Dudley Group NHS Foundation Trust

Independent review of allegations made in relation to poor communication and lack of engagement with clinical staff and alleged bullying and intimidation by the leadership team

Capsticks Solicitors LLP
35 Newhall Street
Birmingham
B3 3PU

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Birmingham B3 3PU

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Part 1. Executive summary

1. We have conducted an independent investigation of allegations made in relation to poor communication and lack of engagement with clinical staff and alleged bullying and intimidation by the leadership team at Dudley Group NHS Foundation Trust (the "**Trust**") as per the requirements of the Trust's Specification.

2. The investigation was commissioned following the receipt of an anonymous letter (the "**Anonymous Letter**") from staff at the Trust raising concerns about the Trust senior management team.

3. Specifically, we were commissioned by the Trust to review the following two areas of concern that were raised in the anonymous letter:

   i) Trust response to concerns raised regarding poor communication and lack of engagement with clinical staff by the leadership team.

   ii) Cultural / systemic issues and the alleged culture of bullying and intimidation.

4. Due to the concerns in the letter being raised on an anonymous basis Capsticks were at no point notified of the identity of the signatories to the letter and therefore were not aware whether those we interviewed during the investigation had signed the letter unless they informed us of this at interview.

5. We adopted the following methodology, further details of which are set out in Appendix III, in undertaking our investigation:

   - A desktop review of over 1000 documents obtained from the Trust;
   - Interviews with 43 Trust staff either in person or by telephone;
   - Interviews with the 4 Executive Directors of the Trust who were named in the anonymous letter;

- A series of focus groups with specific staff groups; Non-Executive Directors and Governors.

6. The Trust provides hospital and adult community services to the populations of Dudley, significant parts of Sandwell borough and communities in South Staffordshire and Wyre Forest.

7. The Trust faces significant challenges in respect of the safety, responsiveness and quality of its services. It has an overall Care Quality Commission (CQC) rating of "Requires Improvement". Urgent and emergency services were rated as "Inadequate" in CQC's report of April 2018 which followed an unannounced inspection between 4th December 2017 and 18th January 2018. In addition, CQC has imposed several conditions on the Trust's registration pursuant to Section 31 of the Health and Social Care Act 2008. The findings of this report need to be viewed in the context of these challenges.

8. During 2017 and 2018 there was a significant turnover of Executive Directors at the Trust with new appointments made to the posts of Chief Executive, Medical Director, Chief Nurse, Director of Finance, Chief Operating Officer and Director of Strategy and Business Planning.

9. We were provided with extensive evidence of the efforts made by the new Leadership Team to promote improved engagement with staff. In addition, there was documentary evidence including the Deloitte Well Led Review and the CQC inspection report of April 2018 indicating that Trust staff consider that engagement has improved under the current Executive team. The CQC inspection was based on interviews with a greater number of Trust staff than participated in this investigation.

10. However, it is clear from our investigation that there are staff within the Trust who do not feel that they have been engaged effectively by the current Leadership team. This is apparent from the contents of the anonymous letter that had 42 signatories and prompted this

investigation, as well as feedback from some interviewees and some of the documentary evidence reviewed. It is difficult to assess how representative these views are of the Trust's staff as a whole.

11. Effective engagement has also been challenged by the need to comply with urgent registration requirements imposed on the Trust by CQC. Whilst we have seen evidence of staff engagement in responding to CQC requirements, given the tight timescales imposed by CQC it is understandable that engagement may not have been as widespread as some may have hoped for.

12. Concerns were also raised in the Non-Executive Director focus group about the Leadership team's engagement with staff, and whether the leadership team was receptive to challenge and the raising of concerns.

13. Engagement with clinical staff was a particular concern that was raised with us by some interviewees. However, we found that the opportunities for consultants to influence clinical and operational policy have increased under the new Leadership Team and that efforts are made to involve the most appropriate clinicians in decision-making.

14. The Trust is already arranging mediation between its Leadership team and Consultants and both parties need to play an active part in this if it is to be successful. As is noted in an Invited Service Review of the Trust's adult emergency medicine service by the Royal College of Physicians (RCP) "*Clinical engagement is a two-way process where doctors and managers need to work together and there are issues here on both sides.*"

15. Although it was suggested that there was limited clinical representation on the Board, our review found that the clinical representation on the Trust Board is at least commensurate with the level of such representation that we would expect to find in Trusts of a similar profile.

16. The Trust is organised into three clinical divisions and in common with other similar Trusts has a “Triumvirate” management structure in place in each of its clinical divisions, comprising a Chief of Service, a Divisional Chief Nurse and a Divisional Director of Operations.

17. Our investigation suggests that the current “Triumvirate” management teams have been inconsistent in acting as a bridge between the Leadership team and frontline staff, which may have contributed to some staff feeling disengaged with management. We have been told that this will be addressed when current Chief of Service tenures come to an end in March 2019 and a new structure and method of remuneration with additional time and development is put in place.

18. Particular concerns were raised with us about the extent of staff engagement in the Trust’s response to matters raised during recent CQC inspections. Whilst it was apparent that some actions needed to be taken at short notice in order to meet regulatory requirements, we were satisfied that there had been engagement with staff in respect of these matters.

19. During the course of our investigation we were told that there had been limited clinical engagement in respect of several specific service changes at the Trust, and that this had resulted in poor clinical governance of those changes. We therefore looked in detail at the following changes:

- The Digital Trust Project;
- Changes to the paediatric service in order to provide a 24-hour emergency service; and
- The establishment of the Immediate Admissions Unit (IMAU).

20. We found evidence of clinical engagement in respect of each of these changes. In the case of the paediatric changes, it was necessary for the Trust to take immediate action in order to meet CQC requirements, and

this may have limited the extent of the engagement undertaken. With regard to the Digital Trust Project, it is apparent that there were challenges with the delivery of the project but it was clear from the documentary record that the Board was sighted on these and took steps to appraise itself as to the risks involved. We did not find poor clinical governance as a consequence of a lack of engagement in respect of this programme. In the case of the IMAU, concerns in respect of the IMAU had originally been identified in an internal Quality and Safety Review. An action plan had been prepared by the Trust to address these concerns and the Medical Director had requested further audit and assurance. However, at the time of the CQC inspection similar concerns were raised by the inspectors and the unit was closed shortly afterwards.

21. Concerns were also raised regarding the Trust's decision to reduce the Trust's "core bed base" during the latter part of 2017. Interviewees felt that this impacted on the Trust's ability to meet the national A&E "4 hour wait" target. We were provided with an explanation of why some beds were closed by the Trust during this period, including reductions in non-elective length of stay and concerns about Evergreen ward, which was a ward for patients awaiting transfer to local authority care provision. Whilst some of these changes were discussed at meetings of the Medicine and Integrated Care Divisional Management Committee; the Clinical Quality Safety and Patient Experience Committee (CQSPE) and the Board it was not clear from our investigation at which of the Trust's decision-making forums the decision to reduce bed numbers was actually taken.

22. Interviewees noted that there had been a significant turnover of executive Board members during 2017 and 2018. Having considered the circumstances in which directors left the Trust during this period we did not find any cause or concern in respect of this turnover.

23. Some interviewees commented that several members of the new Leadership team knew each other from previous roles, and questioned whether appropriate recruitment procedures had been followed in respect of these appointments.

24. We therefore reviewed the appointment arrangements for all executive appointments made by the Trust from the date of appointment of the current Chief Executive. We noted there had been a rapid turnover of executive directors but did not find any cause for concern in respect of the departure of directors. With regard to incoming directors, whilst several directors had either worked together or known each other previously it was clear that all appointments had been advertised externally; most had involved an external assessor; and had been made by both Executive and Non-Executive Directors of the Trust. We were satisfied that the appointments to the executive team followed appropriate recruitment procedures.

25. A further concern raised was that the Trust had not addressed evidence of excess staff workloads, and this had led to an unreasonable approach to job planning for consultant staff.

26. Many of those we spoke to indicated that staffing was a challenge, particularly in respect of the Emergency Department. However, it was clear that the Leadership team was well aware of this issue and actively addressed staff shortages. Three new Emergency Department Consultants were appointed in 2017/18 alongside an investment of over £1.5 million in nursing staff.

27. The Leadership team had prioritised the implementation of formal job planning, and invested in a software solution to assist with this. We did not find evidence of unreasonable approaches to job planning being adopted by the Trust.

28. There had been discussions with clinicians about the impact of annual and study leave on the Trust's performance. A particular issue had been identified in ophthalmology, following some serious clinical incidents where patients had suffered significant loss of sight as a result of delays in follow-up treatment due to the backlog of appointments. The Chief Executive enquired about the levels of annual leave and study leave that were being taken, and subsequently met with consultants to seek a solution. As a result of this meeting, the consultants had agreed to a phased reduction in study leave and a temporary cessation in other professional leave.

29. During the course of the investigation we reviewed the Trust's processes for raising concerns. The Trust has a Raising Concerns Speak Up Safely (Whistleblowing) Policy that is broadly consistent with the policy issued by NHS England and NHS Improvement. The Chief Executive has overall responsibility for the policy, with the Board responsible for monitoring compliance. The Trust has appointed Freedom to Speak Up (FTSU) Guardians as an independent source of advice to staff. They provide regular reports to the Board. In addition, there are Freedom to Speak Up Executive and Non-Executive Leads who are responsible for providing assurance to the Board that the organisation has an embedded organisation-wide framework for staff to feel free to speak up and raise concerns. The Non- Executive Lead is responsible for challenging the Executive Directors for this assurance.

30. Having reviewed the number of concerns raised through the Trust's FTSU processes we found that the Trust was not an outlier in respect of the number of concerns raised when compared with other local Trusts or available national data. In addition, there was evidence that where concerns were raised through the FTSU Guardians effective management action was taken to address those concerns.

31. However, our investigation indicated that some of the Trust's staff did not have trust and confidence in these processes for speaking out. Some felt

that they were not encouraged to speak up, whilst for others this loss of confidence arose from a perception that the FTSU Guardians were managerially accountable to the Chief Nurse, and therefore they were inhibited from raising any concerns relating to the Chief Nurse. As a consequence, some staff have chosen to raise concerns with the Trust Chaplaincy Service rather than the FTSU Guardians. The Chaplaincy Service reports to the Head of Patient Experience who is also accountable to the Chief Nurse. Despite having weekly meetings with the Chief Executive and a number of meetings with the Medical Director, the Chaplaincy Team Leader did not raise these concerns with them.

32. A further concern raised during the investigation was that meetings of the Joint Local Negotiating Committee (JLNC) had been cancelled without good reason, and that the JLNC had not been properly involved in the updating/amendment of some Trust policies. Whilst we found there was a gap of 9 months between JLNC meetings in 2018, this was due to the high number of apologies for one meeting, and a diary mix-up for the next. However, it does appear that certain Trust policies had been implemented without discussion at the JLNC although some of these proposed changes were circulated for comment by email prior to implementation.

33. We do not conclude that that there is a systemic culture of bullying and intimidation by the Trust leadership. The available data in respect of staff experiencing harassment and bullying from other staff within the Trust is below the national benchmark.

34. It was acknowledged by both Executive and Non-Executive Directors that difficult messages needed to be delivered to the organisation in order to make the necessary improvements to performance and safety that were identified by the new Leadership team on appointment, and also highlighted by CQC during its inspections of the Trust in 2017 and 2018. The need for urgent changes was also contributed to by the imposition of conditions on the Trust's CQC registration, which in some

cases required an immediate response that did not allow for widespread engagement. However, interviewees told us that the new Leadership team has adopted a direct management style, which has been described by some as aggressive.

35. We do, however, consider that given the number of consistent accounts from those interviewed, there have been instances of behaviour by members of the Leadership team that were perceived by others as bullying and harassment. Many of those interviewed made reference to this alleged behaviour, although the allegations were not supported by any documentary evidence other than two undated anonymous letters referred to later in this report.

36. Our terms of reference did not require us to form conclusions on any individual claims of bullying or harassment; and we do not consider that there are any specific allegations of bullying and harassment that require further investigation by the Trust.

37. The two anonymous letters referred to alleged bullying behaviour by the Chief Nurse. Upon receipt of the first of these letters, the Chief Executive had a one-to-one discussion with the Chief Nurse but did not feel that any formal action was required. It is acknowledged in the Trust Raising Concerns Policy that when concerns are raised anonymously it can be difficult to investigate them further. The Trust subsequently confirmed the Chief Nurse as a substantive appointment.

38. We also considered concerns that staff were afraid to report incidents and that where incidents were reported they were downgraded by the Leadership team. Our investigation found that the Leadership team had in fact focussed on improving incident reporting and investigating incidents promptly although we were told by some interviewees that they were nevertheless reluctant to report incidents because of fear of intimidation.

39. It will be essential in order to rebuild trust and confidence in the Trust's formal processes that there is no suggestion that anyone who has provided information as part of this investigation should be subjected to any detriment as a consequence.

40. Finally, we were provided with evidence of members of the leadership team adopting role model behaviour. However, an issue that was raised with us consistently during the investigation was that members of the Leadership team had failed to display role model behaviour by regularly using disabled parking bays when parking at the Russells Hall site. Members of the Leadership team confirmed that this had occurred, although they cited some mitigating factors. Nevertheless, it is unfortunate that the Leadership team provided this poor example to other staff of the Trust.

41. On the following pages we set out our key findings and recommendations.

Part 2. Summary of Findings

Phase 1 - Trust response to concerns raised regarding poor communication and lack of engagement with clinical staff by the leadership team.

a) To investigate the allegations that there has been poor communication and a lack of clinical engagement with clinical staff where required and to consider whether:

1(a)(i)clinical staff are sufficiently represented and engaged by the leadership team/s and executives (for example Medical Director/Director of Nursing), enabling them to be involved effectively in decision-making

42. Whilst there is evidence of considerable efforts by the new Executive team to promote greater engagement, it is apparent from the Medical Engagement survey, the anonymous letter of concerns and some of the feedback we received from interviewees that some of the Trust's staff, including in particular some of the consultant body, do not feel that they are effectively engaged by the Trust's leadership.

43. It is difficult for us to judge how widely-held this view is given the limited number of staff that we interviewed as part of the investigation. However, the Medical Engagement survey which compared levels of medical engagement at the Trust with those from a substantial sample of NHS Trusts indicates that levels of engagement are notably low. We appreciate that this was the first time that the survey had been undertaken, and therefore it established a baseline measure of clinical engagement that may in part be attributable to a long-standing culture. Whilst the Medical Engagement Survey was discussed at the Executive Team meeting, Workforce Committee and Clinical Quality, Safety and

Patient Experience Committee (CQSPE) it does not appear to have been discussed by the Board in either public or private session.

44. The CQC Inspection Report of April 2018 noted that most staff felt that communication from the executive team had improved and referred in particular to the hard work of the Medical Director in trying to engage medical leaders. The concerns expressed by some of those we interviewed about the lack of clinical engagement are therefore not shared by all staff.

45. It should be noted that despite the numerous groups and/or opportunities that the Chief Executive, Medical Director, Director of Governance and others identified as modes of engagement, there clearly remain some staff within the Trust who do not feel that the Leadership team is engaging effectively with them. It should be emphasised that this view is not limited to staff in the Trust's Emergency Department. The need for improved staff engagement was recognised by the Trust in its response to the 2017 national Staff Survey. An action plan was developed and approved by the Board in July 2018.

46. We acknowledge, as reported by the Invited Service Review in respect of adult emergency medicine that engagement is a two-way process, and clinical and other staff share responsibility with the Leadership team for achieving improved engagement.

47. The perceived lack of engagement is in our view exacerbated by an inconsistent approach to engagement within the clinical divisions, and through each division's triumvirate structure.

48. Engagement has also been compromised by the need to comply with urgent registration requirements imposed on the Trust by CQC. Whilst we have seen evidence of attempts to engage clinical staff in developing action plans in response to these requirements, given the tight timescales imposed by CQC it is understandable that engagement

may not have been as widespread and considered as some may have hoped for.

49. With respect to the concern around clinical representation on the Executive Board, we find that the clinical representation is at least commensurate with the level of clinical representation that would be found elsewhere in Trusts of a similar size.

1(a)(ii) because of the failure to engage clinical teams, there is poor clinical governance of engagement in change and operational policy, including any undue reliance on external consultants

50. Some changes have been made in respect of clinical services with limited clinical engagement. On occasion this has been due to the need to take immediate action in order to comply with CQC registration requirements. Of these changes, the decision to open the IMAU was subsequently reversed following concerns raised by CQC. Similar concerns had initially been identified by an internal Quality and Safety Review several weeks earlier. An action plan had been prepared to address these concerns and the Medical Director had requested further audit and assurance.

51. We do not consider that there has been undue reliance on external consultants. Where external consultants have been engaged this has reflected the limited internal management capacity to take on the projects concerned. However, on the basis of comments from some of those interviewed we feel that the use of external consultants may have contributed to the feeling on the part of some staff that they had not been engaged, particularly where there has been limited explanation as to why these external consultants have been brought in, and what the outputs of their consultancy work have been. By way of example, several interviewees expressed the view that there had been a lack of

communication about the introduction of external consultants FourEyes to undertake work in the Trust.

1(a) (iii) the quality and financial impact assessment undertaken for significant service changes since April 2017 involved all appropriate stakeholders; there is evidence of appropriate learning and adaptation because of that involvement

52. It is clear from the various minutes that we have reviewed that a range of stakeholders were involved in decision-making in respect of proposed service changes, although these minutes do not generally evidence the extent of stakeholder involvement in the development of the various proposals.

1(a)(iv) the Trust's approach to the management of organisational change, included the line of sight through to the Board and Council of Governors and whether the associated policies and procedures were followed when implementing any significant changes or appointments

53. Whilst we acknowledge that it may have appeared to some within the Trust that there had been a rapid turnover of executive directors, on the basis of the evidence that we have considered we do not find any cause for concern in respect of the departure of directors.

54. Some of those appointed to the Leadership team were known to the Chief Executive prior to their appointment, and this may have contributed to a perception on the part of some staff that the Chief Executive had appointed acquaintances and former colleagues to key director roles and that those appointees would therefore be unlikely to question her decisions and leadership style. We are, however, satisfied

that the appointments to the executive team following the Chief Executive's appointment in April 2017 followed appropriate recruitment procedures.

1(a)(v) there was a failure to act on evidence of excess workload of different staff groups, because of either system or other changes leading to unreasonable approaches to job planning

55. We did not find that there was a failure to act on evidence of excess workload of different staff groups. On the contrary, the new Executive team was well aware of this issue and the documentary record indicates that they actively addressed staff shortages within the Trust.

56. We also did not find evidence of unreasonable approaches to job planning. Historically, there had been very low take-up of formal job planning within the Trust and the steps taken to address this appear to us to have been reasonable.

1(a)(vi) the trust has in place the appropriate and robust channels for staff to feedback any concerns they have regarding organisational change, service change or patient safety; the trust has responded to those concerns at all levels including executive, Board and Council of Governors

57. The Trust has appropriate channels for staff to feedback any concerns they have, and there is evidence that when concerns have been raised through these channels they have been responded to at appropriate levels, including by the Chief Executive. The available data indicates that the raising of concerns through the Trust's Freedom to Speak Up (FTSU) processes are in line with local and national norms.

58. However, we are concerned that these channels are not regarded by some staff as being robust and reliable, and have been bypassed on some occasions, with staff preferring to raise their concerns with the Chaplaincy service or by writing anonymous letters.

59. It is unfortunate that during a period of major change and challenge for the Trust JLNC meetings did not occur for a period of approximately 9 months, and that some changes to policies were introduced without discussion at JLNC meetings. We acknowledge that there were genuine reasons for the cancellation of the meetings. In addition, some of the proposed changes to policies were circulated for comment by email prior to implementation.

1(a)(vii) there has been engagement with clinical staff regarding the management of CQC requirements, resulting from their inspections

60. We find that there has been engagement with clinical staff regarding the management of CQC requirements even where those requirements have required an immediate response. It is hoped that as the urgency of CQC requirements reduces, there will be more time available for the Trust leadership to engage more comprehensively with those that do not feel they have been engaged effectively in response to CQC's requirements to date. There is also a need for senior staff in the Emergency Department in particular to engage more effectively in respect of the required standards of quality and safety.

Phase 2 - Cultural / systemic issues and the alleged culture of bullying and intimidation.

a) To investigate the allegations that there is a culture of widespread bullying and intimidation of staff. To consider whether:

2(a) (i) there have already been incidents since April 2017 of bullying and intimidation reported through the trusts current processes and there is evidence of appropriate learning and adaptation because of that reporting

61. There have been incidents since April 2017 of bullying and intimidation reported through the Trust's current processes. We note that these incidents have been considered further by the executive team. Some of the matters were referred to the HR department and all were resolved without any requirement for a formal investigation. Without further detail of the incidents in question we are unable to say whether this was an appropriate response.

2(a)(ii) there is evidence of widespread bullying and intimidation of staff by executives, and other senior staff at the trust, and whether any specific allegations of such bullying and harassment require further investigation

62. A number of allegations have been made of behaviour perceived as bullying and intimidation of staff by members of the Leadership team. These allegations have not been substantiated, although we received similar accounts of this behaviour from a number of those interviewed.

63. Our terms of reference did not require us to form conclusions on any individual claims of bullying or harassment, but to identify any broad areas of concern and draw attention to any cases that do not appear to have been properly investigated through the trust's own procedures. We do not consider that any specific allegations of bullying and harassment were raised during our investigation that require further investigation.

64. A number of allegations of bullying and intimidation of staff, primarily by the Chief Nurse but also by the Medical Director, were raised with us.

Both the Chief Nurse and Medical Director refuted these allegations. The allegations have not been subject to any investigation within the Trust and insufficient detail has been provided in most cases to enable any further investigation of the allegations to be made. Where some details have been provided our further enquiries have not identified any specific allegations that require further investigation by the Trust. It was in any event beyond the scope of our terms of reference to investigate specific allegations.

65. We were also provided with a letter from a member of staff who had left the Trust and who said that she had raised allegations of bullying and harassment by her line manager and others and stated that "*one thing I have found to my detriment is that if you're in high places you can be untouchable*". This member of staff indicated that no action was taken in response to the concerns she raised although her letter did not indicate who she had raised her concerns with.

2(a)(iii) there is evidence that staff are afraid to report incidents, incidents being downgraded and that patient safety concerns are minimised

66. Whilst there has been a drive from the leadership team to close down incidents, the documentation that we have reviewed suggests that this has been in an effort to comply with the prescribed timescales for the reporting and analysis of those incidents rather than in order to suppress information. The leadership team has focussed on encouraging a reporting culture within the Trust, and we do not find that there have been attempts to minimise reporting of patient safety concerns.

67. We are however concerned on the basis of comments made by some of those interviewed that there may be staff who are afraid to report

adverse incidents and that this is consistent with evidence we heard of staff being afraid to use the Trust's formal Speak Up processes.

2(a)(iv) there is evidence that staff do not trust the effectiveness of (and therefore are not using) the Trust's own bullying and harassment or whistleblowing policies

68. There is evidence that some staff do not trust the effectiveness of the Trust's bullying and harassment or whistleblowing policies and therefore are not using them. We were told that a number of people have approached the chaplaincy service instead of going through the established channels for raising concerns.

2(a)(v) the Trust has taken sufficient steps to ensure that the leadership team display role model behaviour

69. We did receive evidence that members of the leadership team display role model behaviours, and that this has been recognised both within the Trust and externally. One issue raised with us was of members of the Leadership team inappropriately parking in disabled parking bays. Whilst we noted there were some mitigations for this behaviour it was frequently cited by interviewees as an example of members of the Leadership team not acting as role models.

70. In addition, Non-Executive Directors of the Trust reported that Executive behaviour was not promoting a positive culture within the Trust, and that challenge was not encouraged by the Executive team.

2(a) (vi) the Trust's leadership has taken steps to deliver a positive change to its speaking up culture

71. We conclude that the Trust leadership has sought to promote a speaking up culture and there is evidence that the number of concerns raised under the Freedom to Speak Up process has increased under the current Leadership team and is in line with local comparators. However, some staff believe that this is a superficial approach and do not have trust and confidence in the Trust's formal processes.

2(a) (vii) the Board has assessed the impact of the significant turnover in executive and senior management and clinical leadership at trust; and what risk assessment and mitigations it has put in place for current and future possible changes

72. Our enquiries satisfied us that appropriate recruitment processes were followed for all Executive appointments.

73. The Trust has invested in significant leadership development in order to strengthen its leadership capacity in line with the recommendations in the Deloitte Well Led Review. In addition to a Board Development programme the Trust has implemented an Executive Team Development Programme and a further development programme aimed at the divisional leadership teams.

2(a) (viii) the existing board development could be helpfully enhanced around the perceived dynamics between the leadership and the staff.

74. There were mixed views as to whether Board development could address the perceived dynamics between leadership and staff. Some felt that the relationship between the Leadership team and some clinicians

had broken down irretrievably. Others considered that relationships were potentially salvageable but that this would be challenging and would require much greater visibility and engagement on the part of the leadership team.

Part 3. Summary of recommendations

75. We make the following recommendations in respect of Phase 1 of the investigation - Trust response to concerns raised regarding poor communication and lack of engagement with clinical staff by the leadership team.

i. As a priority, Trust leadership and consultants should proceed with the planned mediation process.

ii. For the Trust Leadership to develop a programme to achieve effective engagement with all staff, focussing on the development of a more inclusive and listening culture.

iii. The consultant body to actively engage with the Trust leadership recognising the 2-way nature of effective engagement.

iv. The Medical Engagement Survey should be repeated in May 2019 and the Trust Board should receive the results of the survey and compare these with the results from May 2018.

v. To review the operation of the Triumvirate structure across the Trust's clinical divisions with a view to promoting consistent and effective engagement through the Triumvirates and to assess whether the membership of the triumvirates needs to be refreshed.

vi. To review the governance arrangements for engagement and decision making around service changes. In future, such decisions should be fully-documented, and it should also be clear what the appropriate decision-making forum is, and, if this is not the Board, how this forum will report in to the Board.

vii. To adopt the recommendations of the Invited Service Review in respect of Paediatrics if they have not already been implemented.

viii. To review the Freedom to Speak Up arrangements within the Trust in order to increase staff trust and confidence in those arrangements, including in particular ensuring that the FTSU Guardians are, and are seen to be, impartial and not capable of

being unduly influenced by any member of the Trust leadership team.

ix. To ensure that meetings of the JLNC take place on a regular basis and that the JLNC's role in reviewing policy changes is agreed, and observed consistently.

76. We make the following recommendations in respect of Phase 2 of the investigation - Cultural / systemic issues and the alleged culture of bullying and intimidation.

i. To ensure that where incidents of bullying and harassment are raised through the Trust's processes these are reviewed at an appropriate level within the Trust to ensure that there is appropriate learning and adaptation even if no formal action is taken in response to the incidents.

ii. To consider as a matter of urgency how the Trust can increase staff confidence in its existing processes for raising concerns and whistleblowing.

iii. To reaffirm the Trust's commitment to the values of the national FTSU policy and review the wording of its FTSU policy to consider whether this should more closely follow the national framework.

iv. To agree a protocol with the Chaplaincy Team about how it will report concerns in respect of bullying and harassment in order to enable effective action to be taken in response to those concerns.

v. To review the Trust's Board Development programme in the light of the findings of this investigation as a matter of urgency in order to incorporate into that programme:

a. The importance of Trust directors acting as role-models for the organisation;

b. Reflection by the Leadership team on the manner of their response to challenge and their overall approach to management;

c. The importance of Non-Executive Directors feeling empowered to challenge Executive colleagues effectively;

d. More effective engagement between the Trust leadership and its staff.

vi. To review and if appropriate refresh the Trust's development programmes for the Executive Team and divisional leaders in the light of the findings of this investigation.

Appendix I

Text of letter of concerns from Trust Consultants

Concerns about the executive management team of Dudley Group NHS Foundation Trust.

We, the undersigned, are writing to raise concerns about the senior management team at Dudley Group NHS Foundation Trust - specifically Diane Wake (Chief Executive), Siobhan Jordan (Chief Nurse), Andrew McMenemy (Head of HR) and Julian Hobbs (Medical Director).

Following the appointment of Diane Wake as CEO, there were a number of resignations from the executive board, some at very short notice, which affected the continuity and experience of the team. Subsequently, there has been a significant deterioration in leadership style. Individual members or groups of staff are increasingly blamed for systematic failings. A culture of bullying and intimidation has rapidly developed, where staff are afraid to raise concerns in case they are scapegoated. This is having a very negative effect on staff morale, patient care and the safety agenda.

There have been a number of concerns raised regarding the Consultant job planning process. Changes to this process have not been developed in partnership with the JLNC as in previous years, and the approach has been very heavy-handed. Individual teams are being asked to work to completely unreasonable job plans. The workload of many members of the medical workforce is now unsustainable and a number of consultants have resigned from leadership positions and even their clinical roles.

The opportunities for consultants to influence clinical and operational policy changes has been curtailed. Instead of encouraging dialogue and partnership, the senior executive team is reactive, and inward-looking. In all areas of clinical policy, there is undue reliance on arms-length written reports, which have become an overwhelming burden for staff to submit. Whilst we welcome insight and challenge from clinical experts, there is now an over-reliance on advice from costly external management consultants. Moreover, these external reports are not always shared with clinical teams in a timely manner,

particularly those that are critical of corporate management. As a result of the failure to engage clinical teams, there is poor clinical governance of changes in clinical processes, without always considering the wider impacts. This was noted in the recent CQC inspection.

There has been a striking deterioration in the clinical and financial performance of the Trust which we hold the current senior management team responsible and accountable for. The Trust is underperforming in key clinical performance indicators, such as the 4 hour target. The Trust failed to manage winter pressures as well as in previous years, resulting in poor patient experience and an extremely challenging working environment for clinicians, and there is little evidence of robust plans for the coming winter. The recent CQC inspection identified a number of priorities to address, but there has been an incoherent strategy and poor engagement with staff to respond to these concerns. The executive team have not taken any responsibility for their role in the deterioration in Trust performance indicators. The financial position has deteriorated sharply, and the recovery plan, to deliver £20 million CIP in the context of failing clinical performance, is unachievable.

We no longer have confidence in the executive director team to deliver the leadership that the Trust needs. We urge you to step in to ensure the proper management of the Trust for the sake of our patients and the clinical teams who care for them.

Appendix II

Terms of Reference

Dudley Group NHS Foundation Trust (DGFT) whistleblowing concerns - scope for investigation

The investigation itself will need to be conducted in such a way as to give confidence to staff that their views will be heard. It will be conducted in such a way that will maintain confidentiality of individuals where necessary and appropriate to avoid the opportunity for repercussions on them. The investigation will be commissioned by the trust, with terms of reference that are agreed by NHSI and NHSI will be a joint recipient of the report.

The objective is to undertake an independent investigation of allegations raised by an anonymous group of consultants at DGFT, with a specific focus on the following areas:

Phase 1 – Trust response to concerns raised regarding poor communication and lack of engagement with clinical staff by the leadership team.

a) To investigate the allegations that there has been poor communication and a lack of clinical engagement with clinical staff where required and to consider whether:

i) clinical staff are sufficiently represented and engaged by the leadership team/s and executives (for example Medical Director/Director of Nursing), enabling them to be involved effectively in decision-making

ii) because of the failure to engage clinical teams, there is poor clinical governance of engagement in change and operational policy, including any undue reliance on external consultants

iii) the quality and financial impact assessment undertaken for significant service changes since April 2017 involved all

appropriate stakeholders; there is evidence of appropriate learning and adaptation because of that involvement

iv) the Trust's approach to the management of organisational change, included the line of sight through to the Board and Council of Governors and whether the associated policies and procedures were followed when implementing any significant changes or appointments

v) there was a failure to act on evidence of excess workload of different staff groups, because of either system or other changes leading to unreasonable approaches to job planning

vi) the trust has in place the appropriate and robust channels for staff to feedback any concerns they have regarding organisational change, service change or patient safety; the trust has responded to those concerns at all levels including executive, Board and Council of Governors

vii) there has been engagement with clinical staff regarding the management of CQC requirements, resulting from their inspections

b) To make any recommendations in the light of the findings in relation to the matters above, including any proposals for further action to the taken by the trust, with findings to be shared with NHSI and the Trust Chair being the joint recipients of this work.

Phase 2 - Cultural / systemic issues and the alleged culture of bullying and intimidation.

a) To investigate the allegations that there is a culture of widespread bullying and intimidation of staff*. To consider whether:

i) there have already been incidents since April 2017 of bullying and intimidation reported through the trusts current processes and there is evidence of appropriate learning and adaptation because of that reporting

ii) there is evidence of widespread bullying and intimidation of staff by executives, and other senior staff at the trust, and whether any specific allegations of such bullying and harassment require further investigation

iii) there is evidence that staff are afraid to report incidents, incidents being downgraded and that patient safety concerns are minimised

iv) there is evidence that staff do not trust the effectiveness of (and therefore are not using) the trust's own bullying and harassment or whistleblowing policies

v) the trust has taken sufficient steps to ensure that the leadership team display role model behaviour

vi) the trust's leadership has taken steps to deliver a positive change to its speaking up culture

vii) the Board has assessed the impact of the significant turnover in executive and senior management and clinical leadership at trust; and what risk assessment and mitigations it has put in place for current and future possible changes

viii) the existing board development could be helpfully enhanced around the perceived dynamics between the leadership and the staff.

** We are not required to form conclusions on any individual claims of bullying or harassment, but should identify any broad areas of concern and draw attention to any cases that do not appear to have been properly investigated through the trust's own procedures.*

b) To make any recommendations in the light of the findings in relation to the matters above, including any proposals for further action to the taken by the Trust. NHSI and the Trust Chair being the joint recipients of this work.

Appendix III

Methodology

On 13 August 2018 Capsticks Solicitors LLP was commissioned by the Trust Chair to conduct an investigation into the concerns raised in the Letter. These concerns were consolidated into the Terms of Reference (the "**Terms**"), which are set out in Appendix II.

Due to the concerns in the Letter being raised on an anonymous basis Capsticks were at no point notified of the identity of the signatories to the Letter and therefore were not aware whether those we interviewed during the investigation had signed the Letter unless they informed us of this at interview.

The Investigative Team comprised Peter Edwards and Bridget Prosser, Partners, and David True, solicitor.

The Investigative Team were also supported by Ian Anderson, who has worked as a Director of Human Resources in the NHS and the private sector as well as serving as a Non-Executive Director of several companies. He facilitated the focus groups that were made available to members of the Trust.

Over one thousand separate documents, comprising several thousand pages in total, have been received and considered as a part of the investigatory process. Only those documents considered material have been explicitly referred to within the body of this report.

Each Named Executive confirmed that they wished to be involved in the investigation and therefore members of the Investigative Team carried out interviews with each of them.

The initial interviews with each of the Named Executives lasted between 3 and 5 hours, depending on their availability and the nature, content and number of questions being asked. Where it was apparent that not all issues had been dealt with during the first interview then a second interview was subsequently scheduled and took place.

In late August 2018 an announcement was made on the Trust's intranet that explained why the investigation had been commissioned along with how Trust employees could get involved if they wished to do so, providing a deadline of 12 September 2018 for any responses to be provided. A specific Capsticks email account was created to allow Trust employees to contact the Investigative Team.

Although Trust employees had initially been given until 12 September 2018 to request an interview with a member of the Investigatory Team, it was agreed by the Investigation Recipients that this deadline should be extended to allow more employees to engage with the process where possible.

Over a period of two weeks, from 10 September 2018 until 21 September 2018, members of the Investigative Team met or spoke with 31 Trust employees on a one to one basis. These interviews lasted between one and two hours, with only one or two exceptions.

Despite the passing of the extended deadline imposed by the Investigation Recipients, Trust employees continued to request interviews with the Investigatory Team. The Trust Chair and NHS Improvement authorised a further extension of time for those who had missed the original deadline and a further 12 employees were interviewed on a one-to-one basis, either in person or over the phone, during this period.

At the commencement of each interview the individual was introduced to the investigator, provided with a brief background as to how the investigation had come about, notified that the interview was being recorded but that the recording would not be provided to the Investigation Recipients and was to

be used solely as an *aide memoire* by the Investigative Team, and informed that they had the right to remain anonymous throughout the process and within the report if they so wished. The investigator took this opportunity to draw to the interviewee's attention the fact that if they provided information that was so specific to that individual that it may identify them then their anonymity would be at risk if it was included within the report. The investigator clarified that if such information was provided and the investigator thought that this may be included in the investigation report this would be discussed with the interviewee during the interview or, alternatively, the investigator would contact the interviewee to discuss the matter further when drafting the investigation report.

At the same time that the one-to-one interviews were being arranged employees were given the opportunity to request involvement in role-specific focus groups as an alternative to an interview.

While a number of employees expressed an interest in attending both a one-to-one interview and a focus group, it was agreed between the Investigative Team and the Investigation Recipients that this would not be appropriate in order to ensure that there was no over-representation of any individual's viewpoint when the information was collated and the report prepared.

In accordance with the principles of fairness each Named Executive was provided with a copy of relevant extracts from the draft report for their review and comment prior to the completion of the report and its submission to the Trust Chair and NHS Improvement.