee members, will fulfil this role.	Chair	N/A	Complete	People and Culture Terms of Reference	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** Trust Board
7.	The Trust Board must consider ways to **ensure the Council of Governors develop a more active role** in holding senior leaders to account.	CoG away day being organised with NHS Providers	Chair	N/A	Complete	27/4/23NED/Gov meeting	**External Oversight:** Update on progress will be shared with the Health Overview Scrutiny Committee and the ICB and NHSE via the oversight meeting **Trust Oversight:** Trust Board

University Hospitals Birmingham NHS Foundation Trust Developmental Well-led Review

Findings and Recommendations

May 2023

Contents

1. Executive Summary

NHS England's National Intensive Support team was commissioned by NHS England's, Midlands Region to provide an independent developmental well-led review, to support the Trust in their improvement journey. This is one of the three reviews which have been commissioned to address clinical safety, culture, leadership and governance issues at the Trust.

This review occurred between January and April 2023 and used the framework set out in the well-led framework guidance published by NHS Improvement, which incorporates the CQC well-led lines of enquiry (2017). A multistage review process was conducted which included an online self-assessment for Trust Board Directors, well-led interviews for all Executive and Non-Executive Directors and senior leaders, reviews of key documentation and in person and virtual focus groups with approximately 229 staff across the four main sites and drew on data from a survey link sent to all staff, which was completed by 371 participants.

We have captured the summary using four headings: leadership, governance, strategy and culture.

Leadership

The Trust is currently undergoing a period of leadership changes, which includes the Interim Chair and Interim Chief Executive. The Interim Chair and Interim Chief Executive are actively reviewing the Trust's operational infrastructure and is responding to recommendations as set out by the Professor Bewick Review into Clinical Safety (2023).

Strategy

This Trust was formed following the acquisition of Heart of England NHS Foundation Trust in 2018; Heart of England initially merged with Solihull and then Good Hope Hospitals. The current Trust lacks an overarching strategy. The Trust has strategic aims and strategic priorities, but these are not embedded and well known by senior leaders; it is not obvious that the strategic aims and objectives drive the Trust Board agendas or the Board Assurance Framework.

Culture

This Trust could do more to balance the medical patriarchy which dominates and we saw demonstrated in part by new consultant joiners who are invited to observe a Chief Executive's Advisory Group meeting, other senior clinical joiners do not have this opportunity; at this same meeting, nursing and midwifery directors and allied healthcare professional (AHP) leaders are not invited, thereby contributing to diminished nursing, midwifery and AHP voices.

We heard a real strength of passion from staff to provide high quality patient care, however the pride in working for the Trust for some staff, has waned in the last few years.

It is notable that some staff attended the focus groups on their days off or after their shifts had ended. Some staff were concerned about speaking with us for fear of personal repercussion.

Staff consistently stated that they want to be more engaged, currently they are in the main, 'told' and they are keen to see senior leaders evolve their style to be more inclusive and respectful. Staff also told us that inequity and cronyism are a feature of recruitment processes at all levels in the Trust, limiting the potential of some staff, protecting others and disadvantaging staff from diverse backgrounds. The Trust Board at the start of this review was from a black and minority ethnic perspective, relatively homogenous. However, the Interim Chair has recruited new Non-Executive Directors and Associate Non-Executive Directors who are more reflective of the local community; further focus is needed regarding the diversity of new appointments to the Executive Team.

Patient voices must be further amplified and authentic opportunities created to hear from all services users from all diverse backgrounds to influence positive and tangible change.

The Interim Chair has externally commissioned an independent review of organisational culture with ongoing support. The review will listened to all staff and the report is due in June 2023.

Governance

The Trust needs to focus on delivering the fundamentals of good governance. This organisation has a wealth of data but its use to highlight timely risks, support decision making and data extraction is often constrained by systems which do not fully integrate with each other and compounded by multiple systems and legacy software.

In this report, we make a total of 16 recommendations, which we have themed using the CQC KLOE and are set out below:

- **R1.** Review the Executive Director portfolios to ensure clear accountability and ensure this is clearly communicated to all staff and relevant stakeholders. A national and transparent recruitment process should be started quickly to appoint a Chief Executive.

- **R2.** Review and refine the Trust Board development programme to ensure it addresses any areas for improvement identified from the safety and well-led reviews. This should specifically include the effective operation of a unitary Board.

- **R3.** Implement a mandated development programme for Governors from a recognised external provider.

- **R4.** Develop a Trust wide strategy in consultation with staff and system partners that reflects the current challenges and future opportunities faced by the Trust, which in turn shapes the Board and Board-committee agendas.

- **R5.** Ensure that staff can operate in environments that are psychologically safe where poor behaviours are consistently addressed and bullying and cronyism are eradicated at all levels of the organisation.

- **R6.** Improve the governance and accountability by improving systems, processes at meetings, to gain assurance against delivery of the strategic objectives.

    - Review the workplans for the new and the existing committees to ensure they are driven by the strategic objectives and the agenda items provide assurance for the relevant BAF risk. Ensure that action logs are consistently used across the Trust.

- Review Terms of reference of the leadership meetings to ensure Divisional Directors of Nursing and Midwifery and senior AHPs are included and attend the meeting.

- Work with the NHS England FTSU team on the areas that need strengthening, as identified in December 2021 and commission the NHS England FTSU team to undertake an evaluation in Q4 23/24.

- Improve the governance process for external reviews. This needs to include timely discussion, oversight and review of progress at the relevant Board sub-committee and or the Trust Board as appropriate. The Trust must also ensure learning from these reviews are effectively communicated to relevant staff.

- **R7.** Review and update the Board Assurance Framework following the refresh of a Trust wide strategy to reflect the new strategic objectives. The Trust should also take action to improve the quality of discussion on risks and how strategic risks drive Trust Board and sub-committee agenda.

- **R8.** Improve the effectiveness of information to support decision making such as Trust Board, sub-committee and Divisional reports. Pay particular focus to how the information meets users needs and ensure it is accessible and understandable. Work with NHS England's Making Data Count Team to adopt a best practice approach to information using statistical process control.

- **R9.** Review the analytical team resource within the Trust and ensure there is sufficient capacity and capability to support the production of high quality information to enable effective decision making.

- **R10.** Trust Board Directors and senior leaders to engage more often and openly with all staff and foster a collaborative, inclusive and compassionate leadership culture.

- **R11.** Ensure that Trust Board meetings held in public create time for questions from members of public.

- **R12.** Trust Board to continue to improve relationships with external partners and foster a positive and open culture.

- **R13.** Ensure appropriate arrangements are in place for Governors to have their questions from constituents fully heard and act in accordance with the Code of Governance for NHS Provider Trusts

- **R14**. Ensure that all communication on websites and patient information is reflective of the most used languages in the community that the Trust serves.

- **R15.** Improve the support available to staff undertaking improvement work via a trust wide quality improvement approach.

- **R16.** Ensure all staff have adequate time, support and encouragement to undertake learning and development.

2. Introduction and Context

University Hospitals Birmingham NHS Foundation Trust employs approximately 22,000 staff across all the sites including, Birmingham Chest Clinic, Heartlands Hospital, Good Hope Hospital, the Queen Elizabeth Hospital Birmingham, and Solihull Hospital and Solihull's community services. The Trust provides specialist cardiac, liver, neonatal and neurosurgery services to patients from across the UK. The Trust is also a regional centre for trauma, cancer services, bone marrow transplants, trauma, renal dialysis, burns and plastics, HIV, cystic fibrosis and thoracic surgery. The Trust cares for approximately 2.2 million patients each year.

The Trust currently has an overall Care Quality Commission (CQC) rating of 'Requires Improvement'.

The Trust was moved from segment 2 to segment 3 of the NHS oversight framework, by NHS England in October 2021. Segment 3 denotes that the Trust is in receipt of regionally mandated support.

This report set outs the methodology, findings and recommendations for the Trust Board. The purpose of this independent developmental review was to identify areas of focus and good practice to support the organisation on its improvement journey towards being a well-led organisation.

3. Methodology

This review uses the eight key lines of enquiry (KLOE) set out in the 2017 well-framework published by NHS Improvement and Care Quality Commission as the overarching framework for assessment (NHS Improvement, 2017), outlined below:

Figure 1: Well-led Framework Eight Key Lines of Enquiry

We recognised that our colleagues in CQC are moving from the KLOE stated above to the Single Assessment Framework for quality and you will see in this document we have mapped the current KLOE with the new Single Assessment Framework KLOE.

The reviewed followed a 5-stage process:

1. **Desktop review of key documents**
   The NHS England team undertook a desktop review of key documents including Trust Board papers and minutes, CQC reports, organisational charts and governance structures and sub board committee papers. A list of the documents reviewed in included in Annex 2.

2. **Self-assessment against Well-Led KLOEs by all Executive and Non-Executive Directors**

Each Trust Board Director independently and anonymously assessed the Trust's position against each of the eight KLOEs. This self-assessment was undertaken in March 2023 and completed by nine Executive Directors and six Non-Executive was analysed by the NHS England review team.

The results of the self-assessments were analysed and included under each of the KLOEs in the findings. Each rating from inadequate to outstanding was assigned a number from one to four (one for inadequate and four for outstanding). The graphs included in the report show the average rating score for each KLOE and the minimum and maximum scores. These will be used in the NHS England facilitated Trust Board Development session with the Trust during May 2023.

3. **Observations of key meetings**

The review team observed the Trust Board, sub-committee meetings, divisional and senior leadership meetings. Full details are included in Annex 2.

4. **Conversations with key staff**

Conversations were undertaken by the NHS England review team drawing from the 'CQC Next Phase Methodology Well-Led' questions, which focus on the eight Well-led KLOEs, but are also bespoke to individual roles and responsibilities. For example, the Chief Executive Officer and Chief Medical Officer were asked some different questions focused on the specific nuances of their respective roles, nevertheless, the unitary responsibilities of Trust Board Directors was a feature and so many of the questions were similar. The NHS England review team also asked additional questions based on the Trust's context and based on what was discussed in the interview. Full details of the individuals involved are included in Annex 2.

5. Focus groups

The focus groups were conducted in March 2023 in order to listen to staff across all Trust sites. The review team conducted 25 focus groups (22 in person and 3 virtually) with staff at all levels. The review team spoke to approximately 229 staff. The review team used Slido, a digital engagement tool, to gather anonymous staff feedback. This link was sent to all staff by the Trust's Communications Team; 371 staff completed the survey and provided free text comments. The feedback from Slido is grouped together with the comments from staff focus groups and further strengthens the triangulation of the review findings. It is notable that many staff attended the focus groups, after their shift had ended or on their day off. Full details are included in Annex 2.

Board Development

The NHS England review team facilitated a development session for the Trust Board during May 2023, whereby the overview of the report was discussed. The Non-Executive Directors led the discussion which culminated in the production of actions for improvement.

4. Findings

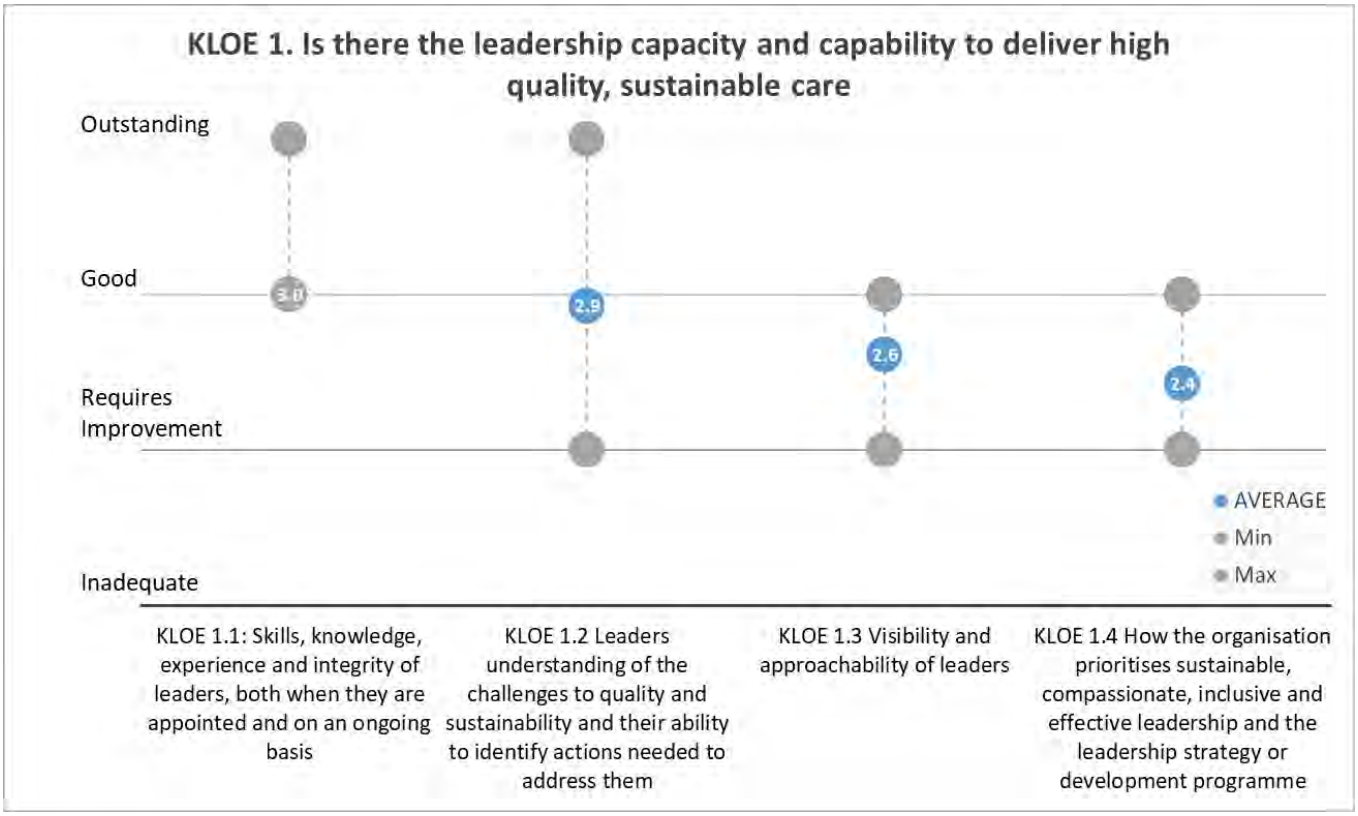
Overall, there was broad consensus in the ratings that each Trust Board Director applied to each of the well-led KLOE, during the self-assessment process, with most scores landing on either good or requires improvement. There was, as expected, some outlier scores of outstanding and inadequate. Findings from the five-stage well-led review process are presented here, stratified against each of the eight well-led key lines of enquiry.

4.1 KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?

Mapping to SAF Quality statements:
1. Capable, compassionate and inclusive leaders

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.8). The detail of the assessment is illustrated in figure 2:

Figure 2: The Trust Board Director's rating for Leadership KLOE



Key findings:

- The Trust Board has been through significant change over the last two years with three Chairs and two Chief Executive Officers. The current interim arrangements and the appointment to the Chief Executive post is likely to create further disruption and so a swift but national and transparent recruitment process will be critical. Staff reported that this disruption has created a lack of sense of direction and confidence in the Trust Board.

- Feedback from Trust Board Directors indicate that the Interim Chair and the Interim Chief Executive Officer are respected by the Trust Board.

- The Trust Board of Directors Fit and Proper Person status had not been checked since November 2021.

- The demographic diversity at Trust Board level was not representative of the local population. The Interim Chair stated in the Trust Board meeting, held in public during January 2023 that the intention was to ensure that the new NEDs would be more representative of the local community.

- Several of the Non-Executive Directors (NEDs) were recruited prior to the acquisition and subsequently joined the Trust, however their terms have concluded. The Interim Chair has recruited four new NEDs and two new Associate NEDs to complement the skills required at the Trust Board level. There are arrangements in place for the new NEDs to shadow the outgoing NEDs to ensure retention of organisational memory and comprehensive handover.

- During December 2022, there were two NEDs with clinical skills and experience, one NED resigned and so by January 2023 the skills assessment completed by the Trust Board in January 2023 highlighted that there was one NED with clinical skills and experience. In the new round of NED recruitment, it is the intention of the Trust Chair to increase clinical representation in the cohort of NEDs. During the recruitment of new NEDs in March 2023 the Interim Chair has successfully appointed two medical doctors and is in the process of pursuing a third appointment with a nursing, midwifery and or allied health professional background.

- Some NEDs stated that the opportunity to be a fully optimised unitary Trust Board has been diminished as there appears to be limited opportunities for them to challenge because considerable information is held at Executive Level. At the time of this review, the Executive team comprised 15 Chief Officers and Directors, out of which 7 are voting members of the Trust Board.

- Trust Board meetings held in public, currently occur on a quarterly basis. The frequency of the meetings must be increased to ensure that there is greater transparency for the public and to increase the contemporaneous nature of the discussions.

- The Chief Executive Advisory Group (CEAG) is attended by key Executives and partial attendance of the Divisional triumvirates and quadrumvirates; the Divisional Directors of Nursing and Director of Midwifery are not included in the Terms of Reference of this meeting. We were told by two Executive Directors that nurses and midwives would prefer to 'just get on with patient care' and 'would not want to be bothered with attending more meetings'. The nursing, midwifery, and Allied Healthcare Professional (AHP) voice is diminished. The Chief Nurse said she was uncomfortable with the lack of nursing, midwifery and AHP representation at this meeting and had mentioned this to the Interim Chief Executive and the Chief Nurse was hopeful of change.

- When reviewing Executive Director portfolios, we found a complex division of portfolios in particular the workforce and people functions: The Chief People Officer portfolio covers workforce in its broadest sense as well as occupational health, with aspects of organisational development. The Director of Communications has elements of organisational development as part of their portfolio, collaborating with Chief People Officer's team. The Chief Strategy and Projects officer is responsible for equality, diversity and inclusion and Freedom to Speak Up. Staff told us that they find it difficult to navigate which Executive Director is accountable for the various portfolios, a view which was corroborated by some Executive Directors.

- It was observed at Trust Board in January 2023, that there was limited participation of Executive Directors in areas other than their own portfolios, which reduced the ability of the Trust Board to operate in a unitary manner.

- Some Governors reported that they felt distanced, tolerated and sometimes treated with disdain. We heard that some of the most recent appointees had not been introduced to the existing members. A regular mandated programme of education was not evident. Limited training and education may have led to governors seeking assurance through Executive Directors rather than NEDs. There are number of forums in which some of the Governors gather; some of these forums are work streams to improve Governor induction, which has seen minimal impact and outcome.

- The CQC inspection report in October 2021 set out a 'should do' recommendation for the Trust to consider how the Council of Governors are utilised; the impact of change following this recommendation has not been evidenced. We heard and observed a state of learned helplessness in the Governors group.

- The Chair has initiated a Governor education programme which will be delivered by NHS Providers, which will be designed to further develop the Governors to fully execute their role in holding the Non-Executive Directors to account.

- The Lead Governor of the Trust has been in post for the last 11 years. The Trust constitution does not allow for terms of office to cease for this post. We asked the Chief Legal Officer about the term of office and he advised that this work is in progress but a date for completion was not known.

- The Trust established new Trust Board sub-committees in February 2023 to seek assurance and improve governance. The observations completed during the review were of the inaugural meetings of these Committees, hence the review cannot comment on the effectiveness of these new meetings. It is positive that the Trust has invited Governors to regularly observe the committees.

- One of the predominant mechanisms for Trust Board Directors to engage with front line staff is via unannounced governance visits to wards and departments. Feedback from these visits is discussed at Trust Board. Despite these visits staff told us that they see the Executive Team on the wards and departments when the service is under significant pressure.

- From what we have read and heard, several assurance visits led by various teams occur at differing frequencies, which can include CQC mock inspections, patient safety walkabouts and bi-monthly visits by Patient and Carer Community Council members; there may be a need to co-ordinate this activity. Some staff expressed a wish for more informal ways to interact with the Trust Board Directors.

- There is variability in visibility of Divisional leadership teams. The review team heard from staff that some Divisions conduct staff briefing sessions with their teams but this is inconsistent practice across the Trust.

- Staff consistently told us that they would like to see more transparency and openness from the Executive team; it was also acknowledged by staff that the style seen more recently from the Interim Chief Executive was more open which was welcomed.

- Trust Board seminars have not fully reflected the wealth of challenges that this organisation faces. The seminars appear to have missed the opportunity to have improved approaches between Trust Board Directors to support effective unitary working.

- The Trust Board has recognised that the existing operating model does not consistently provide them with the required line of sight from point of care to Board. As a result, they have commissioned and are in the midst of developing of a new operating model which is proposed will create local leadership at hospital level, retain the optimum elements of working at scale, build a stronger values-led culture and prioritise staff wellbeing. The new operating model is an essential element in improving cultural challenges, the first phase of which should be in place by Summer 2023.

- There is evidence of an induction plan for NEDs, which is being further refined to consider the needs of the newly appointed NEDs.

  The 2022 Workforce Race Equality Report indicated that out of approximately 22,000 staff there were nine Black and Minority Ethnic backgrounds (BAME) staff at Agenda for Change (AFC) band 9 and Very Senior Manager (VSM) level which denotes a missed opportunity for enriching the leadership with BAME staff and demonstrates that this Trust falls below what other similar sized Trusts can achieve. The Workforce Race Equality Standard (WRES) data reported on staff on AFC and VSM pay scales and omitted the medical workforce, the Trust must rectify this for the forthcoming 2023 survey.

Recommendations for KLOE 1:

- **R1.** Review the Executive Director portfolios to ensure clear accountability and ensure this is clearly communicated to all staff and relevant stakeholders. A national and transparent recruitment process should be started quickly to appoint a Chief Executive.

- **R2.** Review and refine the Trust Board development programme to ensure it addresses any areas for improvement identified from the safety and well-led reviews. This should specifically include the effective operation of a unitary Board.

- **R3.** Implement a mandated and rolling development programme for Governors from a recognised external provider.

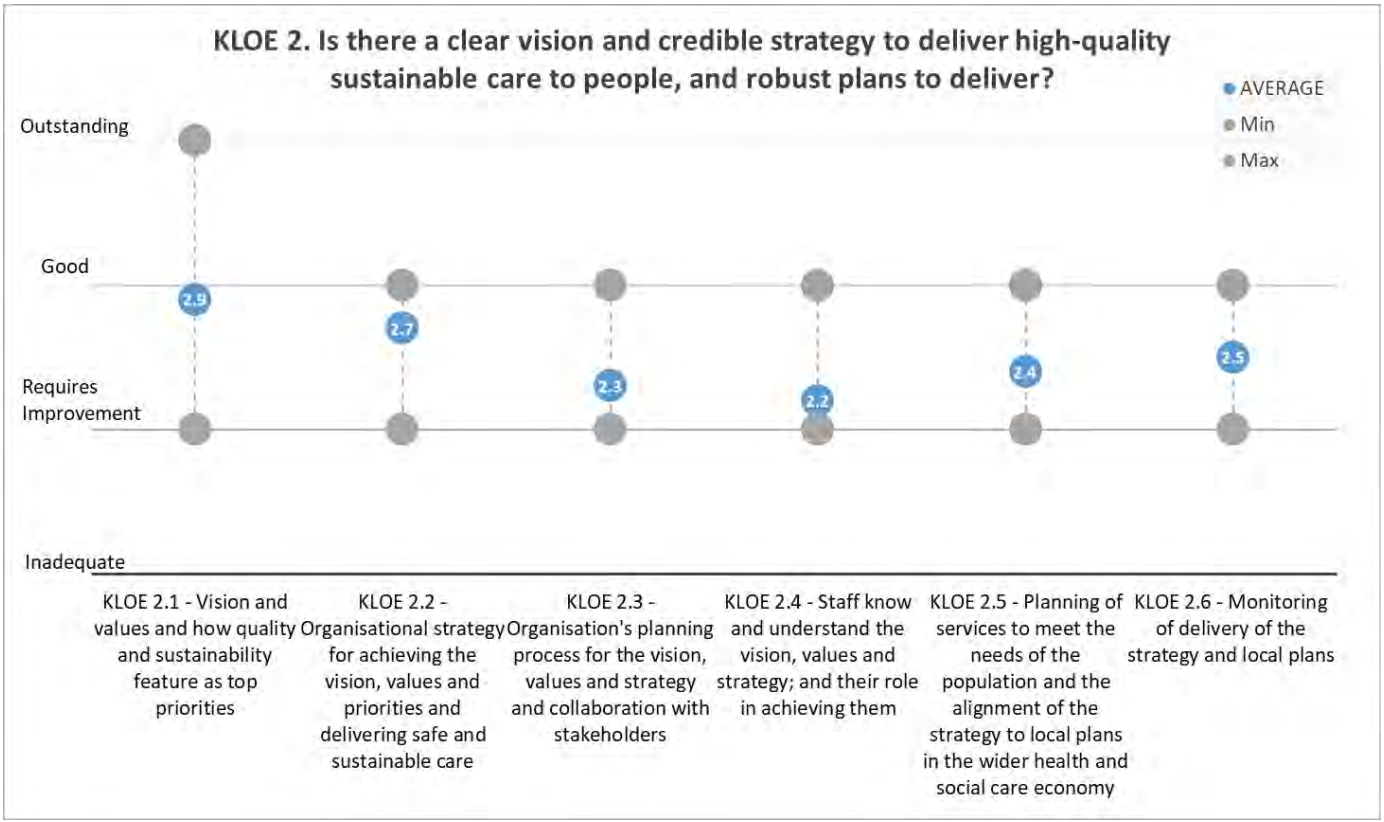
4.2 KLOE 2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?

Mapping to SAF Quality statements:
2. Shared direction and culture
6. Environmental sustainability - sustainable development

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.5). The details of the assessment is illustrated in figure 3.

The survey results indicate that most Trust Board Directors believe that more needs to be done to co-design and communicate the vision, values and strategy to staff.

Figure 3: Trust Board Director's rating for vision and strategy KLOE



Key findings:

- The Trust's vision and values are published on its website and were updated in February 2022. Most staff we spoke to were aware of the values and were able to recite them.

- In relation to the Trust's strategy, the Trust shared a set of Strategic Aims published on the website (last reviewed on the 10 January 2023), a document named 'Our strategy to build healthier lives' (not published on the website and not dated) and a 2022/23 Strategy Implementation Plan (not published on the website), these documents do not appear to fully align.

- A small number of Trust Board Directors had a consistent view on how the delivery of the Trust's strategic aims were monitored. The Chief Strategy and

Projects Officer shared with us a document which tracks the progress against the strategic aims which focusses on the input but this document did not capture the impact.

- Trust Board Directors and Divisional triumvirates were unable to consistently articulate the Trust's strategy. Despite this lack of clarity at Trust level, some Divisional triumvirates have recognised the importance of a clear strategy and have written Divisional level and or service level strategies.

- During January 2023, the Interim Chief Executive commissioned external support for the development of a new Trust strategy; two facilitated workshops have already occurred. Further engagement is planned to enable of senior leaders, staff and external stakeholders to contribute to shaping the new Trust strategy.

- The Board Assurance Framework (BAF) reflects the objectives as set out in the Trust 2022/23 Strategy Implementation Plan but not those as set out in the document titled 'Our strategy to build healthier lives', which is the document that was submitted to the review team as being the Trust's Strategy.

- Aside from the ambiguity that surrounds the Trust's Strategy, the BAF contains all the elements we would expect, in line with good practice, and is a sufficiently concise document that it can be considered in a meaningful way by Board Directors.

Recommendations for KLOE 2:

- **R4.** Develop a Trust wide strategy in consultation with staff and system partners that reflects the current challenges and future opportunities faced by the Trust, which in turn shapes the Board and Board-committee agendas.

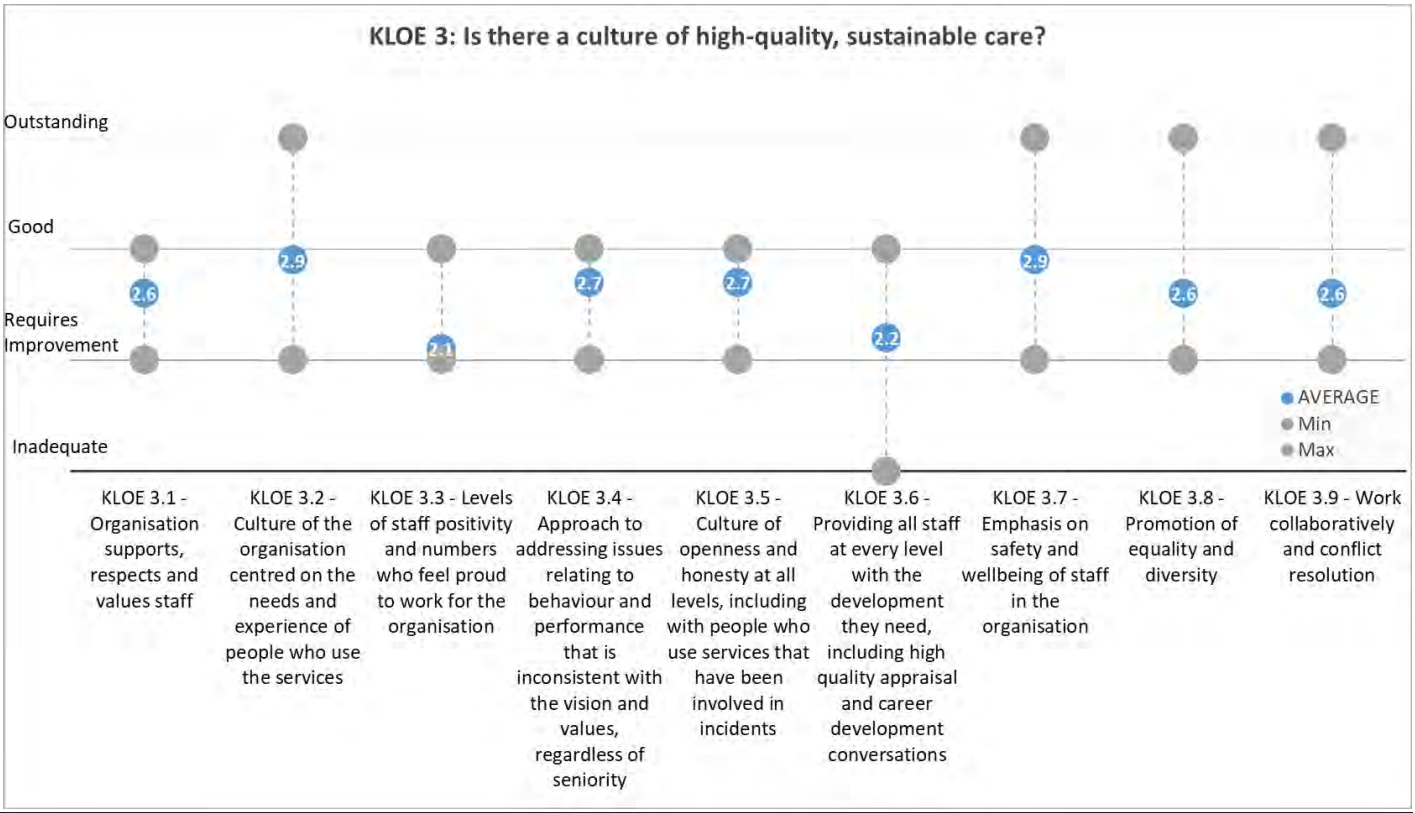
4.3 KLOE 3: Is there a culture of high-quality, sustainable care?

Mapping to SAF Quality statements:
2. Shared direction and culture
3. Freedom to speak up
7. Workforce equality, diversity & inclusion

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.6). The details of the assessment is illustrated in figure 4.

The survey results indicate that ongoing focus is required in relation to the culture of the organisation. The survey results are illustrated in figure 4:

Figure 4: Trust Board Director's rating for Culture KLOE



Key findings:

- In conversations with Trust Board Directors there was a clear recognition that there are different cultures and micro cultures across the organisation, some of which were positive and others identified as concerning.

- Cultural challenges were a common a theme from staff with examples of bullying, cronyism, a blame culture and a reluctance to speak up for fear of reprisal. Staff have spoken about micro aggressions which they have experienced which have left these staff felt, diminished, have questioned their self-worth and been or feel excluded. Staff have reported that they have either experienced themselves and have seen colleagues actively side-lined after they have spoken up; these were recurring themes across the sites and staff groups.

- Several staff shared examples of when senior colleagues had repeatedly not acted in line with Trust values and no obvious action had been taken against them. Conversely, staff who have reported poor behaviour of senior managers have subsequently seen some of those managers promoted. The Freedom to Speak Up (FTSU) report to the Trust Board held in public on 27 October 2022 identified similar concerns and highlighted that some of these behaviours may have become normalised. The National Staff Survey 2022, published in March 2023 highlights a significant decline in staff being confident that the organisation would address their concern (Q19b). The same survey also showed that the level of responses from staff had declined from 36.6% in 2021 to 26.2% in 2022; the average response rate for similar Trusts was 44.5%.

- The Trust has an established FTSU programme with reporting into the Trust Board. The service has been recently recruited to, to expand its reach. An NHS England review was undertaken of the service in December 2021 with several areas for strengthening put forward, which have yet to be progressed.

- From the feedback we received from staff, there was mixed awareness of FTSU service. Some staff reported in the focus groups that they were reluctant to use this route as they were concerned that the FTSU Team may not maintain their confidentiality.

- The 2022 National Staff Survey published March 2023, also indicates a deterioration against the People Promise Element 3: We each have a voice that counts.

- There is no evidence of a cultural transformation programme. However, the Trust established a Fairness Taskforce in 2020 to support culture change and comprises a range of staff into which staff network leads attend alongside representatives from the Executive Team, Inclusion and Wellbeing and Communications Teams. The impact of change for staff that we listened to had not been consistently felt or seen.

- The National Staff Survey results 2022 indicated a deterioration against the Q23c (I would recommend my organisation as a place to work) and Q23d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation).

- There is a belief by both staff and Trust Board Directors that the Interim Chair and Interim Chief Executive are committed to making positive changes to improve the culture. The Interim Chair has already commissioned external support to enable the development of an improved organisational culture.

- We asked Non-Executive Directors whether challenge is welcomed by the leadership and diversity of opinion valued. The response was mixed, with some NEDs feeling less able to challenge and others reflecting on whether they had challenged enough in certain areas.

- There was a strong view by Governors that challenge was not welcomed by the Trust Board.

- The agendas for the Trust Board meetings held in public showed that most items were discussed in this meeting with only those items considered commercially sensitive being considered at Trust Board held in private, which does appear to be an appropriate balance between the two agendas.

- The Workforce Race Equality Standard (WRES) report of 2021 highlighted that fewer BAME staff are being recruited to Agenda for Change (AFC) Band 8a and above posts compared with those from other ethnic groups; this was also recognised by Executive Directors as an issue that needed greater focus. The minutes of the Trust Board meeting held in public, in October 2022, where

this report was discussed, do not reflect the urgency of the situation; the action plan developed does not indicate clear timescales or monitoring arrangements.

- Appraisal compliance at the end of January 2023 was 73.6% against Trust target of 90%.

- The NHS Staff Survey identified that 77.1% of respondents have had an appraisal in the last 12 months, this is below the national average (81.4%).

- The Trust has a well-being offer for staff and this was viewed as a comprehensive offer Trust Board Directors. The 2022 National Staff Survey (shows that 46.1% of respondents believe that the Trust takes positive action on health and well-being, the national average (55.6%).

- The Trust Board Directors highlighted that reciprocal (known as reverse mentoring in other Trusts) mentoring is in place and some staff also highlighted that because of this they saw some positive improvements in some areas.

- The culture and approach to learning to improve care quality and work with other external bodies is also paramount. The Parliamentary and Health Service Ombudsman told us:

> *We share preliminary findings to enable those involved to tell us if they think we have got something wrong, and we welcome discussion where there is disagreement. However, during engagement with UHB about this investigation [avoidable death of a patient during 2022], senior clinicians were hostile, defensive, and confrontational. There was an unwillingness to consider PHSO's proposed findings, and a lack of acceptance about the impact of the failings PHSO had found. Blame for one of the errors identified was directed towards junior medical staff, with no recognition of the wider organisational issues. We expect NHS organisations to be open and willing to learn from failings. [The Trust] did not meet these expectations in their engagement with us.*
>
> *Subsequently, I wrote to the Trust's previous leadership to resolve matters and to gain the Trust's agreement to our findings and recommendations before we issued the final investigation report. This was met with further evidence that [the Trust] was unwilling to accept responsibility for failings, reinforcing the defensive attitude and lack of openness to learning we had already encountered.*

The Trust did ultimately agree to comply [our] recommendations. However, despite this, it still refused to accept that the death that those recommendations flowed from was avoidable. We saw no evidence of any meaningful attempt to learn lessons from what had happened or to understand the compounding harmful impact of taking this position. To make matters worse, the way the recommendations were complied with fell far short of what a grieving family have a right to expect.

Chief Executive PHSO March 2023

Recommendations for KLOE 3:

- **R5.** Ensure that staff can operate in environments that are psychologically safe where poor behaviours are consistently addressed and bullying and cronyism are eradicated at all levels of the organisation.

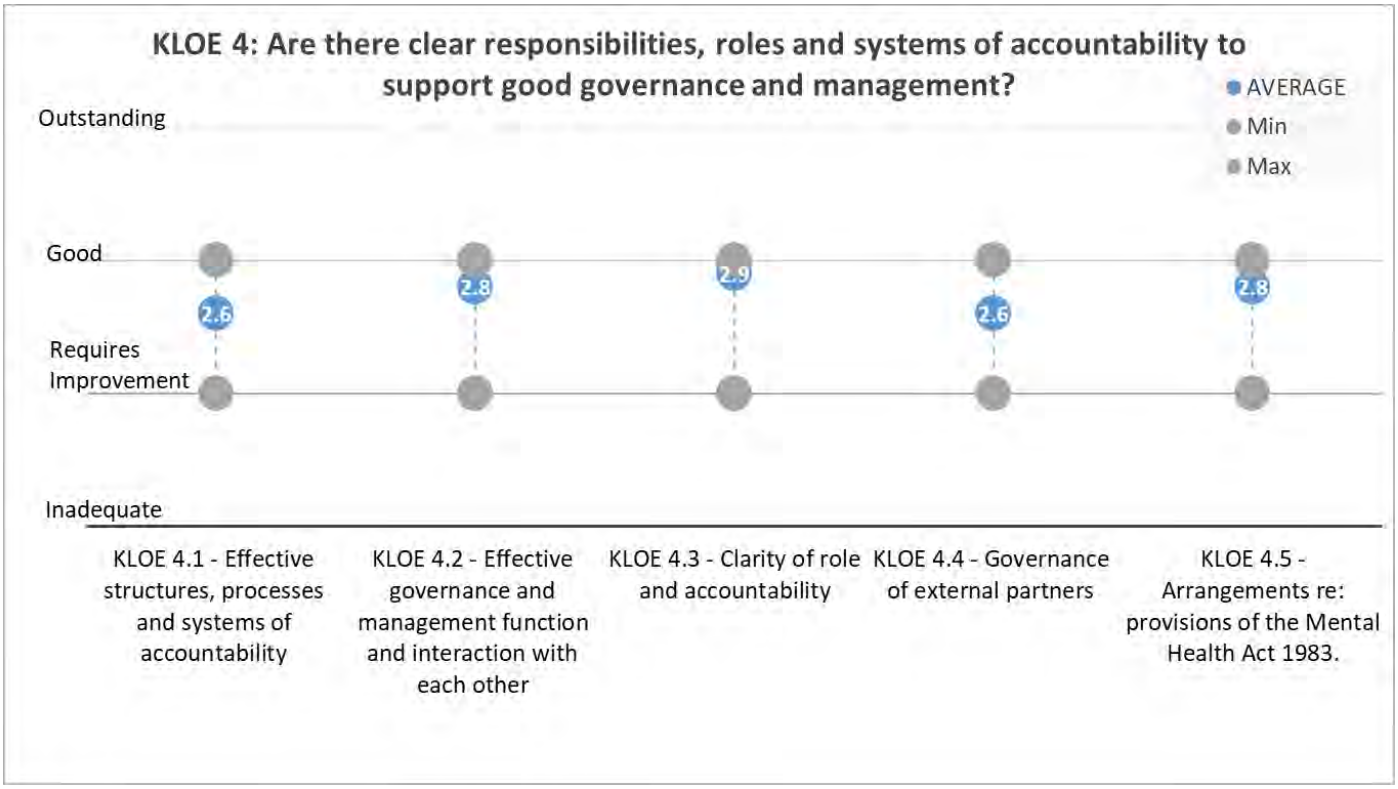
- **R6.** Ensure that the Trust culture develops to embrace learning from internal and external sources to improve outcomes for patients.

4.4 KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Mapping to SAF Quality statements:
4. Governance, management and sustainability

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.7). The details of the assessment is illustrated in figure 5:

Figure 5: Trust Board Director's rating for governance KLOE



Key Findings:

- The Trust has recently introduced sub-committees of the Board for Finance and Performance Committee, the People Committee and Culture, and the refreshed Clinical Quality and Patient Safety Committee.

- The newly introduced Board sub-committees complement the existing Audit and Investment Committees. The strengthened Committee structure now reflects structures in other NHS Trusts. The sub-committees understandably need time to mature supported with workplans and formal annual effectiveness reviews. The review team provided feedback to the Interim Chair on the Terms of Reference for the revised and new sub-committees. An early recommendation by the review team to the Interim Chair was to invite Governors to observe the sub-committee meetings. This suggestion has been threaded into the revised sub-committee terms of reference which will support the Governors to fulfil their role.

- The revised of sub-committee structure should strengthen assurance processes and thereby enable the Trust to review and minimise the Executive Director led assurance meetings.

- During conversations with NEDs, it transpired that sometimes assurance from Executive Directors is sought outside the previous sub-committee structure; seeking assurance is often sought via casual conversations, or at times via WhatsApp.

- The action log discussed at the Audit Committee in March 2023 had one overdue action from November 2021. The Trust Board meeting held in public in January 2023, Council of Governors held in February 2023, CEAG held in February 2023 had no action logs. The Audit Committee did not discuss matters to escalate to the Trust Board at the end of the meeting. The Interim Chair stated in the January 2023, Trust Board meeting held in public that action logs were to be commenced.

- The new NEDs education package needs to focus on good governance and assurance mechanisms.

- The Trust holds a CEAG, which is attended by the Executives and Divisional Leaders, excluding Divisional Directors of nursing and midwifery. Currently, most major decisions about operational delivery and sign-off of policies come via this group. This group also receives business cases and we heard from staff that decision making with such cases is significantly prolonged.

- Details of four recent external reviews commissioned by the Trust were shared with the NHS England review team. The team noted minimal transparency regarding acceptance and delivery of the recommendations from these external reviews. For example, a review conducted by the Good Governance Institute, completed in January 2020 was not discussed at the Trust Board seminar until March 2021. It is recognised that at this time, the country's focus was managing the COVID-19 pandemic, however, as of March 2023 3 out of the 17 recommendations were for further consideration and had not progressed.

- The accountability framework does not include the accountabilities or responsibilities at Divisional level, which may be helpful to address as part of the new operation model.

- **Recommendations for KLOE 4:**

- **R7.** Improve the governance and accountability by improving systems, processes at meetings, to gain assurance against delivery of the strategic objectives.

    - Review the workplans for the new and the existing committees to ensure they are driven by the strategic objectives and the agenda items provide assurance for the relevant BAF risk. Ensure that action logs are consistently used across the Trust.

    - Review Terms of reference of leadership meetings to ensure Divisional Directors of Nursing and Midwifery and senior AHPs are included and attend the meeting.

    - Work with the NHS England FTSU team on the areas that need strengthening, as identified in December 2021 and commission the NHS England FTSU team to undertake an evaluation in Q4 23/24.

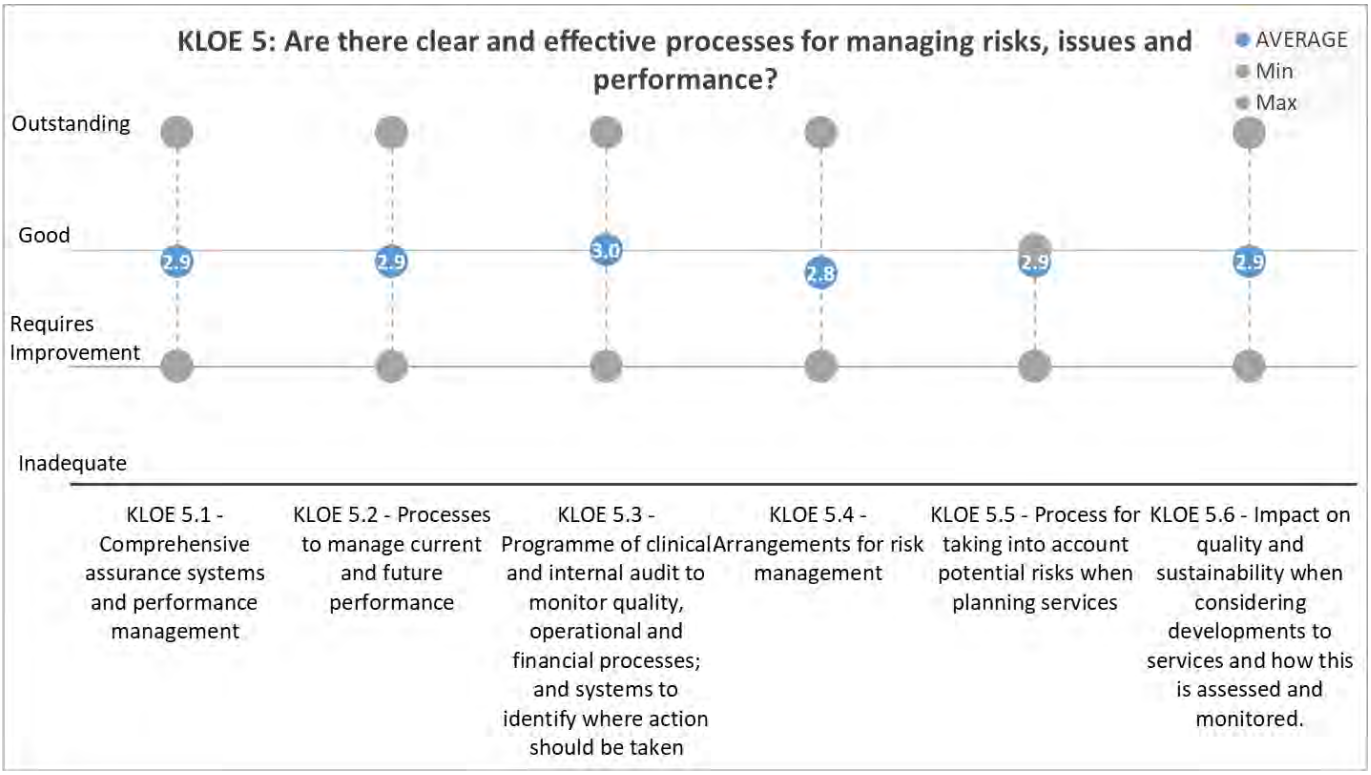
    - Improve the governance process for external reviews. This needs to include timely discussion, oversight and review of progress at the relevant Board sub-committee and or the Trust Board as appropriate. The Trust must also ensure learning from these reviews are effectively communicated to relevant staff.

4.5 KLOE 5: Are there clear and effective processes for managing risks, issues and performance?

Mapping to SAF Quality statements:
4. Governance, management and sustainability

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.9). The detail of the assessment is illustrated in figure 6:

Figure 6: Trust Board Director's rating for risk and performance KLOE



Key Findings:

- The Trust's governance arrangements are undergoing a period of change following change to leadership in late 2022. In January 2023 a new scheme of delegation was agreed which documents in detail responsibilities of the Executives. The Trust Board sub-committees have also been updated with three new committees forming in February 2023. The terms of reference of the existing Trust Board sub-committee have been reviewed to ensure alignment. The Trust is reviewing its governance arrangements with a view to move to more site-based leadership, with changes expected to occur during late Spring 2023.

- The Audit Committee observed was well attended and contained detailed papers from internal audit and external audit. There is a comprehensive internal audit programme for 2022/23 covering payroll, workforce, IT, financial controls and sustainability, ambulance handover, waiting list data quality amongst others.

- As noted under KLOE 2 more work is needed to refresh the Trust's strategy to ensure it addresses the current challenges and opportunities.

- The Board Assurance Framework (BAF) is a crucial document for driving the agenda of the Trust Board and sub-committees. The BAF is comprehensive and reported to Trust Board quarterly, however, it was not clear to what level that document was driving the focus of discussions.

- The Trust has a comprehensive risk management policy which details the process for managing risks. While the paperwork is in place it is not clear that effective and consistent discussions about risk are happening as the Divisional Board meetings observed demonstrated limited discussion on risks. Staff were able to describe their top risks but there was limited knowledge of whether these were reflected on divisional or local risk registers. A further example can be seen in the corporate risk register reported to January 2023 Trust Board meeting held in private. To illustrate, a risk related to staffing in a department was entered onto the register in September 2020 with an initial and current score of 20 and a target score of 4. The risk status was marked as green which is defined as “risk is on track to meet target score in the agreed time frame”. There was no further detail of the date of the agreed timeframe, no further commentary in the report and no discussion on this risk was observed in the meeting. A further observation of the corporate risk register was that for one Division, the risk status was not given a score and instead stated “meeting cancelled”; this item was challenged by the Interim Chair.

- Many risks reported by staff during focus groups relate to staffing levels which is reflected in many Trusts across England. There was significant concern amongst staff of the potential impact of this to quality of care and staff wellbeing. Staffing levels feature on the Trust’s corporate risk register.

- Staff told us they were familiar with the Trust’s incident reporting system and confident in its use. Incidents, Patient Advisory Liaison (PALs) concerns, complaints and inquests are included in the Trust’s integrated quality report to the Trust Board. The Trust has set a target of 65 working days for responding to complaints. During January to March 2022 performance of this target was between 70 and 80%. Since April 2022 performance has fallen to circa 20% with the most recent data from September 2022 at 21%.

- Staff were familiar with how to raise concerns and report incidents. Some staff said they would be happy and have raised concerns and reported incidents. There was also consistent feedback that some staff feared repercussions and

described a culture of bullying and intimidation. Staff told us there was too much focus on finding out who was responsible following an incident rather than focussing on system change.

Recommendations for KLOE 5:

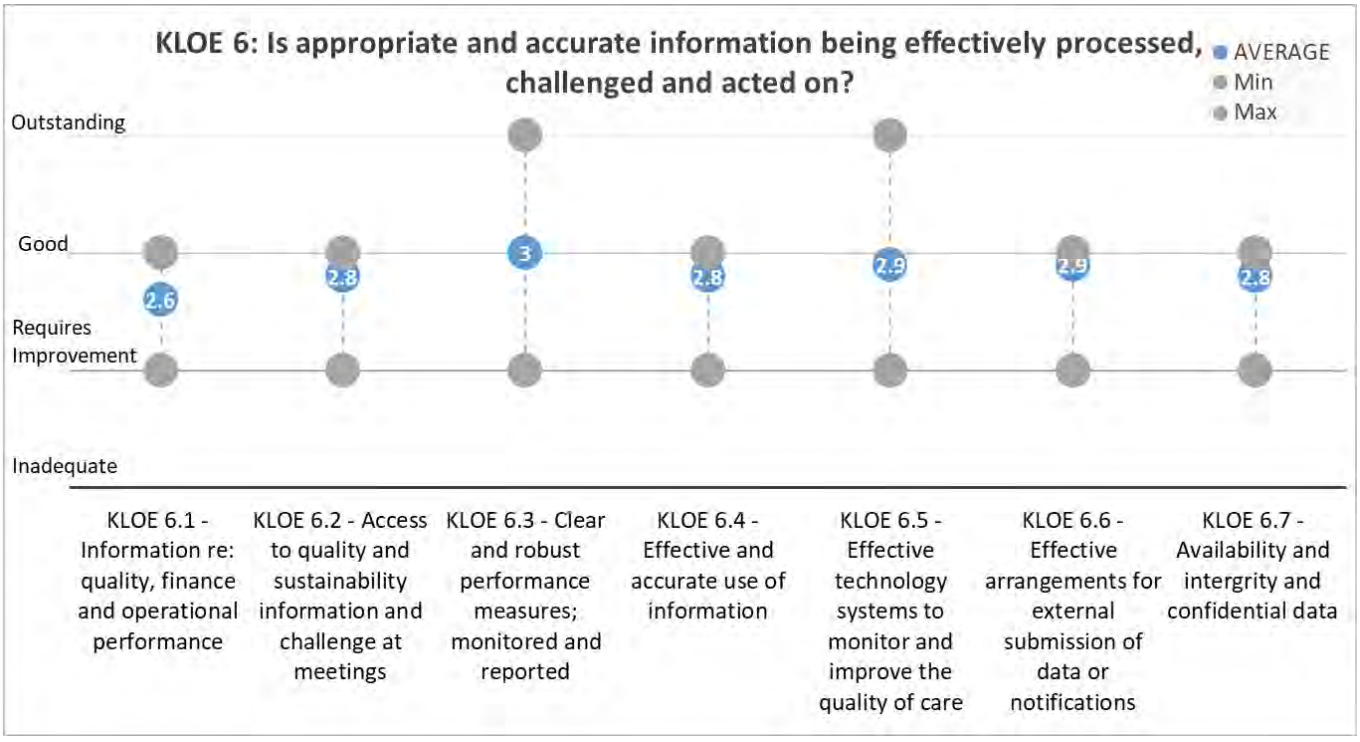
- **R8.** Review and update the Board Assurance Framework following the refresh of a Trust wide strategy to reflect the new strategic objectives. The Trust should also take action to improve the quality of discussion on risks and how strategic risks drive Trust Board and sub-committee agenda.

4.6 KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?

Mapping to SAF Quality statements:
2. Shared direction and culture
4. Governance, management and sustainability

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.8). The detail of the assessment is illustrated in figure 7:

Figure 7: The Trust Board Director's rating for information KLOE



Key findings:

- The Trust has large amounts of information related to clinical quality which predominantly is driven by the relatively new patient information system.

- We heard that performance and workforce data are difficult to access with multiple local systems which remain to be aggregated across the whole Trust. Staff told us that it can take up to three days collate a patient tracking list for elective care; staff also told us that data on theatre performance had to be drawn from three data captures, that the attendance rate for outpatients was not visible and was difficult to interpret.

- During Divisional Board meetings we observed that data in accompanying papers is siloed by professional group: separate nursing, performance and AHP data is submitted, rather than one dashboard of patient, outcomes and experience. The data currently provided limits the ability for senior leaders to be able to identify at an early stage emerging trends, risks and interdependencies which hinders the ability to seek stronger levels of assurance from ward to Board. We were told that new dashboards are being constructed.

- There are currently two finance systems and staff had developed a variety of 'work arounds' and reliance on personal relationships to obtain data.

- There was a consensus view by staff that the Trust had a good level of information but the variety of systems used to report and capture the information were onerous.

- At the Trust Board meeting held in public during January 2023 and in previous meeting papers in 2022, limited data was presented and was not reflective of datasets presented in other NHS Trusts. The data missed the opportunity to tell the story of the Trust's performance. Therefore, the ability for Non-Executive Directors to effectively challenge is diminished. The data that was presented showed some areas of continual delivery under trajectory which at the Trust Board meeting observed in January 2023 and in previous meeting papers, demonstrated minimal challenge and curiosity.

Recommendations for KLOE 6:

- **R9.** Improve the effectiveness of information to support decision making such as Trust Board reports, sub-committee and Divisional reports. Pay particular focus to how the information meets users needs and ensure it is accessible and understandable. Work with NHS England's Making Data Count Team to adopt a best practice approach to information using statistical process control.

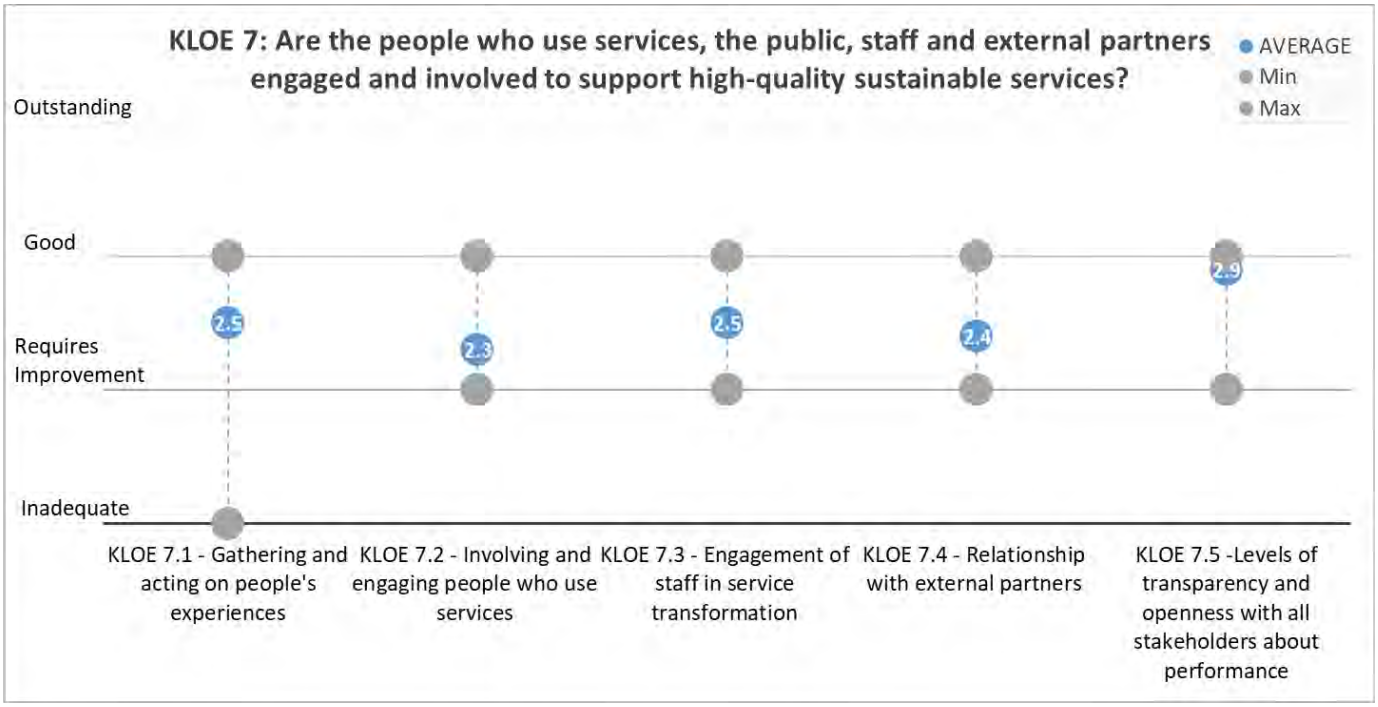
- **R10.** Review the analytical team resource within the Trust and ensure there is sufficient capacity and capability to support the production of high quality information to enable effective decision making.

4.7 KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

Mapping to SAF Quality statements:
8. Partnership and communities

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.5). The detail of the assessment is illustrated in figure 8:

Figure 8: Trust Board Director's rating for engaging public, staff and external partners KLOE



- We asked all Trust Board Directors to self-assess the organisation's progress anonymously and individually this line of enquiry. The range of responses are set out in the table above. The data demonstrates there is wide variation from Trust Board Directors about how the Trust is currently performing. Most of the respondents felt that the Trust's current performance would be rated 'requires improvement' with a couple of outliers for outstanding and inadequate.

- Birmingham city and the surrounding areas enjoy a diverse population with 48% of the population from a white background and the remainder from an 31% Asian, and 11% Black Caribbean or Black African heritage (UK Census 2021). On entering the hospital sites information for patients and carers in languages that are predominately used locally could not be seen, thus limiting the opportunities for engagement from the whole community. The Trust website does not appear to have a translation facility.

- To enhance the care of patients with learning disabilities there have been positive co-production events to develop 'all about me' passports. There is also evidence of working with families and patients who have complained about care. The Trust had arranged local drop-in meetings and presentations for the public and community groups at all hospital sites particularly focussed on service changes to gather views.

- The Trust's Engagement, Health Care Careers and Talent and Recruitment teams have actively engaged with people in the local area to promote the NHS as a career to young adults and other possible employees.

- The Trust's Patient Participation Team facilitated several Patient, Carer and Community Councils across Birmingham during 2022 and a variety of members attended. The main focus of discussions are patient experience, complaints response times, estates and food provision. The impact of changes following input from patients and carers is variable however amendments to clarify outpatient letters have been implemented.

- During conversations with Executive Directors, they stated that more could be done to strengthen partnership arrangements with external stakeholders, evidence of plans to strengthen partnerships was not evident.

- Most Governors that we spoke with told us that they have found the Trust at times to be secretive and often defensive. Because of this prevailing style Governors told us they have been unable to fully hold to account the NEDs; Governors have stated that there is often frustration from constituents because the responses from the Trust are either absent or superficial. However, Governors did report that the openness of the new Interim Chair showed a more open and helpful style which was welcomed.

- The practice of patient stories at the Trust Board held in Public has not featured. The Interim Chair during the January 2023 Trust Board meeting held in public requested that patient stories become a permanent feature of the agenda. Within the Integrated Performance Report tabled at Trust Board Meetings, included are summaries of experiences from patients. Patient experience videos have also been produced to support staff learning.

- Questions for Trust Board Directors at the Trust Board meetings held in public are required to be submitted prior to the meeting. From the observation of the Trust Board Meeting held in public during January 2023, there was no opportunity provided for ad hoc questions at the end of the meeting and no time allocated on the agenda. For previous meetings held in July and October 2022 there were no questions from the public recorded in the minutes.

- On staff engagement, the recent work led by the Chief of Out of Hospital Services to expand virtual ward capacity across various clinical pathways has engaged internal staff and external partners including primary care networks.

- Staff from community services who had worked in the service for many years said they could not recall a senior leader or Executive Directors spending time with staff or shadowing a staff member.

- Many of the staff we spoke with told us that senior managers and Trust Executive Directors engage variably. The visibility and the willingness to answer questions by the Interim Chief Executive at the Connected virtual sessions was welcomed across all sites and by various levels of staff, approximately 500 staff join these live events with others accessing the recording later which was more convenient to them. Whilst acknowledging the Interim Chief Executive's visibility, staff did say it would be timely for other Executive Directors to be equally visible on screen and in person to connect with staff.

- Divisional monthly team briefings hosted by the Divisional Managing Directors see approximately 180 attendees.

- Staff told us that within their immediate teams they felt engaged and valued. In some instances, staff felt that they were being told rather than engaged with. Staff said they have suggested to senior managers areas for improvement or offered contributions to shape a proposal which have been on occasion dismissed or ignored. Staff told us that they felt that senior managers had already made decisions and that staff engagement was an option rather than integral to the role of a leader.

- The 2021 NHS Staff Survey captured some headline feedback which included: challenges with travelling to work, slow recruitment processes, the need to be authentically thanked and recognised and a call for leaders to be appropriately skilled and demonstrate fair behaviours.

- The Trust responded by recruiting 279 internationally registered nurses, 150 new consultants and overall, approximately 4000 staff joined the Trust. The Trust has also initiated monthly divisional award schemes and in November 2022, within two months of the programme commencing, 650 nominations had been submitted. Long service awards and 'thank you' toolkits are also active.

The Chief Nurse has developed her own ‘thank you’ pack for ward leaders, encouraging staff to focus on their wellbeing.

- The 2022 NHS Staff Survey published in March 2023, showed that the level of responses from staff had declined from 36.6% in 2021 to 26.2% in 2022; the average response rate for similar Trusts was 44.5%.

- Some staff explained to us that there was a level of suspicion regarding the National Staff Survey that managers and directors could see who had responded and the responses. Staff also told us that they were not aware or had not been involved in improvements related to the 2021 NHS Staff Survey and so did not see the value in completing a subsequent survey. A small proportion of staff said that they had seen much improvement in their team because of the 2021 survey. The Trust had created an animation accessible by Trust staff explaining the improvements from the 2021 findings and encouraging staff to complete the 2022 survey.

- During November 2022 and early 2023 engagement sessions were held with senior leaders and triumvirates from the divisional teams. The goal was to reset the organisation and to focus on strategy and site identify, recruitment, retention and reward, staff experience, integration of information technology, culture, operational processes, and the estate.

- The Trust has a range of staff networks which include disability, BAME and LGBTQ+. All the staff networks feed into the Fairness Taskforce which is chaired by the Chief Strategy and Projects Officer.

- Some external partners have in the recent past found the Trust Executive Directors to be defensive, closed and difficult to engage with. More recently, colleagues from the Parliamentary and Health Service Ombudsman (PHSO) (as set out in KLOE 3), the Care Quality Commission (CQC), the Workforce, Training and Education Directorate in NHS England and the General Medical Council (GMC) have found that with the new Interim Chair and Interim Chief Executive that discussions are more open, productive and there is a willingness to work in partnership. These National and regional organisations are hopeful that this style of working will continue.

Recommendations for KLOE 7:

- **R11.** Trust Board Directors and senior leaders to engage more often and openly with all staff and foster a collaborative, inclusive and compassionate leadership culture.

- **R12.** Ensure that Trust Board meetings held in public create time for questions from members of public, including ad hoc questions.

- **R13.** Trust Board to continue to improve relationships with external partners and foster a positive and open culture.

- **R14.** Ensure appropriate arrangements are in place for Governors to have their questions from constituents fully heard and act in accordance with the Code of Governance for NHS Provider Trusts

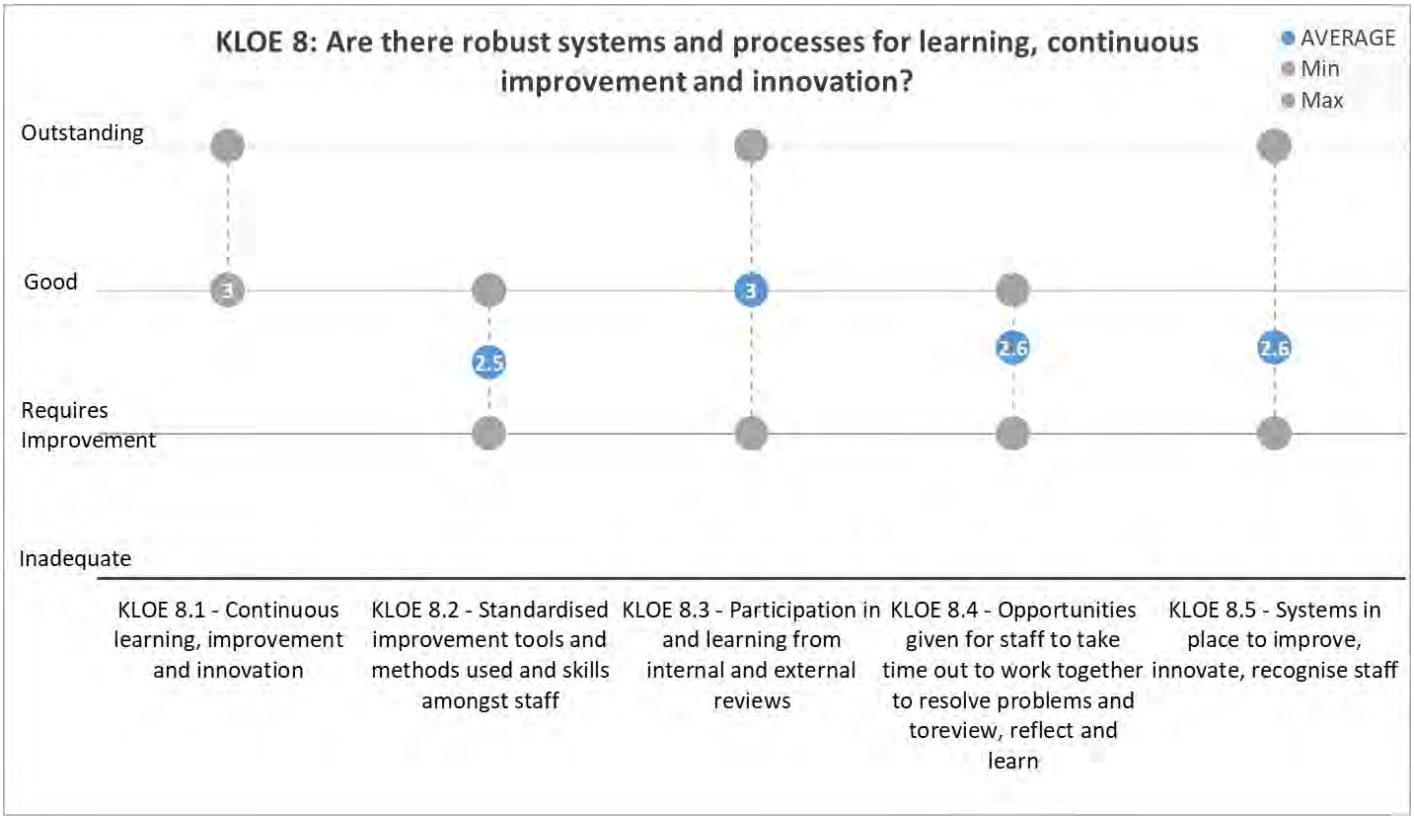
- **R15.** Ensure that all communication on websites and patient information is reflective of the most used languages in the community that the Trust serves.

4.8 KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

Mapping to SAF Quality statements:
5. Learning, improvement and innovation

The Trust Board Directors rated the Trust's position against this KLOE as Good (an average score of 2.7). The detail of the assessment is illustrated in figure 10:

Figure 10: The Trust Board Director's rating for improvement and innovation KLOE



- The Trust's quality improvement work is led by a Deputy Chief Medical Officer who leads a Quality Improvement Team.

- Many staff reported being involved in improvement projects and they were supported and encouraged by their line manager. Some felt they would like to be involved but were told they were too junior to be involved. Some staff said they would like to be involved in improvement projects but they were too busy. Corporate quality improvement projects such as *Improving ward rounds* and *Improving the safety of invasive procedures* are reported at Trust Board.

- Some staff told us that locally generated quality improvement projects are not consistently encouraged; the Trust Executive team told us that the reach of quality improvement needs to be improved.

- Staff reported they were not aware of an overarching improvement approach and methodology in place at the Trust. They were not aware of any resource or team they could access for guidance and support on how to approach their improvement projects.

- Many staff reported feeling too busy to undertake their personal learning and development. Some staff reported they undertook their learning and development including continued professional development requirements in their own time as they felt they were too busy to do this during work hours. Some divisions for example reported excellent access to leadership development courses but others did not. Other staff reported difficulties in accessing certain mandatory training as it is provided only on some hospital sites. Many staff reported they wanted more opportunity for learning and development, including quality improvement work.

- In KLOE 4 we stated that the governance regarding the response to external reviews would benefit from strengthening. The increased level of governance applied would support organisational learning.

Recommendations for KLOE 8:

- **R16.** Improve the support available to staff undertaking improvement work via a trust wide quality improvement approach.

- **R17.** Ensure all staff have adequate time, support and encouragement to undertake learning and development.

5. Recommendations

Following the findings of this review, a total of 16 recommendations are made aligned with their respective well-led KLOEs.

KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?

- **R1.** Review the Executive Director portfolios to ensure clear accountability and ensure this is clearly communicated to all staff and relevant stakeholders. A national and transparent recruitment process should be started quickly to appoint a Chief Executive.

- **R2.** Review and refine the Trust Board development programme to ensure it addresses any areas for improvement identified from the safety and well-led reviews. This should specifically include the effective operation of a unitary Board.

- **R3.** Implement a mandated development programme for Governors from a recognised external provider.

KLOE 2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?

- **R4.** Develop a Trust wide strategy in consultation with staff and system partners that reflects the current challenges and future opportunities faced by the Trust, which in turn shapes the Board and Board-committee agendas.

KLOE 3: Is there a culture of high-quality, sustainable care?

- **R5.** Ensure that staff can operate in environments that are psychologically safe where poor behaviours are consistently addressed and bullying and cronyism are eradicated at all levels of the organisation.

KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

- **R6.** Improve the governance and accountability by improving systems, processes at meetings, to gain assurance against delivery of the strategic objectives.

    - Review the workplans for the new and the existing committees to ensure they are driven by the strategic objectives and the agenda items provide assurance for the relevant BAF risk. Ensure that action logs are consistently used across the Trust.

    - Review terms of reference of the leadership meetings to ensure Divisional Directors of Nursing and Midwifery and senior AHPs are included and attend the meeting.

    - Improve the governance process for external reviews. This needs to include timely discussion, oversight and review of progress at the relevant Board sub-committee and or the Trust Board as appropriate. The Trust must also ensure learning from these reviews are effectively communicated to relevant staff.

- **R7.** Ensure that the Trust culture develops to embrace learning from internal and external sources to improve outcomes for patients.

KLOE 5: Are there clear and effective processes for managing risks, issues and performance?

- **R8.** Review and update the Board Assurance Framework following the refresh of a Trust wide strategy to reflect the new strategic objectives. The Trust should also take action to improve the quality of discussion on risks and how strategic risks drive Trust Board and sub-committee agenda.

KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?

- **R9.** Improve the effectiveness of information to support decision making such as Trust Board reports, sub-committee and Divisional reports. Pay particular focus to how the information meets the users needs and ensure it is accessible and understandable. Work with NHS England's Making Data Count Team to adopt a best practice approach to information using statistical process control.

- **R10.** Review the analytical team resource within the Trust and ensure there is sufficient capacity and capability to support the production of high quality information to enable effective decision making.

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

- **R11.** Trust Board Directors and senior leaders to engage more often and openly with all staff and foster a collaborative, inclusive and compassionate leadership culture.

- **R12.** Ensure that Trust Board meetings held in public create time for questions from members of public, including ad hoc questions.

- **R13.** Trust Board to continue to improve relationships with external partners and foster a positive and open culture.

- **R14.** Ensure appropriate arrangements are in place for Governors to have their questions from constituents fully heard and act in accordance with the Code of Governance for NHS Provider Trusts

- **R15.** Ensure that all communication on websites and patient information is reflective of the most used languages in the community that the Trust serves.

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

- **R16.** Improve the support available to staff undertaking improvement work. This could be through implementation of a trust wide quality improvement approach.

- **R17.** Ensure all staff have adequate time to undertake learning and development and feel encouraged and supported in their own personal development.

Annex 1. Terms of Reference of the Review

Introduction:

- This is a developmental well-led review commissioned by the NHS England Midlands region. The review will follow the well-led framework which is an agreed methodology used by the CQC and NHS England.

- The purpose of the review is to identify areas for potential improvement in the leadership and governance at UHB. It is a developmental review, and no formal rating will be provided. The purpose is to identify good practice and areas for improvement. The review will particularly focus on areas relevant to well-led identified by review of patient safety at UHB (Led by Professor Mike Bewick).

- The aim is for the trust to act on any feedback as part of any wider governance or improvement programme. The findings from this review may also inform the scope of any subsequent review into culture at UHB which is planned for early 2023 commissioned by the Trust's interim Chair and interim Chief Executive.

- This review is completed by the National Intensive Support team from NHS England.

Review Process:

The process will comprise of six key areas as set out below.

1. Desktop review of key documents:

   This is not an exhaustive list, but includes:

   - Most recent CQC quality report and Trust evidence of improvement
   - Organisational Charts, governance structures
   - Public and Private Trust Board papers (last 3 meetings)
   - Sub - Board committee papers (last 3 meetings)

2. Self-Assessment against Well-Led KLOEs

The Board will self-assess against well-led KLOEs, which will be used to triangulate against information obtained through conversations, focus groups and document review and will contribute to a board development session.

3. Observation of key meetings:

Based on the mapping exercise, the review team will recommend which meetings would be valuable to observe. For any meeting which is observed, the review team will require the papers for that meeting and the one before. If individual staff members want to meet members of the review team to provide context, or discuss the work of their group, reviewers will accommodate this as far as possible.

4. Conversation with key staff:

This is not an exhaustive list, but in the main includes the members of the Trust Board, Divisional triumvirates, Council of Governors, corporate leads and other key internal stakeholders.

5. Focus groups:

Several focus groups will be facilitated by the review team to engage with senior staff.

Time Frames:

The review will aim to commence in January 2023 and complete by the end of March 2023. However, timeframes will depend on:

- Provision of the information
- Access to individual UHB staff
- Frequency of the meetings included in the observation exercise

Responsibilities:

UHB:

- Communicate with the staff involved in the review to explain the purpose and scope of the work and provide contact details for key people to the review team
- Advise on the practicalities of undertaking the review
- Administrative support to collate papers for the mapping and any observed meetings, ensure calendar invitations for meetings are provided and support set up of any interviews requested
- Develop the action plan to respond to the review findings

Review team:

- Undertake the desk top mapping, observations and any conversations required
- Escalate any concerns to the Interim Chair and Interim Chief Executive
- Produce a report and recommendations for consideration by the Trust

Governance of the review:

- This review is commissioned by the NHS England Midlands region.
- The review team will compile the draft findings and share with the Executive Director from UHB co-ordinating this review for factual accuracy.
- Once the factual accuracy process is complete, the report will be shared with the NHS England Midlands regional team, as the commissioning organisation.
- UHB is responsible for any onward sharing arrangements related to this review and final report.

Confidentiality:

For the review to be successful in its aim of assessing and developing current arrangements, it is recognised that the trust will need to provide information that is confidential and would not ordinarily be in the public domain, and that there will need to be open dialogue. Any information gathered as part of the review will be kept in confidence and will not be shared without prior discussion with the trust.

Limitations to the review:

- Due to time and how meetings fall, the team might not be able to observe all the key meetings.
- The evidence collation from the trust will be reviewed at a high level, this might not be the same scrutiny that the CQC would be able to offer.
- Views from the interviews, focus-groups and committees will be based on observations at a snapshot in time.

Annex 2: Detailed methodology

Documents reviewed

Closed board agenda and papers for the last 3 meetings
Council of Governors agenda and papers for the last 3 meetings
Audit committee agenda and papers for the last 3 meetings
Trust management board agenda and papers for the last 3 meetings
CEOs Advisory Group papers for the last 3 meetings
CQC improvement plan and progress update to address the outstanding must do actions and recent warning notice
Evidence of board development during 2022
Quality committee papers for the last 3 meetings
Terms of reference of external reviews commissioned in the last 12 months
Terms of reference and reports of other external reviews completed in 2022
Board structure including NED and Exec portfolios
Trust Governance structure, including meeting structure across all sites
Litigation and Insurance Annual Report (as shared with the Board in October 2022)
Risk report that was shared with the Board in October 2022
Complaints policy and procedure
Terms of reference for new sub board committees
Declarations of interest
Elective care board update
FTSU policy and annual report
Workforce plan
Risk Management strategy
Risk Appetite statement - if not included in the policy
Risk Management Policy and SOP
internal Audit reports - Risk management, Patient safety
Action plan for 2021 NHS staff survey
Internal audit plan for 2022-2023 and draft for 2023-2024
Leadership development programme - for leaders at sub-Board level
Learning report - last 3 meetings
Staff well-being offers
Most recent data on staff appraisals - all disciplines
Most recent data on staff mandatory training - all disciplines
Accountability framework
Staff engagement plan
Patient engagement programme

Last 3 internal staff survey results and action plan
Board and Sub-committee forward plans for 2022-2023
WRES report - data and action plan for board
EDS2 report - leadership domain
Minutes of meetings with ICB (performance and contracting) - last 3 meetings
Staff grievance procedures and policies
Trust vision and values
Trust strategy
Strategy delivery plan
NED development programme and skills gap analysis
Board engagement plan, Patient safety walkabout, 15 steps challenge
Governance framework
EQIA - examples in the last 12 months
Workforce disability standards report
Complaints data over the last months - Need only reference numbers and type of complaint and Division
Good Governance Review – November 2019
Fit and Proper person's audit report
Minutes and papers from the Patient and Carer Community Councils – last three occasions
PPI forums – meeting minutes, evidence of impact and outcome – last three meetings across the sites and geography

Self-assessment

The self-assessment against the CQC KLOEs and rating characteristic was sent to Trust Board Directors during March 2023. Nine Executive Directors and six Non-Executive Directors completed the self-assessment.

The results of the self-assessments were analysed and included under each of the KLOEs in the findings. Each rating from inadequate to outstanding was assigned a number from one to four (one for inadequate and four for outstanding). The graphs included in the report show the average rating score for each KLOE and also the minimum and maximum scores. The average score was then used to give an overall rating for each self-assessed KLOE. For example, KLOE 1 scored an average of 2.8 and therefore a rating of good. These results will be discussed in the Board Development session with the Trust on 27 April 2023.

Meetings observed

Trust Board held in public	26 January 2023
Trust Board held in private	26 January 2023
Chief Executive Advisory Group	22 February 2023
Finance and Performance Committee	23 February 2023
Clinical Quality Committee	23 February 2023
People Committee	23 February 2023
Council of Governors meeting	23 February 2023
Divisional Board – Division 4	28 February 2023
Divisional Board – Division 3	2 March 2023
Audit Committee	2 March 2023

Conversations with Trust Board Directors and Senior Leaders

Dame Yve Buckland	Interim Chair
Jonathan Brotherton	Interim CEO
Jon Glasby	Non-Executive Director
Harry Reilly	Non-Executive Director
Debu Purkayastha	Non-Executive Director
Paul Jennings	Non-Executive Director
Jackie Hendley	Non-Executive Director
Catriona McMahon	Non-Executive Director
Ruth O'Leary	Director of Safeguarding and Vulnerabilities
Mehrunnisa Lalani	Non-Executive Director
Katy Hogan	Managing Director, Division 6
Dr Mark Garvey	IPC Lead
Stuart Dale	Managing Director, Division 4
Dr Khaled Elfandi	Medical Director, Division 3
Stephen Chilton	Chief Digital Officer
Sandra Haynes MBE	Lead Governor
Margaret Garbett	Chief Nursing Officer
Julian Miller	Chief Financial Officer
Tim Jones	Chief Innovation Officer
Kevin Bolger	Director of Delivery and International Programmes
Andrew McKirgan	Chief Officer, Out of Hospital Services
Nick Barlow	Chief Digital Transformation Officer
Amelia Godson	Managing Director Operations
Professor Simon Ball	Chief Medical Officer
David Burbridge	Chief Legal Officer
Louisa Sorrell	Head of Clinical Governance and Patient Safety
Karen Kneller	Non-Executive Director
Fiona Alexander	Director of Communications
Mark Garrick	Chief Strategy and Projects Officer
San Ting Gilmartin	Director of Capital Planning and Developments
Cathi Shovlin	Chief People Officer
Professor Julian Bion	Freedom to Speak up Lead

Focus groups

Twenty-four focus groups were set up across the four sites and virtually to engage with the wider group of staff and the governors; two of these groups were held virtually. The focus groups were advertised by the Trust Communications Team and staff were asked to book in through Eventbrite platform. The attendance at the focus groups was variable. In total, 229 staff and governors attended the focus group to share their view. Staff were provided access to a questionnaire on Slido (a digital engagement platform) to gather anonymous views. Slido was advertised in the focus groups and staff were encouraged to share the access details with colleagues who were unable to attend - 370 staff responded.

Staff were advised of the purpose of the review a safe space for discussion was created. The emerging themes from the focus groups and the Slido questionnaire were triangulated with other data obtained during the review.

Date	Site	Focus group
20 March 2023	Queen Elizabeth Hospital Birmingham	Trainee Doctors
		Nursing midwifery and AHP – AFC bands 2-6
		Nursing midwifery and AHP – AFC bands 7-9
		Staff AFC bands 2-6 – administration, porters and staff from corporate and divisional teams
		Open any grade any staff
		Governors
21 March 2023	Good Hope Hospital	Trainee Doctors
		Nursing midwifery and AHP – AFC bands 2-6
		Nursing midwifery and AHP – AFC bands 7-9
		Staff AFC bands 2-6 – admin, porters and staff from corporate and divisional teams
		Open any grade any staff
22 March 2023	Heartlands Hospital	Trainee Doctors
		Nursing midwifery and AHP – AFC bands 2-6
		Nursing midwifery and AHP – AFC bands 7-9
		Staff AFC bands 2-6 – admin, porters and staff from corporate and divisional teams
		Open any grade any staff

		Governors
23 March 2023	Solihull Hospital	Trainee Doctors
		Nursing midwifery and AHP – AFC bands 2-6
		Nursing midwifery and AHP – AFC bands 7-9
		Staff AFC bands 2-6 – admin, porters and staff from corporate and divisional teams
		Open - any grade, any staff
29 March 2023	MS Teams	Open - any grade, any staff
30 March 2023	MS Teams	Open - any grade, any staff
6 and 20 April 2023	MS Teams	Consultants
21 April 2023	MS Teams	Governor

Annex 3: Glossary

Throughout the body of this final report, we include reference to several terms and abbreviations. A full glossary is included below.

AFC	Agenda for Change is the current NHS grading and pay system for staff, ie registered nurses, healthcare assistant, pharmacists, occupational therapists, registered midwives, scientists and porters with the exception of doctors, dentists, apprentices and some senior managers.
Associate Non Executive Directors	Associate non-executive directors work alongside Board members to support our Board's succession strategy and to achieve a balance of Board level skills and expertise. Associate non-executive directors do not participate in any formal voting business at Board but gain the opportunity to develop non-executive skills in preparation for becoming a non-executive director in the future.
BAF	Board Assurance Framework: This brings together in one place all of the relevant information on the risks to the board's strategic objectives.
Chair	The Chair has a unique role in leading the NHS trust board. The Chair is responsible for the effective leadership of the board and the Council of Governors. They are pivotal in creating the conditions necessary for overall Trust Board and individual director effectiveness.
CEO	Chief Executive Officer - acts as organisational head, with quality, performance, financial and managerial responsibility.
CQC	Care Quality Commission - the independent regulator of health and adult social care providers in England.
Corporate Risk Register	Comprises of operational risks arising from the Trust's day-to-day activities
Council of Governors	The Council of Governors is made up of elected and appointed governors. Governors are volunteers and are not paid. Governors hold non-executive directors to account for the performance of the board and represent the interests of NHS foundation trust members and the public.
Executive Director	The Executive Directors are employees, are led by the Chief Executive and are responsible for the day-to-day management of the foundation trust.
Non-Executive Director (NED)	The non-executive directors are not employees. They bring an independent perspective to the board meeting and have a particular duty to challenge decisions and proposals made by Executive Directors.
FTSU	Freedom to Speak Up is a process to support staff to speak up when they feel that they are unable to in other ways.
GMC	General Medical Council regulates doctors in the United Kingdom. They set standards, hold a register, quality assure education and investigate complaints.

Good Governance Institute	Good Governance Institute is a consultancy firm who supports organisations to assess and improve their leadership, governance and risk management amongst other services
KLOE	Key Lines of Enquiry
PALs	Patient Advisory and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman - This is organisation looks into complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right.
ToR	Terms of Reference
Trust Board Directors	Made up of mix of Executive and Non-Executive Directors. The main role is to provide coherent leadership and direction of the organisation as well as holding collective responsibility for the Trust's performance
Trust Board Sub-Committees	Several Committees which support the work of the Trust Board. Each of these Committees is chaired by a Non-Executive director, reports directly into the Board and provide assurance over key matters pertinent to that committee. These committees escalate emerging issues for the Trust Board's attention.

Annex 4: References

Bewick M (2023) University of Birmingham NHS Foundation Trust Phase 1 Review – Clinical Safety IQ4U

NHS England (2023) Code of Governance for NHS Provider Trusts NHS England » Code of governance for NHS provider trusts

NHS Improvement (2017) Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts June 2017. Accessed 16 March 2023 Accessed -led_guidance_June_2017.pdf (improvement.nhs.uk)

UK Census (2021) Ethnic Minority Data, Birmingham Accessed 24 April 2023 How life has changed in Birmingham: Census 2021 (ons.gov.uk)

NHSE Well-Led Review 2023
Action Plan

KLoE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?						
NHSE Recommendations **R1.** Review the Executive Director portfolios to ensure clear accountability and ensure this is clearly communicated to all staff and relevant stakeholders. A national and transparent recruitment process should be started quickly to appoint a Chief Executive. **R2.** Review and refine the Trust Board development programme to ensure it addresses any areas for improvement identified from the safety and well-led reviews. This should specifically include the effective operation of a unitary Board. **R3.** Implement a mandated and rolling development programme for Governors from a recognised external provider.						
Ref. No.	**Action**	**Person Responsible**	**Deadline**	**Progress**	**Status**	**Evidence**
R.1.1	Review Executive Director Portfolios.	Interim CEO	n/a	Review of portfolios undertaken in May 2023. Restructure of Exec Team to reduce from 14 to 12 including five new positions including four Hospital Executive Directors	Complete	EARC 12/05/2023
R.1.2	On completion of consultation process, communicate changes to staff via Comms channels, and ensure structures are amended on Trust intranet site.	Director of Communications (DComms)	07/07/2023		On-going – dependent on above	Use Comms when done
R.1.3	Initiate recruitment process for	Chair	n/a	Recruitment process started	Complete	EARC 12/05/2023

	substantive Chief Executive.			May 2023. Interviews taking place first week of July 2023.		Staff Comms – 16/05/2023
R.2.1	Document Board Development Programme and present at June Board Seminar.	Chair	22/06/2023	Presented at Board Seminar on 9th June 2023.	Complete	Copy of plan.
R.3.1	Appoint external provider for Governor Development Programme.	Chair	07/07/2023	NHS Providers undertaking development programme.	Complete	Ask DB for it
R.3.2	Creation of Governor Development Programme.	Chair	27/07/2023	Governor Training Group creating a Governor Development Programme to be approved at Council of Governors on 27/07/2023	On-going	Copy of programme.

KLoE 2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?

NHSE Recommendation

R4. Develop a Trust wide strategy in consultation with staff and system partners that reflects the current challenges and future opportunities faced by the Trust, which in turn shapes the Board and Board-committee agendas.

Ref. No.	Action	Person Responsible	Deadline	Progress	Status	Evidence
R.4.1	Complete the review and amendment of the current Trust-wide strategy.	Chief Strategy and Projects Officer (CSPO)	30/09/2023	Board engaged at seminars on 27/04/2023 and 09/06/2023 to refresh strategy and agree top lines.	On-going	Slide decks from 27/04/2023 and 09/06/2023.
R.4.2	Define the strategic objectives for the organisation.	CSPO / All Board members	30/09/2023	Board engaged at seminars on 27/04/2023 and 09/06/2023 to refresh strategy and agree top	On-going	Slide decks from 27/04/2023 and 09/06/2023

				lines.		
R.4.3	Identify the risks to delivering strategic objectives.	CSPO / Corporate Risk Lead (CRL)	03/07/2023	Will form part of the Board Seminar on 03/07/2023 which is focussing on risks.	On-going	Slide decks from 03/07/2023.
R.4.4	Identify the consultation process with relevant stakeholders, such as staff, patients and external organisations.	DComms / CSPO	n/a	Consultation plan agreed at Board Seminar on 09/06/2023.	Complete	Slide decks from 09/06/2023.
R.4.5	Agree implementation plan to deliver revised strategy across the organisation.	CSPO	30/09/2023	The implementation plan will be created following the review and amendment of the strategy.	On-going	Copy of plan.
R.4.6	Agree method by which performance against the strategy will be monitored.	CSPO	30/09/2023	The Board, supported by the Finance and Performance Committee, will monitor the performance against the strategy.	Complete	ToR of Finance and Performance Committee.

KLoE 3: **Is there a culture of high-quality, sustainable care?**

NHSE Recommendations

R5. Ensure that staff can operate in environments that are psychologically safe where poor behaviours are consistently addressed and bullying and cronyism are eradicated at all levels of the organisation.

R6. Ensure that the Trust culture develops to embrace learning from internal and external sources to improve outcomes for patients.

Ref. No.	Action	Person Responsible	Deadline	Progress	Status	Evidence
R.5.1	Review HR Governance Model to ensure it is able to prevent, and identify, any opportunities for cronyism.	Chief People Officer (CPO) / Deputy	30/06/2023	Under review in line with deadline.	On-going	

		Director of HR (DDHR)				
R.5.2	Review outcomes of HR investigations to understand where there may be inconsistencies in the management of poor behaviour.	CPO/DDHR	30/06/2023	Under review in line with deadline.	On-going	
R.5.3	Review training programme for staff who line manage to ensure they understand how to manage poor behaviour consistently with Trust process.	CPO /DDHR	30/06/2023	Under review in line with deadline.	On-going	
R.6.1	Ensure that the external cultural review of the organisation has the following included within their scope / terms of reference: a. focusing on listening to and engaging with as many staff as possible ensuring psychological safety; taking positive action to improve how it feels to work and thrive at UHB, b. identify any systemic issues, practices or processes, organisational development and other gaps that need urgently addressing and a framework to address them	CPO	25/05/2023		Complete	ToR for the review
R.6.2	Following the outcome of the external review, agree actions based on	CPO	30/09/23		On-going	

	recommendations.					

KLoE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?						
NHSE Recommendations **R7.** Improve the governance and accountability by improving systems, processes at meetings, to gain assurance against delivery of the strategic objectives. • Review the workplans for the new and the existing committees to ensure they are driven by the strategic objectives and the agenda items provide assurance for the relevant BAF risk. Ensure that action logs are consistently used across the Trust. • Review Terms of reference of leadership meetings to ensure Divisional Directors of Nursing and Midwifery and senior AHPs are included and attend the meeting. • Work with the NHS England FTSU team on the areas that need strengthening, as identified in December 2021 and commission the NHS England FTSU team to undertake an evaluation in Q4 23/24. • Improve the governance process for external reviews. This needs to include timely discussion, oversight and review of progress at the relevant Board sub-committee and or the Trust Board as appropriate. The Trust must also ensure learning from these reviews are effectively communicated to relevant staff.						
Ref. No.	**Action**	**Person Responsible**	**Deadline**		**Status**	**Evidence**
R.7.1	Identify elements of strategy and BAF which need to be covered at Board and Committee meetings, and include in work plan of the meetings.	Director of Corporate Affairs (DCA) / Head of Operational Support (HOS)	03/07/2023	Will form part of the Board Seminar on 03/07/2023 which is focussing on risks.	On-going	
R.7.2	Review current Board and Committee meeting cycles to ensure alignment with	Chair	April		Complete	Committee Calendar

	other meetings that report into them.					
R.7.3 R.8.2	Review process of current Board and Committee meetings to include actions logs, level of assurance, impact on BAF / Strategy, how strategic risks drive Trust Board and sub-committee agenda submission and content of papers, and level of detail of minutes - and document the new process.	Chair/DCA/HOS	30/07/2023	Initial review undertaken. Additional external secretariat resource and support is to be externally provided.	On-going	
R.7.4	Identify at which other Trust meetings, such as senior executive level ones, the new meetings process should be adopted.	Chair/HOS	n/a	Identified that new process will be adopted at Hospital Boards on new site-based operational model, as well as Board committees.	Complete	TBC from Moorhouse
R.7.5	Review attendance at Senior Management meetings in the Trust to ensure that they are inclusive. In particular, ensure that senior nurses and AHPs are included and attend.	Chair/HOS	n/a	Hospital Executive Boards and CDGs in new operational structure have increased inclusivity, including AHPs and nursing.	Complete	Moorhouse slides
R.7.6	Ensure that the Trust's Scheme of Delegation and Standing Financial Instructions are fit for purpose, and that they are reflected in an Accountability Framework that includes the responsibilities of those below executive level.	HOS/Chief Finance Officer (CFO)	31/08/2023	The documents are being reviewed as part of the hospital redesign work to reflect the new roles and accountability. An Accountability Framework is also in production to reflect the roles and responsibilities.	On-going	
R.7.7	A refresh of the FTSUG Guardian role and	Chair	n/a	The review has been completed	Complete	Board paper

	how the board interacts with this system. (linked to Bewick Action Plan)			and will be presented at Board on 12th July with the recommendation to approve.		
R.7.8	Review the current Trust 'Management of External Agency Visits, Inspections and Accreditations Policy' to assess whether external advisory reviews should be included within it, or whether a separate policy is required. Include within whichever document the requirement for a Senior Director has overall responsibility for each review and that for specific major Governance reviews a NED is also assigned for assurance.	Head of Clinical Governance and Patient Safety (HCGPS)	16/06/2023	LS has completed the review. Sign-off awaited from CLO.	Complete	Approved document.
R.7.9	Commission the NHS England FTSU team to undertake an evaluation in Q4 23/24	Chair	December 2023	Evaluation to be commissioned by the end of the year.	On-going	

KLoE 5: Are there clear and effective processes for managing risks, issues and performance?

NHSE Recommendation

R8. Review and update the Board Assurance Framework following the refresh of a Trust wide strategy to reflect the new strategic objectives. The Trust should also take action to improve the quality of discussion on risks and how strategic risks drive Trust Board and sub-committee agenda.

Ref. No.	Action	Person Responsible	Deadline	Progress	Status	Evidence
R.8.1	Review the BAF to ensure it reflects new strategic objectives.	CRL	Dependent on R.4.2	Once strategic objectives have been agreed (see action R.4.2) BAF will be reviewed.	On-going	

				In addition, current BAF will also be reviewed at Board Seminar on 3rd July which is focussing on risk.		
R.8.2 R.7.3	Improve how strategic risks drive Trust Board and sub-committee agenda	Chair/HOS/DCA	30/07/2023	This is incorporated into action 7.3, for which additional secretariat support is being provided.	See R.7.3	
R.8.3	Ensure that the review of the current governance structure of the organisation, in preparation for the Hospital Operational Model redesign work, includes consideration of how risk discussions can be effective, and demonstrate that strategic risks drive the agenda of the new Group Executive Board and its sub-committees.	HOS	01/10/2023	This will be included in the governance work being done for the hospital operational model redesign work.	Ongoing	
R.8.4	Review Trust risk appetite statement.	CRL	03/07/2023	This is being undertaken at the Board seminar on 03/067/2023	On-going	

KLoE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?
NHSE Recommendation **R9.** Improve the effectiveness of information to support decision making such as Trust Board reports, sub-committee and Divisional reports. Pay particular focus to how the information meets users needs and ensure it is accessible and understandable. Work with NHS England's Making Data Count Team to adopt a best practice approach to information using statistical process control. **R10.** Review the analytical team resource within the Trust and ensure there is sufficient capacity and capability to support the production of high quality information to enable effective decision making.

Ref. No.	Action	Person Responsible	Deadline	Progress	Status	Evidence
R.9.1 R.10.1	Engage NHSE Making Data Count to ensure reports are fit for purpose and meet requirements of Committees / Board.	HOS/ Head of Informatics (HOI)	n/a	Informatics have met with the Making Data Count team. The use of SPC is now being rolled out to UHB reports. UHB staff have been asked to present the work on SPC as best practice to other NHS organisations. Making Data Count team will also be asked to attend a Board Development day to work with the Board.	Complete	TBC with CS
R.9.2 R.7.3	Ensure information presented to Board leads to appropriate Action Plans and measurement / tracking / follow up plans.	Chair/DCA/HOS	30/07/23	This action will be incorporated into action 7.3 with the support of external secretariat resource.	See R.7.3	
R.9.3	Review quality of data in Operational Performance and Productivity reports to ensure key points are highlighted & regulatory requirements are met, at the same time as ensuring that the data provided is consumable for Board members.	HOI / Head of Strategy (HOS)	n/a	New SPC format is in use for Operational Performance, and Productivity reports.	Complete	Operational Performance Report and Productivity Report

R.9.4	Identify other reports (such as workforce) for Board and committees which require a review of the quality of data to ensure key points are highlighted & regulatory requirements are met, at the same time as ensuring that the data provided is consumable for Board members.	Chair	n/a	Initially Finance & Performance Committee was identified and the new format of reports are in use. The Quality and Safety Committee are now introducing the new report format. The People and Culture Committee, and the Board, have been identified as also requiring changes to the reports.	Complete Ongoing	TBC with YB

KLoE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?
NHSE Recommendation **R11.** Trust Board Directors and senior leaders to engage more often and openly with all staff and foster a collaborative, inclusive and compassionate leadership culture. **R12.** Ensure that Trust Board meetings held in public create time for questions from members of public, including ad hoc questions. **R13.** Trust Board to continue to improve relationships with external partners and foster a positive and open culture. **R14.** Ensure appropriate arrangements are in place for Governors to have their questions from constituents fully heard and act in accordance with the Code of Governance for NHS Provider Trusts **R15.** Ensure that all communication on websites and patient information is reflective of the most used languages in the community that the Trust serves.

Ref. No.	Action	Person Responsible	Deadline	Progress	Status	Evidence
R.11.1 R.13.1	Brief the NEDs on the current programme of staff and stakeholder engagement so that everyone thoroughly understands how the Trust reaches out to those who use the services, staff, and external partners.	DComms	25/05/2023	At a Board Development session on 25/05/2023, this was discussed with the NEDs.	Complete	Slides 25/05/2023
R.11.2	Board discussion on the stakeholder map to understand the engagement landscape and share networks/contacts so that existing relationships can be used to support the Trust. Agree how to do this so that there is consistent messaging, central intelligence on key contact engagement, how feedback will be captured, etc.	DComms	25/05/2023	At a Board Development session on 25/05/2023, this was discussed with the NEDs.	Complete	Slides 25/05/2023
R.11.3	Look at introducing some form of "You said ….. We did ……" mechanism to existing staff/stakeholder engagement channels. Try to engender trust by showing that we are listening and acting.	DComms	n/a	'You said…we did' has been introduced at the organisation.	Complete	Comms plan
R.11.4	Re-set the values and define behavioural expectations (enabling behaviours/de-railing behaviours) amongst all leaders, starting with those most senior) across the organisation (circa 4,000) to ensure that they know how they're expected to	DComms	n/a	The requirements of this action have been included in the new 'Welcome to Leadership' plan and pack which is going live in June 2023.	Complete	Copies of the 'Welcome to Leadership' content

	act – and reinforce the need for them to lead from the front.			There may also be additional work, contingent on the outcome of the Cultural Review.		
R.11.5	Find a way of introducing the NEDs to staff through some form of staff engagement but focus on them as human beings: explain the emotive 'why' about their involvement and what motivates them.	DComms	n/a	A programme has been agreed to involve NEDs in events throughout the organisation over the coming months.	Complete	See 'Events' work email with NEDs
R.12.1	Review time allocated to public board meetings, and agenda contents.	Chair	n/a		Complete	Last agenda BoD
R.13.1	Raise the patient/staff voice in the Board Room. Find ways of making sure that Board Meetings become more patient/staff centred so that decisions are made with them in mind. Could be playing patient videos or getting staff to talk to the Board about their experience and their customer journey.	DComms	n/a	The Board meetings now have a patient story as part of the agenda. The People and Culture Committee will have a staff story.	Complete	Agendas

KLoE 8: Are there robust systems and processes for learning, continuous improvement and innovation?						
NHSE Recommendation **R16.** Improve the support available to staff undertaking improvement work via a trust wide quality improvement approach. **R17.** Ensure all staff have adequate time, support and encouragement to undertake learning and development.						
Ref.	**Action**	**Person**	**Deadline**	**Progress**	**Status**	**Evidence**

No.		Responsible				
R.16.1	Utilising support from NHS Impact, determine the optimal Quality Improvement approach to be adopted across all of UHB.	Chief Medical Officer (CMO) Deputy Chief Medical Officer (Dep CMO)	31/07/2023	As well as considering NHS Impact approach, the Trust is utilising experience from across the NHS. Meetings have been held with other similar Trusts.	On-going	
R.16.2	Develop a governance model to ensure effective Quality Improvement across UHB.	CMO/Dep CMO	31/07/2023	This action is dependent on R.16.1.	Ongoing	
R.17.1	Realign teams across UHB that are currently involved in the Quality Improvement agenda to ensure effective delivery of integrated support for QI work.	CMO/Dep CMO	31/07/2023		On-going	
R.17.2	Roll out an implementation plan to ensure the correct structure, methodology and education is in place.	CMO/Dep CMO	30/09/2023	This implementation plan will be ready to roll out when the new hospital structure is live in October 2023.	On-going	