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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This report is confined to those issues that came to our attention during the course of our investigation.

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Capsticks Solicitors LLP
35 Newhall Street
Birmingham B3 3PU

To:
Ms Jenni Ord
Chairman
Dudley Group NHS Foundation Trust

And:

NHS Improvement

Dear Sirs

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

In accordance with our contract dated 13th August 2018 for the provision of Consultancy Services to support a Trust investigation, and the specification of services issued to us by the Trust, we now enclose our report dated February 2019 (the Report).

In accordance with the specification, this Report is submitted to the Trust Chair and NHS Improvement.

The matters raised in this Report are those that came to our attention during the course of our work and are not necessarily a comprehensive statement of all the strengths or weaknesses of the Trust's leadership team or its engagement with staff. Any recommendations for improvements should be assessed by the Trust for their full impact before they are implemented.

Yours faithfully

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Capsticks Solicitors LLP

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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. We adopted the following methodology in undertaking our investigation:

- A desktop review of documents obtained from the Trust;
- Interviews with 43 Trust staff and 4 Executive Directors of the Trust either in person or by telephone;
- A series of focus groups with specific staff groups.

Full details of our methodology are set out in Part 5 of this report.

5. 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.

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6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.*"

14. 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.

15. 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.

16. 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.

17. 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.

18. 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).

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. 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

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phased reduction in study leave and a temporary cessation in other professional leave.

28. 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.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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.

36. 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.

37. 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.

38. 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.

39. 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.

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

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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

41. 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.

42. 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.

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43. 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.

44. 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.

45. 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.

46. 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.

47. 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.

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48. 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

49. 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.

50. 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

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51. 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

52. 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.

53. 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

54. 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.

55. 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

56. 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.

57. 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.

58. 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.

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

59. 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

60. 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

61. 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.

62. 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.

63. 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..

64. We were also provided with a letter from a member of staff who had left the Trust and who said that they had raised allegations of bullying and

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harassment by their 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 raised although the letter did not indicate who they had raised 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

65. 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.

66. 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

67. 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

68. 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

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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.

69. 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

70. 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

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

72. 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.

73. 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

74. 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

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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.

75. 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.

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Part 4. Introduction

Background to the investigation

76. The Dudley Group NHS Foundation Trust (the "**Trust**") is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and communities in South Staffordshire and Wyre Forest.

77. Currently the Trust serves a population of around 450,000 people from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. The Trust provides the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The Trust also provides specialist adult community based care in patients' homes and in more than 40 centres in the Dudley Metropolitan Borough Council community. The Trust employs nearly 5,000 staff, and had operating income of £352m in the financial year 2017/18.

78. The overall Care Quality Commission (CQC) rating for the Trust is currently "Requires Improvement". However, there are particular challenges in respect of the quality of urgent and emergency services, and these 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.

79. The Trust has a Board of Directors which, when fully occupied, comprises seven non- executive directors (NEDs), including the chairman, one Associate Non-Executive Director and five voting Executive Directors including the Chief Executive. In addition, there are 4 non-voting Executive Directors.

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80. The requirement for an independent investigation was initiated by the receipt by NHS Improvement of a letter signed by 42 employees within the Trust (the "**Letter**") in which they raised concerns about the senior management team at the Trust, specifically the Chief Executive, Chief Nurse, Director of Human Resources and Medical Director. Together these individuals are referred to as the "**Named Executives**" in this report.

81. The full text of the letter is attached as Appendix 1.

<u>Terms of Reference</u>

82. The terms of reference for our investigation were set out in the Specification provided to us by the Trust dated 25th July 2018. These were as follows:

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:

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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.

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.

* 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.

Part 5. Methodology

83. 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**") by the Trust Chair and NHS Improvement and provided to Capsticks. It was agreed that the Trust and NHS Improvement (together the "**Investigation Recipients**") would be joint recipients of the report once it was completed.

84. 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.

85. Capsticks had been invited to tender for the investigation by the Trust in July 2018. As part of a detailed tender document the profiles of those individuals who would be conducting the investigation were provided to the Trust, along with redacted examples of previous investigations that Capsticks has undertaken.

The Investigative Team

86. The Lead Investigator, Peter Edwards, is a Partner at Capsticks Solicitors LLP and is a qualified solicitor, having trained and worked in the areas of employment and public law for 30 years. Mr Edwards' work includes advising on governance matters in public services organisations.

87. The Lead Investigator was assisted throughout the preparation for and drafting of this report by his co-investigators Bridget Prosser and David True (all three together the "**Investigative Team**"), who are also qualified solicitors at Capsticks Solicitors LLP. Ms Prosser has previously worked

as an independent consultant specialising in conducting and managing workplace investigations, and both she and Mr True currently specialise in the area of employment law.

88. 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. The content and nature of these focus groups is discussed in further detail below.

<u>Documents</u>

89. Given the volume of material that has been reviewed as part of this process relevant documents have not been appended to the report with the exception of the initial letter of concern the text of which is attached as Appendix 1. The inclusion of appendices in respect of each salient document would have led to an unwieldy report with a disproportionately large number of appendices.

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

91. Documents that were considered include, but are not limited to:

a. Monthly Public and Private Board Meeting Minutes, from April 2017 to July 2018;
b. Council of Governors' Meetings from March 2017 to August 2018;
c. CQC reports dated 18th April 2018, 6th September 2018; 17th October 2018 and s.31 notices;
d. CQSPE Meeting Minutes from April 2017 to July 2018;

e. Clinical, Medicine and Surgery Performance Meeting Minutes from March 2018 to July 2018;
f. Finance and Performance Minutes from April 2017 to July 2018;
g. Freedom to Speak Up Guardian Updates to Board for March and July 2018;
h. Executive and Non-Executive Directors Quality and Safety Reviews from December 2017 to June 2018;
i. Service Improvement Group Minutes from July 2018;
j. System oversight and assurance papers from June to August 2018;
k. The external Deloitte Well Led review dated 21 December 2017;
l. Medical Engagement Scale (MES) survey conducted by Engage to Perform in May 2018;
m. Invited Service Review of the Trust's adult emergency medicine service by the Royal College of Physicians.

92. Relevant Trust policies were also reviewed, including:

a. Raising Concerns Speak Up Safely (Whistleblowing) Policy;
b. Consultant and Specialist Doctor Job Planning Policy;
c. Management of Organisational Change Policy; and
d. Bullying and Harassment Policy.

<u>Interviews</u>

Named Executive Interviews

93. It was clear from an early stage of the investigation that it would be important for the Investigative Team to speak to the Named Executives if they were willing to engage with the process. Ms Prosser therefore spoke to each of the Named Executives separately by telephone in late August 2018 to introduce herself, explain the forthcoming investigation process, and to ask whether they would be willing to engage in a formal interview.

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94. Each Named Executive confirmed that they wished to be involved, and accordingly the Investigative Team arranged and conducted initial interviews with the Named Executives on the '1st Interview' dates provided below:

Job title	1st Interview Date	2nd Interview Date
Director of Human Resources	28 September 2018	16 November 2018
Medical Director	10 October 2018	17 October 2018
Chief Nurse	11 October 2018	18 January 2019
Chief Executive	12 October 2018	23 October 2018

95. With the exception of the Medical Director's interview all first interviews were transcribed and copies provided to the interviewees as a written record of what was said. It was unfortunately not possible to transcribe the Medical Director's interviews due to the quality of the audio recording, and he was therefore provided with a copy of the recording itself.

96. 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.

97. Following his interview the Director of Human Resources emailed Ms Prosser a supplementary statement that referred to a number of matters

discussed during the interview. He then requested a second interview to clarify further matters that had arisen, and as a result Mr Edwards met with him on 16 November 2018.

98. Following receipt of the initial draft report, and as is discussed in greater detail below, as part of the process of giving those people who might face criticism in the report an opportunity to respond to such criticism prior to finalisation of the report, the Chief Nurse also requested a second interview and this took place on 18 January 2019.

Other Interviews

99. It was agreed between the Investigation Recipients and the Investigative Team that no individuals could be required to attend an investigatory interview, and as such 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 by email if they wished.

100. During Ms Prosser's initial calls with the Named Executives, as referred to in paragraph 92 above, she was provided with the names of other Trust employees who the Named Executives felt may be able to assist the Investigation. A separate email was therefore sent to these individuals by the Trust's Director of Governance and Board Secretary, again detailing the reasons behind the investigation and inviting them to take part if they wished. It was stressed that the process was entirely voluntary and that individuals' anonymity would be protected as far as possible.

101. On the same date members of the Trust's Board of Governors were sent an email by the Trust's Director of Governance inviting them to attend a

focus group, referred to in greater detail below, should they wish to be involved in the investigation.

102. 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.

103. 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.

104. Despite the passing of the extended deadline imposed by the Investigation Recipients, Trust employees continued to request interviews with the Investigatory Team. The Investigation Recipients 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.

The Interview process

105. 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 either of 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.

106. The investigator then asked the individual to confirm their name, their role, how long they had worked at the Trust overall, and how long they had worked in their current role. It was confirmed with the interviewee that they had been emailed, and had subsequently received, a copy of the Terms in advance of the interview and the investigator then explained that the interviewee could either work through the Terms one by one or alternatively were welcome to simply discuss whatever matters they felt were relevant to any of the Terms.

107. Before finalising the report the investigation team sent relevant extracts to those interviewees who were potentially identifiable from the content of the report and sought their confirmation that their identities were sufficiently protected. Further changes were made to the report in the light of feedback received.

Focus Groups

108. 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.

109. 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. It was further agreed that this approach remained

consistent for all participants, whether Trust employees, Executive members of the Board, Non-Executive Directors, or Governors.

110. Perhaps as a result of the requirement for individuals to choose one of either a one-to-one interview **or** a focus group, the number of individuals who engaged with the each of the focus groups was small. Five focus groups took place, as follows:

Focus Group	Date	Number of participants
Administrative and AHP staff	17 September 2018	1
Medical	18 September 2018	4
Nursing	19 September 2018	3
Governors	20 September 2018	7
Non-Executive Directors	24 September 2018	6

111. Focus groups were facilitated by Ian Anderson on behalf of the Investigative Team. Within the groups individuals were informed that their identities would not be included in the report and were encouraged to be open and honest. The Terms were discussed and people were given the opportunity to comment on each of them.

112. Following the focus group meetings Mr Anderson completed a table which summarised the discussion in each focus group in respect of each of the Terms and provided this to the Investigative Team.

Responding to potential criticisms

113. In accordance with the principles of fairness for those individuals who may be subject to criticism within the final report, 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 Investigation Recipients.

114. Each Named Executive took the opportunity to respond with substantial comments and, in some cases, a large number of further documents. The Medical Director, for example, provided over 240 further documents as part of this process.

115. The Investigative Team considered these comments and further documents in preparing the final report.

General Approach

116. The Investigative Team considered the Trust's Raising Concerns Speak Up Safely (Whistleblowing) Policy when determining its approach to the investigation. Whilst the Terms of Reference for the investigation did not provide that the investigation should be carried out in accordance with this policy, we observed the following provisions of the policy in our investigation:

"When you raise an initial concern or when you have been unable to resolve the matter with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we

will notify you of). Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring."

117. A telephone call of between half an hour and an hour took place each week between at least one member of the Investigative Team and the Investigation Recipients in order to update them as to the progress of the investigation.

118. The findings in this report are based upon the views expressed by those individuals we interviewed, our analysis of documentation provided to us by the Trust, and our own observations. We have not carried out detailed investigation into specific, individual grievances or individual claims of bullying or harassment as this was outside the scope of the Terms.

119. Where there have been substantive matters of dispute in the verbal accounts we received from different individuals this has been noted in the report.

120. Due to the nature of the anonymous evidence provided it was not possible to provide the Named Executives with specific examples to substantiate allegations that had been made against them by some of those interviewed. This is noted in the report where appropriate. Where a proportionately high number of interviewees made similar comments and there was no contradictory written evidence, this is also noted.

121. Where findings of fact are made and conclusions are drawn within this report they are based on the interviews that have been conducted, the focus groups and documents reviewed by the Investigative Team.

122. The Investigative Team confirm that they are not decision-makers as to what action, if any, the Investigation Recipients will take on receipt of this report.

Part 6. Detailed findings and recommendations

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.

117. We have considered a wide range of evidence in respect of the measures that the leadership team has introduced aimed at improving staff engagement.

118. Board Minutes of 4th May 2017 included a report on the Trust's response to the national Annual Staff Survey for 2016 (prior to the appointment of the current Leadership team) which noted a number of actions had been taken to increase engagement since the publication of the results of the 2016 survey :

- *Focus groups had met and the majority of feedback received showed appreciation of engagement.*
- *The Trust will take forward the focus group and other feedback received.*
- *Greater engagement had resulted following the Chief Executive briefings.*

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- *Directors were now producing blogs on a variety of issues which were available on the intranet.*
- *The Chief Operating Officer raised the "breakfast with the boss" sessions and stated that the Trust had received some excellent feedback from staff attending.*

119. The Trust Well-Led Review carried out by Deloitte between September and November 2017, and reporting in December 2017, notes:

"There are a range of activities and forums through which (Board Members) can engage with the wider organisation, including:

Team Briefs; Quality & Safety Visits (Q&S visits); Board walkabouts; induction and recognition events; and 'Breakfast with the Boss', the latter of which has recently been introduced. These initiatives have been well received, with a range of positive feedback in relation to the visibility of some EDs, notably, the CEO, CN and the former COO, all of whom are well-known and well-regarded across the Trust. While BMs are engaged in a number of engagement activities, interviewees across the organisation commented that there is scope for broader Board and triumvirate leadership visibility across the organisation. This mixed feedback is aligned to the results of our Board and staff surveys (see Figs. 3 and 4).

We note a range of good practice in leaders adopting an inclusive and engaging approach with staff, through activities such as Team Brief and 'breakfast with the boss' focus groups. With regards to the raising of concerns, the Trust has appointed two Freedom to Speak Up Guardians and there is a nominated NED Guardian as part of this initiative. These are well-publicised, both internally and externally, with induction coverage and a dedicated 'Freedom to Speak Up' page on the Trust's intranet. Staff spoke positively about their ability to raise concerns and this is reflected

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in our Board and staff surveys (see Fig. 12 and 13). We received feedback that referenced a more open and transparent culture under the current Trust leadership team. However, we also received feedback from interviews and surveys (see Fig. 14) that the communication of actions taken and changes made as a result of staff feedback, including from the National Staff Survey, could be improved. In our view, though this does not necessarily mean that no action was taken, there is certainly scope for clearer communication in this regard.

Staff engagement

- *The 2016 National Staff Survey results and engagement scores were average when compared with similar Trusts.*

  BMs recognise that these could be improved upon and that more can be done to ensure the voices of all staff are heard and acted upon (see Fig. 35). Action plans have now been agreed with staff representatives and these are being monitored by the Workforce and Staff Engagement Committee. Notably, while a Staff Engagement Strategy is referred to in the Committee terms of reference, we have not seen evidence of this through our desktop analysis or review of papers.

- *Other findings in relation to staff engagement include:*

  – Staff reference an on-going sense of separation between the acute and community services of the Trust. The Executive Team are sighted on this and are endeavouring to visit some of the services and to take the Team Brief out into the community.
  – Through interviews and surveys, staff have said that they are not always aware of actions or changes that are made as a result of their feedback. Good practice would support staff engagement

in local action planning and the adoption of 'You said, we did' methodology for the communication of Trust-wide changes;
– Positive examples and feedback in relation to Listening into Action events. However, this engagement activity does not seem to have been used for some time.

120. The Chief Executive told us that the sense of separation between acute and community services that was referred to in the Well-Led Review had been evident since community services became part of the Trust several years earlier. This had been raised with the Chief Executive by community services' staff, and she made it a priority to make them feel valued and part of the Trust. The actions taken to address this included:

- Team brief delivered in both community and hospital every month;
- Listening Into Action events;
- Shadowing with community team;
- Acknowledgement of successes in all services;
- Investment in community nursing in terms of people and IT;
- Skills framework for District nurses and HCAs to aid retention;
- Involving community staff as members of the core team in preparation for the CQC visit;
- Healthcare hero awards for both team and individuals in community;
- Community staff were recognised for their achievements at the Staff Awards in June 18; and
- Making it happen events in both community and hospital services.

121. We were also provided with evidence of other engagement activities including:

- Leadership team participation in charity fundraising activities;
- Establishing a monthly "Healthcare Heroes" award scheme and launching of new style Committed to Excellence staff awards;
- Preparation of a "Communicate, connect care" video;

- A "Dragon's Den" where staff could pitch ideas to improve patient experience, generate income or save money to a group of Directors;
- A series of "Make it Happen" events for staff to talk openly about what really matters to them, what gets in their way and what the Trust needs to change;
- Strategic objectives roadshows and Team Briefs with the Chief Executive;
- Personal emails from the Chief Executive to a range of clinical leaders offering them the opportunity to meet with her to share their aspirations and vision for their services;
- Weekly Surgeries with the Medical Director;
- Monthly Medical Director updates as Town Hall meetings; and
- A Medical Director's email.

122. We have also considered evidence that indicates that notwithstanding the various engagement activities referred to above there remains scope for improvement in respect of staff engagement.

123. Following the release of the results of the 2017 Annual NHS Staff Survey in March 2018, a Board report noted that the Trust's engagement score had decreased, albeit the Trust performed a little better than the national comparator for engagement. The need for improved staff engagement was recognised by the Board, and an action plan was developed and approved by the Board in July 2018.

124. The Trust commissioned a Medical Engagement Scale (MES) survey from Engage to Perform in May 2018. 108 members of Trust medical staff completed the survey. The Trust's survey results were compared with over 120 other UK NHS Trusts and more than 17,500 medical staff.

125. We were told by the Chief Executive that the decision to commission the MES survey was to have a baseline indicator of medical engagement so that the Trust could see where its focus needed to be.

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126. The survey indicated that overall medical engagement at the Trust was low compared to the external norms, with the Trust's scales in respect of Working in a Collaborative Culture, Good Interpersonal Relationships, Being Valued & Empowered and Development Orientation all falling within the lowest relative engagement band compared to the external norms. On eight of the ten MES scales, there was a consistent differential pattern in the MES scale profiles between those consultants with managerial responsibility compared to consultants without managerial responsibility. Consultants with managerial responsibility rated only one of the ten MES scales in line with the low relative engagement band compared to the external norms whereas consultants without managerial responsibility rated all ten MES scales in line with the lowest relative engagement bands compared to the external norms.

127. The survey found that senior managers overestimated actual levels of medical engagement, and that "*this may reflect a tendency for senior managers not to be fully aware of the issues that members of medical staff face at work possibly indicating a lack of appropriate concern with encouraging and maintaining the level of medical involvement in planning, designing and delivering improved clinical services.*"

128. The Chief Executive confirmed that the survey was discussed at the executive team meeting, workforce committee, and CQSPE. An action plan was developed and stated that it would be reviewed weekly at the operational meeting and monthly at the strategic meeting. It was confirmed that the MES would be repeated at 12 months.

129. Whilst it is acknowledged that the MES survey results may be indicative of a long-standing culture rather than being limited to recent events, they provide an objective indication of the extent to which clinical engagement within the Trust needs to improve.

130. A perceived lack of clinical engagement was also reflected in the anonymous letter that prompted this investigation. This letter stated that:

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"The opportunities for consultants to influence clinical and operational policy changes has been curtailed."

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."

131. We also considered the report of an Invited Service Review undertaken by the Royal College of Physicians (RCP) regarding the adult emergency medicine service at the Trust. This noted, amongst other things, that:

"*None of the changes we identified as necessary will be achievable unless attention is given to repairing the breakdown in the working relationship between the executive team and the consultants in emergency medicine, and also to a lesser degree, acute medicine. Clinical engagement is a two-way process where doctors and managers need to work together and there are issues here on both sides."*

132. During our interviews, some of those interviewed described the organisation as having a "different feel" in the last 18 months since the new Leadership team has been in post. Interviewees commented that in contrast to their predecessors who had been at the Trust for a number of years, members of the new team did not know the organisation or its staff well and had not as yet established effective relationships.

133. This view was not shared by members of the executive team, with the Medical Director for example stating that he has good relationships with all directorates and has met regularly with them and had significant dialogue. It should, however, be noted that the Medical Director also stated that he has been subjected to bullying by some consultants which

suggests that the relationship between the Medical Director and some clinicians requires significant improvement.

134. Some interviewees stated that the previous management team was very inclusive in its approach, whereas the current management team was not. Whilst it was felt by some that the current Executive Directors “make all the right noises”, and that there had been lots of meetings and activities scheduled to promote engagement, some commented that these meetings were sometimes cancelled at short notice and that in their view this did not result in effective engagement, particularly with the consultant body.

135. In contrast, the Medical Director stated that opportunities for consultants to influence clinical and operational policy have increased and cited the following initiatives in support of this view:

- A Trust Management Group which meets quarterly;
- Clinical Leaders group which meets monthly;
- A series of away days for Vascular, Ophthalmology, ED and Acute Medicine, and Endoscopy; and
- Two bi-annual workshops on leadership and patient safety at which clinicians helped develop the leadership and safety strategy.

136. One interviewee said that communication from the new Leadership team was initially “challenging” and there was a perception by some other staff that the Executives were “doing things to them rather than with them”. This interviewee described the Trust as being on a journey but that the Executives had not taken people with them.

137. Some other interviewees did not share this view, and examples were provided of support being offered to individual clinicians to develop and implement new initiatives.

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138. Some of those interviewed expressed concern that decisions were taken without always involving the most appropriate people. One example cited was that one of the Clinical Directors was not involved in some of the day to day management issues in respect of the Emergency Department, and had been "bypassed" by the Medical Director. This concern needs to be viewed in the context of an organisation that has faced significant challenges in respect of ED performance, including repeated inspections from CQC and enforcement action. We were also provided with documentary evidence that the Medicine & Integrated Care Divisional Committee received regular feedback and was involved in management issues in respect of the Emergency Department. The Clinical Director referred to was a member of this Committee.

139. We also noted that the CQC Inspection report in respect of the Trust dated 18th April 2018 stated that:

"Overall, most staff felt that communication from the executive team had improved and that the leadership team were engaged, driven to listen and reacted when concerns were raised. Staff also felt engaged and informed. They felt that the culture was one of openness and honesty and told us that members of the executive team attended regular meetings, focused on quality and were visible in patient areas at times of high pressure", and:

"The medical director had worked hard to engage the medical leaders and consultants within the organisation since his appointment in October 2017. Staff working in these roles told us that they felt the medical director had made a significant positive impact since his appointment. They also told us that the work and changes he had implemented had made them feel more valued and supported as both clinicians and leaders."

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140. It therefore appears that the concerns expressed by some of those we interviewed about the lack of clinical engagement (as reflected in the Medical Engagement survey and Invited Service Review) are not shared by all staff. It should also be noted that CQC spoke to a larger number of staff than we interviewed during this Investigation, and therefore their findings may be more representative of the views of the Trust's staff generally.

141. The Trust is organised into three clinical divisions – Surgery and Women's and Children's Services; Clinical Support; and Medicine and Integrated Care. There is a "Triumvirate" management structure in place in each of the Trust's clinical divisions, comprising a Clinical Director, an Associate Director of Nursing and a Divisional Director of Operations. This triumvirate was seen by some as having an important role in communication and engagement, and some of those we interviewed described this arrangement as working well, particularly in the Surgical division. Others felt that the triumvirate may contribute to other clinical staff feeling disengaged and not connected with the Trust's decision-making.

142. The report of the Trust's recent Well Led Review conducted by Deloitte noted:

"Divisions have recently been re-structured, with triumvirate leadership teams established in line with good practice. Interviewees referenced the lack of induction and (multi-disciplinary) development and we have observed varying levels of experience and team maturity across the divisions. We have also been told that reliance is placed on a small cohort of individuals and that, in some cases, operational pressures have impacted on their ability to attend key governance meetings. This is reflective of broader capacity challenges, with a focus on short-term performance limiting the ability of divisional leadership teams (DLTs) to step back from the front-line and

consider the long-term trajectory and performance of their services."

143. These findings from the Deloitte Well Led Review are in line with the evidence that we heard from interviewees during this investigatory process about inconsistencies in the triumvirates' approach.

144. The Chief Executive told us that the triumvirate structure had been in place since 2016 but that the effectiveness of the structure is challenged by the limited amount of time that clinicians in the medical service positions have in their schedule to engage and undertake the role. We were told that this will be addressed when current Clinical Director 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.

145. The Director of Governance and Trust Board Secretary provided some additional information as to structures within the Trust by which clinical staff could be represented and engaged. These include:

a) the Senior Management Team (consisting of senior clinical team leaders, Clinical Directors, Deputy Medical Directors, Chiefs of Division and Matrons/Nurses), which would meet monthly; and

b) the Trust Management Group, which appears to largely incorporate the Senior Management Team and further includes (but is not limited to) the Junior Doctor lead, the Caldicott Guardian, and the Head of Patient Experience, which meets on a quarterly basis.

146. The Director of Governance commented that the expectation for the Trust Management Group was that it would provide an opportunity for greater engagement in respect of strategy and key objectives, and would sit outside an operational line-management structure. He felt that it had been recognised within the Trust that historically there were limitations with the way in which the Trust Management Group worked, particularly

in that it only provided a mechanism to feedback on decisions that had been made at an operational level rather than an opportunity for senior individuals to engage and input into strategy and key objectives.

147. Below the abovementioned forums for senior staff the Director of Governance also identified a number of groups that allowed for a more direct involvement from consultants and senior nurses (such as meetings with the Medical Director , Service Leads, Chief Nurse and Matrons).

148. The information provided by the Director of Governance on this matter was consistent with that of the other Executives interviewed.

149. Concerns were raised by some interviewees in respect of the extent of staff engagement in the Trust's response to recent CQC inspections, and the requirements that CQC imposed on the Trust following these inspections. This is addressed in more detail under term of reference 1(a) (vii).

150. There was a perception amongst some of those interviewed that the Leadership Team is anxious to "fix everything immediately" and is constantly putting new initiatives in place, sometimes without seeking sufficient input from others beforehand. One interviewee commented that the new executive team did not appear to have any medium and long term plans for the Trust but was entirely focussed on immediate concerns.

151. We were however provided with evidence of long-term plans being developed and implemented by the executive team, with examples including:

- joining the Advancing Quality Alliance;
- establishing a Leadership Development Programme;

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- securing £20.3m capital funding for the redevelopment of the ED to include a new resuscitation area; and
- developing strategies in respect of Patient Safety, Research and Workforce and Quality Improvement.

152. Particular concerns were raised regarding the challenges facing the Trust Emergency Department. It was commented that attempts had been made to engage with the Medical Director about these challenges but that no changes had been made as a result. In response, the Medical Director pointed out that a number of changes have in fact been made to ED including:

- changes in staffing and the site of triage;
- facilitating the appointment of two new Consultants in January 2018 and agreeing to the appointment of three more Consultants in September 2018;
- agreeing to make the Clinical Director supernumerary and approving back fill to discharge their management duties; and
- arranging mentorship for consultants with colleagues from other Trusts;

153. It was felt by some of those interviewed that the previous Executive team had a greater understanding of the impact of patient flow on ED, and were more inclined to engage with the clinical workforce on this issue. The RCP noted in the Invited Service Review report:

"We conclude that the flow of patients from emergency medicine is a problem. Several factors seem to have affected flow, including an increase in the numbers of patients coming to the ED, closure of some ward beds, the relocation of the AMU, and the opening and closing of extra 'winter' beds. This has further stressed the system and exacerbated crowding in the ED."

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154. It is, however, apparent from the Board minutes that the challenges facing the ED were regularly considered by the Board.

155. It was noted at the Board in December 2017 that the (then) Interim Medical Director had met with all A&E Consultants in order to prepare an action plan. The Consultants had been asked for their perspective on what could be done to assist with flow. They had confirmed that they were pleased with actions taken and the level of engagement. However, the Board discussion at that time also acknowledged that there were concerns about consultant engagement both in ED and with the Acute Physicians.

156. These concerns were reflected in the CQC report, which noted that:

- "*Senior staff within the service were out of touch with the reality of the quality of care and treatment provided in the department. They were unaware of key risks and took assurances from processes which were not being used and exercised by frontline staff.*
- *Senior clinicians within the department did not engage or embrace opportunities to improve the practice within the department and failed to recognise and accept areas of poor practice and compliance."*

157. The report of the RCP Invited Service Review in respect of the adult emergency medicine service at the Trust noted:

"*There has been an apparent breakdown in the working relationship and trust between the executive team and the consultants in emergency medicine, but also to a lesser degree with acute medicine. Clinical engagement is a two-way process where doctors and managers need to work together and there are issues here on both sides. …..We recognise that the executive team is relatively new and trying to embed better ways of working. The COO was cited as someone who spent time in the ED and*

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'got it' but the issues of flow and 'crowding' of the ED remained highly problematic and other members of the executive team need to engage more with the consultants on these issues. Several examples were cited of changes introduced by management without engaging with the consultant body. The problems the Trust faces will only be addressed if the management work closely with consultant staff and vice versa."

158. The Chief Executive attended the ED consultants' away day on 18th September 2018 to take part in a Q&A discussion. She also participated in an away day facilitated by the emergency care intensive support team (ECIST) in October 2018. In addition, she attended a session with staff in ED and acute medicine in March 2018 to work through the CQC concerns and agree plans to increase pace and solutions as well as meeting with the ED teams and included them directly in feedback from CQC "on the day" regarding their department.

159. Whilst it was acknowledged that the Chief Executive had spoken to clinicians after the anonymous letter of concern was written, some interviewees said that she did not appear to be aware of what was happening 'on the floor' clinically. In addition, the discussion forums that have been established to encourage greater engagement were described by some interviewees as "toothless", with some not feeling that they were able to raise concerns about issues such as patient flow in these forums.

160. In contrast, some interviewees reported that there was increased engagement by the new Executive team, and that more clinical meetings are now scheduled, although it was acknowledged that these are sometimes cancelled due to competing commitments. It was also noted that there are now more consultants included in the Medical Director's team, which is seen as a good thing.

161. We have heard from a number of interviewees a concern that clinical representation within the Trust Board was inadequate. It has been explained to us that in fact the Board includes the following individuals who are, or have been, clinically qualified:

- Medical Director;
- Chief Nurse,
- CEO and ex-nurse;
- COO and ex-nurse;
- Non-Executive Director and GP; and
- Associate Non-Executive Director and GP.

162. In view of this we are satisfied that there is adequate clinical representation on the Trust Board, and indeed a greater number of clinically-qualified Board members than in some other similar Trusts.

163. 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 Invited Service review, the anonymous letter of concerns and some of the feedback we received from interviewees that not all 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.

164. It is difficult for us to judge how widely-held this view is. We are mindful, for example, that CQC interviewed a greater number of staff during its inspection in January 2018 than we have during this Investigation, and as noted above its view was that most staff thought that engagement had improved under the new Leadership Team.

165. The medical engagement score provided a baseline measurement of medical engagement, and it will be important for the Trust to repeat the medical engagement survey in 2019 to see whether the efforts to promote greater engagement that are referred to above have improved this score.

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166. We also conclude that there is currently an inconsistent approach to engagement within the clinical divisions, and through each division's triumvirate structure.

167. 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 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.

168. 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 profile.

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

170. Concerns were raised by interviewees about the level of clinical engagement in respect of several specific changes and we deal with these in turn below.

<u>Digital Trust programme</u>

171. We were told that in the Autumn of 2017 formal concerns were raised about the scope of the Digital Trust Project, the ability to meet the deadline of April 2018 for delivery of the project, and the quality of the design process. These concerns were raised firstly with the IT senior leadership team and subsequently with the (then) Operational Medical Director, the Chair, and the Chief Executive.

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172. When we interviewed the person who had raised these concerns it was indicated to us that there were several concerns in respect of this matter. Firstly, the interviewee said that they were prevented from presenting a full report and summary presentation detailing the issues to the Digital Trust Programme Committee on 22nd November 2017. Having attended the meeting, the Board papers contained an extremely brief review by the Programme Director, which did not convey the full concerns that had been raised and, in the interviewee's view, was critical of the focus on quality and clinical governance. The interviewee was concerned as to the deemed focus on quantity rather than quality and the proposed solutions in respect of that.

173. We have reviewed the Board papers from its meeting on 7th December 2017, and note the report of the Digital Trust Programme Committee dated 22nd November includes the following:

Project status

Stage 3 of the project (Configuration) is now in exception, meaning that there is no further contingency time within the stage and that the project critical path through to go live is impacted.

The three main causes for the delay in configuration are:

- *SME time; the delay of 4-8 weeks in getting clinical SMEs freed up from clinical work in order to design and own the forms.*
- *Design process; there has been a focus on building high functionality patient record forms that have been through many iterations of clinical design. This has been to the detriment of delivering clinically approved content; out of the 112 clinical forms none so far have been completed and signed off, although over 50% are in design or configuration.*

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 Governance; application of the governance framework has resulted in excessive redtape for approval of design and configuration work competed by clinicians.

This exception means that it will not be possible to deliver the full scope of the project for the go-live date of 23/4/18.

174. We also considered the minutes of the Board discussion of this item. This records that the CCIO had stepped down and that the Trust was behind schedule on the project due to the lack of availability of subject matter experts to advise on some content. The Board noted that a recovery plan had been produced and whilst the 'go live' in April 2018 would still take place, there would be a reduction in scope, with only four elements now planned to go live in April and the Trust looking to spread the remaining areas over a period between April and October.

175. The interviewee told us that an independent report looking into the Digital Trust Project commissioned subsequently by the Medical Director corroborated their concerns with regard to the delivery of the project. Having considered the relevant Board Minutes it is apparent that the independent report was commissioned in or around the end of 2017/early 2018 which indicates that the Trust was taking steps to address the concerns raised. The author of the independent report spoke with a number of key individuals involved with the project including the CCIO, CIO, IT Programme Manager, Chief Nursing Information Officer and Consultant Anaesthetist and Subject Matter Expert for the EPR Project.

176. Whilst the independent report notes that there are a number of "strengths" with regard to the project, the author identifies 5 key areas of weakness:

i. New Board since original business case accepted;

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ii. Limited strategic support for the EPR project;

iii. Differences in perception as to the readiness of clinical documentation;

iv. Delay to the prescribing solution; and

v. Absence of CCIO/CSO.

177. The report focuses on solutions/recommendations, although it is apparent that the author shares the interviewee's concerns as to the quality of the clinical content of some of the documentation. ,

178. On the issue of staff engagement with the Digital Trust project we noted that this was discussed in the Board on 12th April 2018 when a NED asked about staff engagement with the project and the CIO confirmed that a lot of energy had been put in to staff engagement.

179. In conclusion, it is apparent that there were challenges with the delivery of the Digital Trust project and tension between some members of the project team regarding the delivery of this project. The Board was sighted on the issues and took steps to appraise themselves as to the risk by commissioning an independent report. We did not find poor clinical governance as a consequence of a lack of engagement in respect of this programme.

Paediatric changes

180. As is referred to in greater detail at term of reference 1(vii) below, a number of requirements were placed on the Trust by the CQC with a very short timescale for compliance.

181. One example of this that was brought to our attention was the need to provide increased clinical coverage for paediatrics within the Emergency Department. When the Trust was inspected by CQC on 5th and 6th

December 2017 it was noted that the Trust was not providing a 24-hour paediatric emergency service. As a consequence, CQC reported that *"many children were seen in the adult emergency department, where they were potentially exposed to hostile sights and sounds."*

182. We were told that a decision was made "overnight" to move paediatric clinicians from the Paediatric Department to the Emergency Department as part of an initiative to ensure there was a 24 hour presence of paediatricians within ED. The Medical Director advised us that this change was agreed with the input of the Clinical Service Lead (CSL) for Paediatrics, the CSL and Chief of Surgery in a meeting with CQC.

183. Several interviewees said that this decision was made on a 'knee jerk' basis without proper consideration of the impact that it would have on the Paediatric Department as a whole. There were concerns around the lack of staffing numbers to properly facilitate a 24 hour paediatric presence within ED alongside the ongoing requirement of a fully functioning paediatric department.

184. The CQC report noted that:

"The Trust commenced a trial of 24 hour opening; however, this is only made possible with the utilisation of high levels of agency nursing staff. This trial commenced after the conclusion of our inspection. The children's emergency department only had a complement of three qualified children's nurses, which was not sufficient to operate a 24hours a day seven days, a week service."

185. An Invited Service Review in respect of Paediatrics in November 2018 noted that:

"The recent problems in ED and the wider Trust, and a CQC requirement for ED to seek an early paediatric opinion for any child scoring 5 or above on the new electronic PEWS, was reported to have put pressure

on both teams exacerbated by the recent turnover of ED staff and the small size of the paediatric area requiring beds to be cleared swiftly. The PEWS scoring has been negotiated to 6 or more.   We feel this was an example of overreaction to CQC pressure without considering the expert clinical view or implications. "

186. The Invited Service Review also noted that the children's ED was at busy times covered by a Tier 1 Emergency care doctor and that this could lead to delays in clinical decisions being made. The Review recommended that the Trust should roster paediatric cover within ED at times of regular peak activity.

187. Our conclusion is that it was necessary for the Trust to respond promptly to CQC's requirements in respect of 24 hour paediatric cover in ED. The arrangements that were initially introduced put pressure on staffing and were not welcomed by all clinical staff. There is also an indication from the Invited Service Review that the Trust's response may, in one respect at least, have not fully considered clinical implications.

188. The Trust has obtained expert advice on the Emergency Paediatric Pathway via the Invited Service Review and we recommend that the recommendations of that review are adopted if they have not already been implemented.

<u>IMAU</u>

189. Patient safety concerns have been raised by various individuals within the Trust in respect of the Immediate Admissions Unit (referred to as IMAA or IMAU).

190. The background to the establishment of this unit was that the Trust had experienced delays in transferring patients out of the Emergency Department, and this had meant that each day anything from 20 to 30

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patients were waiting in a corridor for assessment and ongoing care. Co - located to the emergency department was a vacant clinical area which had previously housed the Emergency Assessment Unit (EAU), which had been relocated to the Acute Medical Unit (AMU). This area was therefore re-opened to house those patients with a plan to admit and treat whilst waiting for a bed to become available elsewhere in the hospital. The area was named the Immediate Medical Assessment Unit (IMAU) and was opened fully on the 5th January 2018.

191. In February 2018, following an internal quality and safety round on IMAU, we were told that a number of very serious gaps in care and processes were identified. A report entitled "Quality and Safety Review- IMAA Report" dated 21st February 2018 ("the IMAA Report") rated IMAA as "inadequate". It highlighted a number of areas where, under the CQC five care domains, the department was either inadequate or required improvement.

192. The IMAA Report stated in its summary that:

Medical staff raised concerns as follows;

- *No clear process for medics to work out in which order patients should be clerked dependant on clinical need;*
- *'Clerking list' is very inefficient leaving patients to be missed or clerked twice (medical staff were able to provide examples of this);*
- *Medics unable to accurately locate patients on clerking list, example of a patient who had been waiting 11 hours to be clerked but medic unable to find him*

193. We heard from one interviewee that they raised these issues with the Medical Director, and they provided corroborating documentation to us. This interviewee felt that despite ongoing dialogue between them from February 2018 onwards the Medical Director took insufficient actions to address the issues that had been raised.

194. The interviewee stated that these issues should have been addressed as a high priority and their view was that the Medical Director did not take sufficiently decisive action and this put patients at risk, left staff stressed and unsupported, and damaged the reputation of the Trust.

195. We also saw evidence that the Chief Nurse was very concerned that an incident report was completed in respect of a patient that was referred to the medics but remained unseen in ED after long delays.

196. The Medical Director responded that the issues highlighted were not unique to IMAA and were already being addressed by the Executive team, CQSPE and the Medical Director's office. Some additional actions were taken in the light of his discussion with the interviewee in question such as the introduction of a tracker, and the implementation of human factors training.

197. Following the internal Quality and Safety Review in February 2018 the Trust produced an action plan to address the concerns that had been identified.In addition, the Medical Director provided documentary evidence that showed he sought ongoing audit and assurance in relation to IMAA. Although he requested that a paper should be brought to CQSPE in respect of IMAA and that IMAA risks should be recorded on the risk register we have not seen any evidence that these requests were actioned.

198. During the March inspection CQC recorded that it noted the following concerns in the emergency department and immediate medical assessment area:

- clinical staff members' lack of understanding of NEWS;
- possible sepsis and concept of screening by nursing staff; screening for sepsis;

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- lack of admission criteria; and
- quality of records and governance around the admission referral process from the emergency department.

199. The April 2018 CQC report noted:

- *An overall insufficient management oversight and governance of the IMAU and in particular the use of the NEWS and the management of the deteriorating patients. There were no effective systems in place and they were not monitoring or mitigating risks to patients' welfare.*
- *The arrangements for management responsibility for IMAU area were not clear or robust. The chief nurse and medical director told us that the unit was an extension of ED and fell under the responsibility of ED nursing leadership. When we spoke with the management team, they were unaware that the measuring and monitoring system in place within ED did not extend to IMAU.*
- *There were no standard operating procedure (SOP) or admission criteria for IMAU to ensure patient were transferred appropriately.*

200. The interviewee remains concerned at what they feel was a missed opportunity to actively take steps to avoid potential harm and the lack of engagement by the Medical Director in tackling this issue. In contrast, the Medical Director states that the issues raised by the interviewee were addressed appropriately.

201. What is clear is that shortly after the unannounced CQC visit on 15th March, the IMAU was closed. The Trust's Chief Operating Officer stated that she made the decision to close the unit in conjunction with a medical consultant.

202. Although the Chief Executive did not recall the IMAA report or the dialogue between the Medical Director and the interviewee who raised concerns, it is apparent from documents provided by the Medical Director that those concerns were raised with the Chief

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Executive by the Medical Director and that she in turn asked the Chief Operating Officer to agree with the Medical Director and Medicine Division how to address those concerns.

203. In summary, it is evident that there were significant operational and clinical issues regarding IMAA which were identified internally and externally. An action plan was developed by clinicians in response to the IMAA report but we have not seen evidence that the implementation of this plan was monitored.

204. Whilst the Medical Director sought ongoing audit and assurance in relation to IMAA, there is no evidence that the requested assurance was provided.

205. Ultimately the unit was closed after significant concerns had been highlighted in a CQC inspection. Similar concerns had been identified by the concerned interviewee about 6 weeks earlier, and also described in the IMAA report 3 weeks earlier. However, these did not result in closure of the unit.

External consultants

206. A number of interviewees commented on the use of external consultants on change programmes. This has included external consultants assisting with financial recovery; job planning; patient flow; infection control and the 4Eyes programme. Some felt that this external support was not required and that it meant that Trust expertise had been overlooked. It was also reported that there was a lack of communication in respect of some external consultant appointments, with interviewees being unaware of the reasons for introducing external consultants in respect of some projects. In addition, interviewees reported that they did not receive feedback from some of the external consultants, and this contributed to the feeling of lack of engagement of clinical staff.

207. We were told by the Leadership Team that the Trust has engaged external consultants as Subject Matter Experts, and that this reflected a lack of internal capacity to take on additional projects. This was also acknowledged in the Deloitte report of the Trust's Well Led review which noted:

"A range of interviewees commented on the impact that savings schemes from recent years have had on the corporate functions of the Trust, notably in relation to finance, workforce, estates and information, all of which are perceived as being particularly lean functions. Interviewees reflected that, whilst it is possible to get support from these functions, this can be sporadic and is impacted by a focus on short-term issues."

208. Some interviewees described how the Medical Director asked an external consultant from his previous Trust in Liverpool to undertake an independent review into a patient who had unfortunately died in the ED waiting room. This report was completed in late January 2018 and shared with the Chief of Medicine and subsequently the ED consultants. The consultants wrote to the Medical Director three months later raising a number of concerns regarding the content of the report and indicating a wish "to set the record straight". The Medical Director then arranged for the report and the letter of concerns to be submitted to the coroner.

209. Having considered the specific service changes that were raised with us by interviewees we have found evidence of clinical engagement in respect of all of these changes. We appreciate that on occasion (24 hour paediatric presence in ED) it has been necessary for the Trust to take immediate action in order to comply with CQC registration requirements. This may therefore have limited the extent of engagement.

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210. One of these changes, the opening of the IMAU, was subsequently reversed following adverse comments during a CQC inspection which were consistent with concerns that had been raised internally at an earlier stage. This suggests that this change may have benefitted from more extensive engagement with clinicians prior to its implementation.

211. 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, feedback from some of those interviewed suggests that the use of external consultants on some occasions may have had a negative impact on their engagement with the Leadership Team, particularly where there has been limited explanation as to why these external consultants have been brought in, and where the outputs of their consultancy work have not been shared more widely in the organisation. 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 with the Trust.

(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

212. According to the CQC, the main committee which oversaw clinical quality and safety at the Trust was the Clinical Quality Safety and Patient Experience Committee (CQSPE). We have reviewed the minutes of committee meetings from April 2017 and note that these involved a wide range of stakeholders. Regular attendees included all of the following:

- Non-Executive Directors
- Head of Communications

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- Chief of Medicine
- Chief Operating Officer
- Chief Clinical Information Officer
- Medical Director
- Chief Nurse
- Chief Pharmacist
- Director of HR
- Chair
- Trust Board Secretary
- Chief Executive
- Associate Chief Nurse
- Chief of Surgery
- Chief of Support Services

In addition, others attended meetings either for specific agenda items or for the duration of meetings.

213. The agendas for CQSPE meetings were wide-ranging, but included a number of service changes including providing 24 hour paediatric cover in the ED; obtaining a relocatable MRI scanner and mobile MRI scanner in order to allow for the decommissioning of the Trust's existing scanners; the closure of Evergreen Ward; the engagement of independent consultants to address a backlog in ophthalmology and the development of action plans to address the requirements imposed on the Trust by CQC.

214. It was noted in the minutes of the CQSPE meeting on 25th July 2017 that medical staff were not usually involved in quality and safety reviews. The Chief Executive suggested that this may be because time had not been allocated to them to undertake these roles and it was agreed that the Trust should look at SPA allocation in order to address this.

215. The Chief Executive raised this issue again at the meeting of 24th October 2017 when she noted that reports in respect of clinical matters were not being presented by clinicians.

216. We also reviewed the minutes of the Finance and Performance Committee from April 2017 to July 2018 and identified the following business cases that were considered by the committee:

- ED medical and non-medical staffing;
- Medical HDU;
- EPR end user IT devices;
- 4 Eyes business support.

217. The membership of the Finance and Performance Committee included:

- Non-Executive Directors
- Chief Executive
- Director of Finance and Information
- Medical Director
- Chief Nurse
- Chief Information Officer
- Chairman
- Deputy Directors of Finance
- Director of Human Resources
- Director of Strategy and Business Development
- Chief Operating Officer
- Director of Operations, Clinical Support Services
- Director of Operations, Surgery and Women & Children

218. In addition, we noted from a review of the Board minutes between April 2017 and July 2018 that the following significant service changes were considered by the Board during this period:

- The implementation of the Digital Trust programme
- The outline business case for the Black Country Pathology project
- Redesigning the acute medical area and reducing the AMU bed base

219. As noted earlier in this report, the clinical representation on the Board is at least commensurate with the level of clinical representation that would be found elsewhere in Trusts of a similar size.

220. The Medical Director also referred to two additional forums that had been established that increased clinical involvement, namely the Clinical Effectiveness Committee, and the Risk and Assurance meeting which focusses on SIs and learning and improvement.

221. It is therefore 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.

222. The service change that was most regularly mentioned by those interviewed was the reduction of the Trust's "core bed base" during the latter part of 2017. Some interviewees said that there was no discussion with clinicians as to the potential impact of this change before its implementation. These interviewees believed that this change contributed to the Trust's worsening performance against the national A&E "4 hour wait" target, and that this in turn put patients at risk.

223. The Chief Executive explained that when she arrived at the Trust in 2017 there was a "winter ward" which was a 17 bedded ward located in ward B6. In recognition of the need to reduce the use of agency staff; the progress that the Trust had made in reducing non-elective length of stay, and the fact that the ward had been opened to alleviate winter pressures, it was closed in May 2017. It was acknowledged at this time that the ward may need to reopen in winter time to meet some of the

additional demand that the Trust would be likely to face. B6 was therefore regarded as a “flex” area which could provide additional bed capacity during winter if needed.

224. At or around the same time, there was a need to review the Trust’s Acute Medical Unit (AMU) arrangements due to concerns about falls, pressure ulcers and other quality and safety issues; and also a need to consider the future use of Evergreen ward which was a ward run by a GP and largely staffed with agency staff for patients awaiting transfer to local authority care provision. Concerns had been raised about Evergreen both internally and by families, and therefore the Division of Medicine was asked to consider whether the current arrangements on Evergreen were safe, or whether it may be better to redesignate the ward as the Acute Medical Unit.

225. A decision was subsequently taken not to continue admitting patients to Evergreen, and to relocate the AMU to the ward. These changes coincided with the local authority opening a 60 bedded facility for social care which reduced the need for patients to have to remain in hospital pending a local authority care assessment.

226. We have reviewed an extensive set of documents in respect of various decision-making and assurance forums within the Trust and found that 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. However, we have not been able to identify where these decisions were taken or whether the impact of the changes on the Trust’s services was assessed prior to implementation.

(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

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were followed when implementing any significant changes or appointments

227. A number of interviewees commented that there had been a very significant change of Board personnel in a short space of time. In addition, it was reported to us that there is a perception within the Trust that members of the Board 'club together' and that several members of the Executive team knew each other from previous roles. Some interviewees questioned whether appropriate recruitment processes had been followed in respect of recent appointments.

228. In order to address this issue we reviewed the appointment arrangements that had been made for all executive appointments from the date of appointment of the current Chief Executive. The details of these appointments are as follows:

Role	**Recruitment process**	**Appointment panel**	**Date of appointment**
Chief Executive	Facilitated by Hunter Healthcare. External advertisement; stakeholder panels; presentation and main interview panel over 2 days.	Chair SID NED External assessor (CEO)	3rd April 2017
Medical Director	Initial appointment as Operational Medical Director	For substantive role: Chair	30th April 2018

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	on 28th July 2017. 2 candidates shortlisted and selection comprised stakeholder panel and main interview panel. Following retirement of Medical Director, acted up for 6 months from 1st November 2017. Substantive post advertised externally and 3 candidates shortlisted. Selection by interview panel and presentation.	CEO SID External assessor (Medical Director) NHSI Regional Medical Director	
Director of Finance	Initial advertisement and shortlisting in September 2017 but shortlisted candidates withdrew. Re-advertised through Fine Green Recruitment and 3 candidates	CEO SID External assessor (FD)	1st February 2018

	shortlisted. Selection by stakeholder panel, presentation and interview.		
Chief Nurse	Appointed to acting position in April 2017. Substantive role advertised August 2017 and selection process comprised interview panel and presentation.	Chair CEO External assessor (Chief Nurse)	1st November 2017
Chief Operating Officer	External advertisement in August 2017. Only one candidate shortlisted and selection by presentation and interview.	CEO NED HR Director	1st January 2018
Director of Strategy and Business Planning	Selection by walking tour of hospital, stakeholder panel and interview panel.	CEO NED Deputy CEO HR Director	25th September 2017

229. The Chief Nurse, Chief Operating Officer and Medical Director were known to the Chief Executive prior to their appointments, and the Chief Nurse and Medical Director both served initially on an acting basis prior

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to their substantive appointments. However, it is apparent that all appointments were advertised externally and that in most cases the appointment panel included an external assessor as well as executive and Non-Executive representatives from the Trust.

230. In the focus group for Non-Executive Directors a comment was made that the Chief Executive had "surrounded herself with like-minded and known colleagues". It was acknowledged that NEDs were involved in recruitment but the view was expressed that sometimes NEDs felt that they were expected to "rubber stamp" candidates rather than exercise judgement. On one occasion only 1 candidate was offered for selection.

231. In contrast, another NED said that whilst they were aware that both the Medical Director and Finance Director had been known by the Chief Executive in advance of their appointment, they were content that all appropriate processes had been followed; that there had been a number of candidates for each role; and that the best candidates had been appointed. With regard to the suggestion that the executive team were too 'like-minded', this NED said that the executive team knew that there was an imminent CQC inspection and that it was likely that they were all "pulling together" in anticipation of this.

232. The anonymous letter indicated that:

"there were a number of resignations from the executive board, some at very short notice, which affected the continuity and experience of the team."

233. The Chief Executive explained that when she arrived at the Trust the former Medical Director was acting up as Chief Executive. In addition, the former Chief Nurse had left the Trust on 31st March 2017 in order to take up a role with NHS England. It was therefore necessary to make some urgent appointments in order to strengthen the executive team.

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234. The then Medical Director had expressed an intention to retire in 2019 and had indicated that he did not want to continue as Medical Director. He was also the Trust lead on the Dudley Multi-Specialty Community Provider (MCP) project. The Chief Executive therefore considered that it was necessary to make a succession plan for the Medical Director role. This was the rationale for establishing an Operational Medical Director post. That role would encompass some of the "day-to-day" elements of the Medical Director portfolio such as job planning, serious incident reviews and mortality reviews.

235. The Operational Medical Director role was advertised on NHS Jobs. The Chief Executive knew Dr Hobbs from when she had been a director at Royal Liverpool and Broad Green University Hospitals NHS Foundation Trust, and when she met him at the NHS Confederation conference she drew his attention to the vacancy. Two candidates including Dr Hobbs were shortlisted for the post and he was appointed following interviews with a stakeholder panel and a formal appointment panel.

236. With regard to the Chief Nurse vacancy, the Chief Executive explained that she had met Ms Jordan when they were both members of a CQC inspection team. She approached Ms Jordan to enquire whether she would be interested in undertaking an interim Chief Nurse role for 6 months at the Trust pending the recruitment of a substantive Chief Nurse. Ms Jordan agreed to this.

237. The Chief Executive was mindful of the fact that CQC was due to undertake an inspection of the Trust in the near future, and that it would therefore be desirable to make substantive appointments to executive positions where possible. In addition to the Chief Nurse, the post of Finance Director was occupied on an interim part-time basis. The Chief Executive therefore met with the interim Finance Director to ascertain whether he was prepared to work for the Trust on a substantive, full-time basis but he did not want to do so and instead agreed to step down from his role by December 2017.

238. Finally, the previous Director of Strategy decided to retire on ill health grounds in May 2017.

239. We are satisfied that the appointments to the executive team following the Chief Executive's appointment in April 2017 followed appropriate recruitment procedures. However, there was a perception amongst some of those we interviewed that the Chief Executive had appointed acquaintances and/or former colleagues to key director roles and that those appointees would therefore be unlikely to question her decisions and leadership style. This perception is not accepted by members of the Leadership team.

240. 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.

(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

241. It was widely reported by interviewees that staffing is a challenge, although it was felt that existing staff were working hard to cover the gaps and deliver a safe service to patients.

242. Some interviewees commented that the ED in particular was not adequately resourced and that despite this having been raised with the Executive team there had been a 'complete failure' to act on it. These comments are not, however, corroborated by the documentary records. There is considerable evidence within the Board and committee minutes that staffing levels within the Trust were regularly considered by the

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Trust leadership and that steps were taken to address historically low staffing levels. By way of examples:

- ED medical and non-medical staffing business case considered by the Board in June 2017;
- Nurse staffing review in surgery commenced July 2017;
- Proposal to increase establishment in paediatrics to address appointment backlog in August 2017;
- An additional 120 nurses to be appointed in Medicine and Surgery – November 2017

243. Specifically in respect of staffing in the ED, we were told that there has been significant investment in nursing staff and consultants. Three new Emergency Department Consultants were appointed in 2017/18 alongside an investment of over £1.5 million in nursing staff.

244. With regard to job planning, we were told that when the new executive team took up their posts there was very limited take up of formal job planning within the Trust. This was identified as a priority for the new leadership team, and the Trust invested in software to support the job planning process. It is noted in the Board minutes of November 2017 that:

"The Interim Medical Director confirmed that really good progress had been made and meetings had been held with all 3 Divisions. The Trust needs a licence for the relevant Allocate module and the timeframe is around 6 months for this work to be completed. Support Services are ahead of the other 2 Divisions and training on Allocate will be provided once the module is operational. There is a roll out plan for Medicine and Surgery from January 2018. Ownership at Divisional level was good and the Interim Medical Director commented that the process needs ownership by all Consultants in the use of the electronic system. The Board noted that this was not a change of process but rather using an

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electronic system to support the job planning requirement and the Trust is a national outlier in the level of staff with a clear job plan. The LMC had been kept informed of the Trust's intention to use the Allocate system."

245. Whilst some interviewees felt that job planning was much better under the new Leadership team, others reported that there had been inconsistent messaging about the new system. It had initially been described as a supportive measure to better understand consultant workload but then introduced as a cost improvement measure.

246. In fact, agreeing and adhering to a job plan is a professional and contractual obligation for all consultants and their employers. Whilst there is no requirement to utilise a software solution to support the job planning process, we are aware that the Allocate system is widely used within the NHS. We have not received any specific evidence of unreasonable approaches to job planning being adopted by the Trust.

247. Some interviewees expressed concern about communication around work requirements and annual leave. It was reported to us that the Paediatric consultants had been told by the Medical Director that they would be required to work weekends at no extra cost, and some interviewees said that they had been told that all professional leave was discretionary and now had to be authorised by the Medical Director.

248. The Medical Director stated that professional leave has always been discretionary and approved by the Medical Director. Previously this approval function was delegated to the Deputy Medical Director who had since retired. He also told us that Paediatric Consultants were not told to work at no extra cost at weekends and provided us with evidence of payments being made to consultants for weekend cover as well as details of expenditure incurred on locum cover where this has been required.

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249. Members of the Leadership team informed us that there were specific concerns regarding use of annual and study leave entitlements in some clinical areas and the impact of periods of leave on service delivery. One such concern described by the Chief Executive related to the Ophthalmology Department. On her arrival at the Trust she found that there had been some serious incidents in ophthalmology where patients had suffered significant loss of sight as a result of delays in follow-up treatment. There was a considerable backlog of appointments, and although these were tracked on a monthly basis through the CQSPE committee, the trajectory for clearing the backlog was not being met despite arrangements for outsourcing of some appointments. The Chief Executive enquired about the levels of annual leave and study leave that were being taken, and whether consultants would be willing to agree to there being no study leave for a 3 month period in order to clear the backlog. The Chief Executive, Medical Director and Chief Operating Officer subsequently met with the Ophthalmology consultants to agree a solution. This resulted in the consultants committing to a phased reduction in study leave and to spreading this out across the year. There would also be a temporary cessation, confirmed subsequently to be for the remainder of 2018, on granting further professional leave.

250. The issue of annual leave and study leave entitlements was reported to the Board by the Medical Director in February 2018. He reported that Consultants were entitled to an annual leave allowance and then a potential 30 days professional leave and 30 days study leave (both of these over a 3 year period). The taking of periods of leave could have a significant impact on outpatient clinics, theatre sessions and day case procedures and could have consequential financial impact through the need to fund waiting list initiative work. It was therefore proposed that there should be improved management of overall consultant leave. It was agreed that in future all professional and study leave must be signed off by the Medical Director and waiting list initiative work by the Chief Operating Officer. Where there had been previous irregularities in

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respect of leave arrangements, there would be one to one conversations with the individuals concerned.

251. We were told that the communication of these issues did not have any adverse impact on service delivery. However, some interviewees reported that it had an adverse impact in terms of consultant engagement despite the fact that a joint communication was sent by the chairs of the JLNC, Hospital Consultants Committee and Medical Director to all medical staff.

252. In conclusion, 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.

253. We also did not find evidence of unreasonable approaches to job planning. Historically, there had been poor compliance with formal job planning requirements, and the steps taken to address this appear to us to have been reasonable.

(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.

254. The Trust has a Raising Concerns Speak Up Safely (Whistleblowing) Policy that was ratified in September 2017. This provides that:

"The Trust actively encourages staff to raise concerns at the earliest opportunity about safety, malpractice or wrongdoing at work. If a genuine concern is raised through this policy the individual will not be at risk of losing their job, or having penalties and there will be no reprisals as a

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result. They will have protected disclosure and /or regulator disclosure protection (refer to section 3). The Trust will continue to fully support staff even if they are found to be mistaken or their concerns prove not to be founded. The Public Trust Disclosure Act gives statutory protection to employees and workers who disclose information reasonably and responsibly in the public interest concerning malpractice in the workplace."

255. Under the Policy, the Chief Executive has overall responsibility for ensuring the Trust has in place an effective framework that encourages and supports its staff to raise concerns without recriminations, for these to be investigated and actions implemented and learning ensured as a consequence. The Board of Directors has overall responsibility for monitoring compliance with and effectiveness of this policy and ensuring that effective management systems are in place.

256. The Policy provides for the appointment of a Freedom to Speak Up (FTSU) Guardian who acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the Chief Executive, or if necessary, outside of the organisation.

257. The Trust currently has two FTSU guardians in post and is also appointing FTSU champions. The FTSU guardians provide quarterly reports to the Trust Board giving an update on:

- Numbers and types of recent concerns raised and an outline of outcomes from some of the concerns raised.
- Numbers of concerns raised at the Trust compared with other Trusts.
- National/Regional Guardian activity
- Recent actions and future plans

258. It should be noted that the Trust's policy is not entirely consistent with the national "Freedom to Speak Up: Raising Concerns (Whistleblowing)

Policy for the NHS" issued by NHS Improvement and NHS England in April 2016. The national policy states in its introduction that:

It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

259. The national policy contains the following wording under the heading "Feel safe to raise your concern" which is not fully replicated in the Trust policy:

"If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns."

260. The Trust policy contains the following wording:

"The Trust actively encourages staff to raise concerns at the earliest opportunity about safety, malpractice or wrongdoing at work. If a genuine concern is raised through this policy the individual will not be at risk of losing their job, or having penalties and there will be no reprisals as a result. They will have protected disclosure and /or regulator disclosure protection (refer to section 3). The Trust will continue to fully support staff even if they are found to be mistaken or their concerns prove not to be founded. The Public Trust Disclosure Act gives statutory protection to employees and workers who disclose information reasonably and

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responsibly in the public interest concerning malpractice in the workplace.

The Trust will not tolerate the harassment or victimisation of anyone raising a concern, nor will the Trust tolerate any attempts by its staff to bully individuals into not raising a concern or to give an instruction to cover up or not to raise or pursue any concern. Even if this is a person in authority such as a Manager or Director, the staff member should not agree to remain silent. If this occurs and is upheld following an investigation this will result in disciplinary action."

261. During the course of our investigation we noted that two members of the Leadership team had enquired as to the identities of those who had raised concerns in the anonymous letter. We were concerned that these requests may be inconsistent with the content and spirit of both the Trust and national FTSU policies. We therefore recommend that the Trust reaffirms its commitment to the values of the national FTSU policy and reviews the wording of its FTSU policy to consider whether this should more closely follow the national framework.

262. When comparing the number of concerns raised through the Trust's FTSU guardians compared with other Trusts we noted that in Q3 of 2017/18 17 concerns were raised at the Trust. Other local trusts reported 13 and 18 concerns, and no data was returned by two local trusts. In Q4, 11 concerns were raised at the Trust compared with 12, 17, 6 and 0 in other local trusts. These figures indicate that the Trust is not an outlier in terms of the frequency of reporting through the FTSU guardians compared with other local trusts. The frequency of reporting is also consistent with the national average for combined acute and community trusts which was reported by the National Guardian for the NHS as 43 cases per trust in 2017/18.

263. In her first annual report on speaking up data in England, the National Guardian for the NHS noted that:

The absolute number of cases is not necessarily reflective of the speaking up culture in an organisation. There are many existing routes for workers to raise concerns, through incident reporting mechanisms, via their line manager or educational supervisor, or directly to an executive or non-executive director amongst others. Freedom to Speak Up Guardians are not a substitute for these other routes but work proactively to support a positive speaking up culture throughout an organisation.

264. Therefore, whilst the data on the frequency of FTSU reporting is reassuring, it is also necessary to consider other evidence to assess whether the Trust has an effective approach to speaking up or a culture that supports this.

265. The CQC report in April 2018 also considered the prevalence of FTSU concerns and noted:

We reviewed the Freedom to Speak Up Guardian update (December 2017) and saw that between April 2017 and November 2017 the majority of concerns raised to the Freedom to Speak Up Guardians related to line and senior managers regarding perceived behaviour :bullying, harassment and perceived unfair behaviours such as unfair recruitment, rotas and concerns about redeployment of staff. However, members of the executive team have since told us that the instances regarding bullying had now been considered in greater detail and it had been found that none of the cases associated to bullying involved a senior manager or members of the executive team. Some of the matters had been referred to the HR department and all were resolved without any requirement for a formal investigation.

266. In addition to the FTSU policy, the Trust has a specific policy in respect of the Management of Organisational Change. This provides, amongst

other things, for consultation with affected staff and their representatives where organisational changes are proposed.

267. Interviewees generally felt that there were appropriate channels available for raising concerns. However, some interviewees felt that whilst these channels existed, they did not always result in effective management action being taken when concerns were raised.

268. One interviewee confirmed that appropriate channels existed, but described an “undertone of impatience” when issues were raised. Another interviewee described how they had tried to raise an incident through the Datix reporting system but had been told not to and to keep things on a less formal basis.

269. The Chief Executive provided us with two examples of concerns that had been raised with the FTSU Guardian that led to effective management action being taken.

270. In the first case, a number of concerns were raised with the Speak Up Guardian between July 2017 and June 2018 regarding recruitment processes and latterly about standards of practice in the Maternity Department. The Chief Executive agreed to commission an independent review of the concerns. This was undertaken by the Deputy Regional Maternity Lead (Midlands & East) NHS England. The report was made available in October 2018 and the Chief Executive has met with the Head of Midwifery and the Head of HR Operations to take forward the recommendations from the report.

271. In the second case, in September 2016 a member of staff raised a concern about unfair management practice and an unfair proposal to reduce their working hours. A meeting was held between the staff member’s manager, the Chief Executive and the Speak Up Guardian. It was agreed to make the extra hours permanent. The manager agreed

that they needed support and a development programme was put into place.

272. Whilst interviewees were familiar with the Trust's Freedom to Speak Up Guardians, it was reported that one of the Guardians had been in the Trust for a long time. Some of those interviewed said that this Guardian gave the impression that they did not want to "rock the boat", particularly in dealings with the Chief Nurse. This led to a perception that some concerns were "brushed under the carpet", and not robustly dealt with.

273. There was also a perception on the part of several interviewees that the FTSU Guardians were managerially accountable to the Chief Nurse and this therefore inhibited people in raising concerns about the Chief Nurse with them.

274. The Chief Nurse explained to us that the 2 staff initially appointed to FTSU guardian roles were employed within the Nursing Directorate. However, as noted above, the Chief Executive is the Director lead for raising concerns, and is ultimately responsible for the Trust's FTSU policy, and the Guardians have direct access to the Chief Executive through regular monthly meetings and an agreement that the Guardians can speak to the Chief Executive whenever concerns are raised with them.

275. It was also reported to us that people had raised FTSU concerns with the Trust Chaplains as an alternative to the FTSU Guardians as they were concerned about what the consequences might be if they raised the issues through the FTSU route.

276. A further concern was raised by a number of individuals as to the lack of meetings between the Joint Local Negotiating Committee and Trust management. It was said that changes had been made to certain Trust policies, outside of agreed mechanisms, which had the potential to impact upon clinical staff. This was described by some interviewees as a

significant departure from the previous relationship between the LNC and Trust management which had been one of engagement.

277. The established practice was for JLNC meetings to take place on a quarterly basis, in or around March, June, September and December. We were told that since the appointment of the current Medical Director there had only been JLNC meetings on 27th September and 20th December 2017, although it should be noted that by the time of our interview with the Medical Director in October 2018, there had been a further JLNC meeting which took place on 19th September 2018. However, the previous 2 meetings that had been scheduled for March and June 2018 did not take place.

278. A number of those we interviewed said that the JLNC meetings had been cancelled without a cogent reason. However, the Medical Director told us that in March 2018 he received a significant number of apologies and there was a mix up as to his diary with his PA. He said that the JLNC in June was rescheduled but was then cancelled in error.

279. It is unfortunate that the JLNC meetings were cancelled at short notice, and then not rescheduled in a timely fashion. We note that meetings with the JLNC have now resumed and recommend that these continue on a regular basis.

280. We were told that the normal process for agreeing Trust polices was:

- Staff side and management meet to agree wording of policies;
- Policy referred to LNC and agreed at a JLNC meeting;
- Ratification at Trust Board.

This process is consistent with the approach we have observed in some other NHS organisations and has its origins in the Recognition Agreement between the Trust and staff-side which provides for consultation with the JLNC in respect of non-contractual employment

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matters, terms and conditions that can be varied as a right, and policies/procedures that are specific to senior medical staff.

281. Interviewees told us that the following policies have appeared on the intranet without consultation with the JLNC:

- Consultant and SAS Job planning policy;
- Senior Medical Leave policy; and
- Procedure for the Initial Handling of Concerns about Doctors and Dentists and the Management of Exclusions Policy ("referred to as the "Concerns Policy").

282. We were provided with documentation that evidenced the following engagement with the JLNC in respect of the policies referred to above:

- An email dated 27th December 2017 from the Medical Director's PA that was circulated to all members of the JLNC outlining proposed additions to the Consultant and SAS Job Planning policy that had been highlighted by the Trust's internal audit team, and requesting feedback by 12th January 2018.
- Minutes of the JLNC meeting on 29th March 2017 at which there was a discussion about the Senior Medical Leave Policy and it was agreed that the Chair of the Local Negotiating Committee would amend the policy to reflect the discussion and return it to the Director of Human Resources.
- An email from the Chair of the Local Negotiating Committee dated 3rd May 2017 enclosing the amended Senior Medical Leave Policy.
- Minutes of the JLNC meeting on 27th September 2017 at which there was a discussion about the Job Planning Policy.

283. Whilst the Medical Director and Director of Human Resources told us that the changes to policies were minor amendments we noted from the minutes of the JLNC meeting of the meeting on 19th September 2018 that:

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"*It was noted that a number of policies have been implemented which have not been approved at the JLNC. It was agreed that these policies should be reviewed without delay and it was agreed that a meeting would be arranged in November in order to review and approve"*..

284. The Director of Human Resources told us that he has "revamped" the Workforce and Staff Engagement Committee, the forum which he says is tasked with ratifying any revised workforce policies. A sample of the minutes of the Workforce and Staff Engagement Committee indicates that the members are members of the senior executive team and regular attendees appear to be from a number of management, governance and operational roles. The minutes from April 2018 do indicate that a number of Trust policies, including the Concerns Policy, are under review.

285. We have concluded that the Trust does have 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. However, we are concerned that these channels are not regarded by some staff as being robust and reliable, and appear to have been bypassed on some occasions, with staff preferring to raise their concerns with the Chaplaincy service.

286. It is unfortunate that during a period of major change and challenge for the Trust JLNC meetings only took place infrequently, with no meetings between December 2017 and September 2018.

287. There is evidence that some changes to the various policies referred to by some interviewees were circulated for comment by email prior to implementation. However, the JLNC also noted that a number of policies had been implemented without reference to the committee. We recommend that the Trust agrees with the JLNC what role the JLNC

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have in the consideration and approval of policies in future, and ensures that it whatever role is agreed is then observed consistently.

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

288. Some interviewees said that communication in respect of the recent CQC inspections and the requirements imposed on the Trust following those inspections had been reasonably effective via email and Chief Executive briefings in the lecture theatre. The CQC reports were also published and put on the Trust Hub (intranet).

289. However, some interviewees did not feel that there had been effective engagement with relevant staff in respect of the Trust response to CQC's requirements. One interviewee described how after receiving the latest CQC report the Executive team had made "non-deliverable promises to CQC" without the involvement or inclusion of relevant clinical staff. Another said that the Executive team was "running scared" of CQC and doing everything they could to comply with CQCs requirements, but failing to recognise and address underlying problems. Another interviewee said that everything seemed to be done in a panic, and that it felt like staff were being blamed for the issues raised by CQC.

290. We considered documentary evidence that indicated that relevant staff were involved in the development of CQC improvement plans. The Board minutes for February 2018 note that there had been weekly meetings with relevant teams regarding the requirements imposed by CQC following the inspection in December 2017. CQC action plans were also discussed in Divisional Performance Review Meetings.

291. We reviewed the Trust's action plan in respect of the Emergency Department from June 2018. This demonstrated that a range of clinicians within ED were involved in the development and

implementation of the plan, and were allocated responsibility for specific actions reporting to an Executive Director lead.

292. It should also be noted that the CQC required the Trust to take urgent remedial action following its inspections. Notices were served on the Trust pursuant to section 31 (1) (2) (a) of the Health and Social Care Act 2008 on 12th January 2018 and 5th February 2018, and the conditions imposed by these notices were varied by a notice dated 29th June 2018.

293. The first notice required the Trust to ensure with immediate effect that there was an effective system in place to identify, escalate and manage patients who may present with sepsis or a deteriorating medical condition in line with the relevant national clinical guidelines. In addition, the Trust was required to provide weekly reports to CQC describing the actions it was taking to comply with this requirement; the results of any audits undertaken that provided assurance and details of the staffing levels and leadership cover for ED.

294. The second notice also imposed immediate requirements on the Trust. The details of those requirements are as follows:

1. The registered provider must ensure that there is an effective system in place to robustly clinically assess all patients who present to the emergency department in line relevant national clinical guidelines within 15 minutes of arrival. This applies to the Emergency Department at Russells Hall Hospital.
2. The registered provider must ensure that this clinical assessment and the rationale for level of care provided is clearly documented in patients records.
3. From 5th to 9th February 2018 daily by 4pm the registered provider shall give written assurance to the Care Quality Commission that interim arrangements are in place and implemented to clinically assess all patients within 15 minutes of arrival at the emergency department.

4. From 9th February 2018 and on the Friday of each week thereafter by 4pm until further notice, the registered provider shall report to the Care Quality Commission confirming:

a) The action taken to ensure that an effective system is in place to clinically assess all patients within 15 minutes of arrival at the emergency department and progress on its implementation

b) The process and outcome of auditing, monitoring and implementing this system.

c) The results of all audits undertaken and assurance given to the Board of The Dudley Group NHS Foundation Trust that an effective system is in place.

The provider must ensure that effective governance arrangements exist with all third party organizations providing healthcare services at the Emergency Department at Russells Hall Hospital

6. The governance arrangements with all third party organizations providing healthcare services at the Emergency Department at Russells Hall Hospital must include feedback mechanisms to the registered provider to communicate concerns relating to any and all care delivered in order to ensure patient safety.

7. By 4pm on 5th February 2018 the provider must confirm in writing to the Care Quality Commission the arrangements in place with all third party organizations providing healthcare services at the Emergency Department at Russells Hall Hospital to communicate concerns relating to any and all care delivered in order to ensure patient safety.

8. From 9th February and on the last Friday of each month thereafter until further notice, the registered provider shall report to the Care Quality Commission confirming the ongoing governance arrangements and monitoring relating to any and all third party organisations providing healthcare services within its Emergency Department at Russells Hall Hospital.

295. In addition to these formal notices, the Trust received written feedback from CQC following its unannounced visits to the Trust in December

2017, March 2018, June 2018 and August 2018 and was required to take further action in the light of this feedback.

296. It is therefore clear that the Trust was required to comply with some of the CQC requirements on the same day as it received the CQC notice, and thereafter to provide (initially) daily assurance to CQC. In addition, the Trust needed to take account of the written feedback from CQC following its unannounced inspections, particularly where this feedback indicated significant concerns, and update its action plans accordingly.

297. The Chief Executive explained that when faced with these urgent requirements from CQC she "didn't want a cast of thousands" working on a response. It is therefore understandable that some clinicians may have felt that insufficient time was allowed for engagement, but this reflected the immediate need to introduce improvements that complied with the Trust's legal duties.

298. As noted earlier in this report, the Invited Service Review in respect of the adult emergency medicine service stated that clinical engagement is a two-way process where doctors and managers need to work together. There is some indication in the CQC report that senior clinical staff within relevant departments may not have engaged effectively in respect of the quality and safety requirements for their patients.

299. As noted in the CQC report of April 2018 when commenting on the Trust Emergency Department:

Senior staff within the service were out of touch with the reality of the quality of care and treatment provided in the department. They were unaware of key risks and took assurances from processes which were not being used and exercised by frontline staff.

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Senior clinicians within the department did not engage or embrace opportunities to improve the practice within the department and failed to recognise and accept areas of poor practice and compliance.

300. Specifically in the Emergency Department, CQC reported that:

There was a culture of insularity within the department and we found that staff blamed overcrowding for poor compliance with safety measures and poor practice. Senior staff used overcrowding as a rationale for lapses in care we identified. However, in a number of cases where we identified issues, the department was overstaffed and had significantly less patient attendances than the department's daily average.

301. We find that there was engagement with clinical staff regarding the management of CQC requirements notwithstanding the urgency with which some of those requirements had to be met. 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.

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.

304. We make the following recommendations in respect of Phase 1 of the investigation.

- As a priority, Trust leadership and consultants should proceed with the planned mediation process..
- 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.
- The consultant body to actively engage with the Trust leadership recognising the 2-way nature of effective engagement.
- 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.
- 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
- 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.
- To adopt the recommendations of the Invited Service Review in respect of Paediatrics if they have not already been implemented.
- 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.
- 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.

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 trust's current processes and there is evidence of appropriate learning and adaptation because of that reporting

302. The Performance Dashboard considered by the Board does not include data on complaints of bullying and harassment, and whilst the Workforce and Staff Engagement Committee Summary report is regularly presented to the Board this does not routinely include information about the reporting of incidents of bullying and harassment.

303. The Director of Human Resources explained that detailed information in respect of cases of bullying and harassment has been provided in a report to the Workforce and Staff Engagement Committee since July 2017. There is a mechanism for the Workforce Committee to report on exceptions to the Board, but it has not reported on bullying and harassment because this has not been determined as an area of concern that requires highlighting to the Board.

304. There is evidence from the FTSU Guardian reports that where concerns are raised, they are considered further and actions initiated, and that there is reporting of these actions to the Trust Board. By way of example, the FTSU Guardian report to the Board meeting on 8th March 2018 includes the following findings:

The concerns being raised vary considerably in complexity and as a consequence the time and resources required to come to a conclusion

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do differ markedly. Some issues can be resolved quickly by the Guardian, sometimes with the assistance of the Chief Executive, in liaison with local management while others are handed over, with the agreement of the person raising the concern, to such departments as Human Resources and Complaints.

The following are some latest examples of actions/outcomes as a result of concerns raised on the following topics:

- *Recruitment process: a mistake in an advertisement for an internal post resulting in tighter future management processes*
- *Referrals between clinical teams: meeting arranged between lead consultants of the two areas involved and agreement made on improvements to referral communication*
- *Nervecentre processes: involved the Director of Medical Education in progressing this and a project agreed on clarifying the issues.*
- *Unfair rostering: person undertaking the rostering changed and plan to move to autorostering in place*
- *Unfair behaviour: mediation meeting held with an agreed outcome to all parties.*
- *Working arrangements: An alternative offered to member of staff but this was rejected and so issue handed back to the Human Resources Department.*

305. The CQC inspection report dated 18th April 2018 notes that:

We reviewed the Freedom to Speak Up Guardian update (December 2017) and saw that between April 2017 and November 2017 the majority of concerns raised to the Freedom to Speak Up Guardians related to line and senior managers regarding perceived behaviour :bullying, harassment and perceived unfair behaviours such as unfair recruitment, rotas and concerns about redeployment of staff. However, members of the executive team have since told us that the instances regarding bullying had now been considered in greater detail and it had been found

that none of the cases associated to bullying involved a senior manager or members of the executive team. Some of the matters had been referred to the HR department and all were resolved without any requirement for a formal investigation.

306. The Chief Nurse told us that staff had informed her that they had reported concerns regarding two other executive directors to the FTSU Guardians but we were unable to corroborate this from the documentation that we reviewed.

307. There was anecdotal evidence from interviewees of cases where bullying and harassment had been reported but no apparent action had been taken in response.

308. One interviewee reported that concerns had been raised with the Director of Human Resources about inappropriate behaviour which could have been regarded as harassment from a senior colleague but no action was taken. We have been unable to corroborate this account as the interviewee was not prepared to waive their anonymity in order for us to provide further details to the Director of Human Resources. Nevertheless, the Director of Human Resources told us that he takes all matters related to harassment of staff very seriously and arranges for appropriate advice and support to be provided. The absence of a formal response in this instance may have been because an informal intervention was deemed appropriate in the circumstances.

309. Another interviewee stated that they had spoken with the FTSU Guardian about bullying behaviour, but only on an informal basis.

310. Other interviewees told us that other staff had told them about issues of bullying which had not been reported formally because of concerns as to how the Executive team may react. There is therefore no formal record of these matters or any Trust response to them. This issue is considered further in term of reference 2(a)(iii).

311. In conclusion, therefore, we have found that there have been incidents since April 2017 of bullying and intimidation reported through the Trust's current processes, as identified in the CQC report. These incidents have been considered by the executive team and some were referred to the HR department. All were resolved without the need for a formal investigation. Whilst some interviewees told us that bullying and harassment had been reported but no apparent action taken in response, we were not able to corroborate these accounts.

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

312. ACAS defines bullying and harassment as follows:

Harassment

Harassment is unwanted conduct affecting the dignity of men and women in the workplace. It may be related to age, sex, race, disability, religion, sexual orientation, nationality or any personal characteristic of the individual, and may be persistent or an isolated incident. The key is that the actions or comments are viewed as demeaning and unacceptable to the recipient.

Bullying

Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be

insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual.

313. In considering the evidence we received from interviewees, we were guided by these definitions, and in particular the emphasis that they place on how behaviour is perceived by the recipient of that behaviour. Whilst we recognise that it is sometimes necessary for managers to deliver challenging messages to staff in respect of their performance or conduct, it should be possible to do this without creating a perception of bullying or harassment.

314. In the 2017 National NHS Staff Survey (the most recent survey results that were available during the investigation) the percentage of Trust staff experiencing harassment, bullying or abuse from staff in last 12 months was reported as 21% (up from 20% the previous year). This was not a statistically significant increase. It was also below the benchmarking figure for acute and community trusts of 24%.

315. Some interviewees told us about behaviours that they regarded as bullying and intimidation of Trust staff. Most of these were described in general terms and did not involve the interviewees themselves and so it was not possible to corroborate them. However, some accounts related to specific incidents and we detail these below.

316. The Trust's Chaplaincy Team Leader told us that bullying was Trust-wide, and that people would speak to the Chaplaincy team rather than the Trust's Freedom to Speak Up Guardians as there were concerns about the impartiality and managerial accountability of the Guardians.

317. As noted earlier in this report the 2 staff appointed to FTSU guardian roles were employed within the Nursing Directorate. However, the Chief Executive is the Director lead for raising concerns, and is ultimately responsible for the Trust's FTSU policy, and the guardians

have direct access to the Chief Executive. In contrast, the Chaplains report to the Chief Nurse via the Head of Patient Experience.

318. The Non-Executive Director focus group was asked to comment on whether there was a culture of bullying at the Trust. Non-Executive Directors queried whether there was a culture of bullying, or whether this just reflected the management style of the Leadership team. Some NEDs said that staff had commented to them about an aggressive culture and management style, and that they had heard of examples of staff being treated in an aggressive way. One NED said that they could see why people would consider the current team to be "abrupt", that there had been a definite change in culture, and that in their view this was a cause for concern.

319. The NEDs acknowledged that when this Leadership team came into place they unearthed a number of significant issues that needed to be addressed, but some NEDs felt that their approach to addressing those issues has not been conducive to engagement and had promoted a degree of fear in the organisation.

320. NEDs confirmed that the Trust Board was working towards a positive culture of the organisation, and how they could support this was a matter for regular discussion. In at least one instance a frank discussion took place in a private session of the full board, which involved the presentation of a 'mind-map' to facilitate discussion.

321. It is also important to acknowledge the serious nature of the concerns that were identified by the incoming Leadership team, and the importance to the Leadership team and the Trust generally of addressing them.

322. In addition, it should be noted that the feedback from some interviewees was that there is generally a friendly and supportive

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culture within the Trust, and that this has not materially changed in the last 18 months with the appointment of the Leadership team.

323. One episode that was referred to by several interviewees concerned the attendance of a nurse to present a report at a CQSPE meeting. We were told that the nurse did not know a number of those present at the meeting and was not introduced to them. When presenting the report the nurse was subjected to a lot of questions, and this questioning continued despite it being apparent to some of those present that the nurse was unable to answer the questions. It was also reported to us that the body language of some attendees was unsupportive, and indicated frustration and impatience.

324. The Chief Nurse, who was not present at the meeting, was subsequently approached by a colleague who had attended the meeting and was distressed by what had occurred. As a result the Chief Nurse apologised to the nurse who had attended the CQSPE meeting in person for the treatment that the nurse had received at the meeting.

325. Following this meeting, the nurse reportedly required medical support and according to the Chief Nurse subsequently took a period of sick leave. In addition, the Chief Executive enquired after the i nurse via the nurse's line manager who acknowledged that the nurse should have been properly briefed for the meeting.

326. We were also told by some interviewees that one of the Clinical Directors had been subjected to bullying by the Medical Director. In particular, it was reported to us that the Medical Director had made comments expressing concern about this Clinical Director's professional registration with the GMC. These were perceived by the Clinical Director as being threatening, whereas whilst the Medical Director acknowledges that he made the comments, he said this was

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not in a threatening way. He explained that he had said that the Clinical Director was working to excess clinically and that if he made a clinical error the Trust and he would be professionally compromised.

327. We were also told that the Medical Director had asked the Clinical Director for the identities of signatories to the anonymous letter.

328. The Chaplaincy Team Leader reported comforting individuals who had been reduced to tears as a result of the behaviour they had been subjected to by members of the Leadership team 'on an almost daily basis'. The Chaplaincy Team Leader identified the Chief Nurse and the Medical Director as the two individuals who had been most frequently cited as the causes of this distress.

329. It should, however, be noted that despite having weekly meetings with the Chief Executive, the Chaplaincy Team Leader did not raise these concerns with her. Similarly, the Chaplaincy Team Leader met the Medical Director on a number of occasions without raising such concerns with him. In addition, monthly Chaplaincy reports were submitted to the Nursing and Midwifery Directorate Quality and Governance Meeting and these did not refer to these matters.

330. The Chaplaincy Team Leader explained that what was said to him was said in confidence and therefore he would not divulge the content unless he had consent to do so. Instead he tried to empower members of staff to use the Freedom to Speak Up Guardians to raise concerns. He did, however, raise a general concern about staff morale with the Chief Executive.

331. The Chaplaincy Team Leader's view was that members of staff felt very isolated. Thus, whilst he wished to maintain confidentiality he thought that individuals speaking to him should be made aware that others had similar concerns. He believes that by doing this he

eventually helped lead to the letter of concern that prompted this investigation.

332. We acknowledge the dilemma for the Chaplaincy Team Leader if regular and serious concerns were raised with him but those raising the concerns wished to preserve their anonymity.

333. The Chaplaincy Team Leader also said that he had heard of a number of accounts of intimidatory behaviour from the Medical Director, including the threatened use of the Trust's disciplinary procedures and GMC referral as a form of control over Trust clinicians.

334. The Medical Director has subsequently provided us with information that shows the number of GMC referrals over the past three years has been as follows:

2016 8 (Fitness to Practice)
3 (Revalidation)

2017 2 (Fitness to Practice)
1 (Revalidation)

2018 3 (Fitness to Practice)
3 (Revalidation)

There is therefore no evidence that the number of GMC referrals has increased during the tenure of the current Medical Director. In response to the allegation that he has threatened colleagues with GMC referrals, the Medical Director told us that he had reminded people of their professional obligations and the regulators' interest in the hospital at the request of the NHS Improvement Lead for Professional Development.

335. The Chaplaincy Team Leader also reported that he had several conversations with colleagues regarding the Chief Nurse's behaviour;

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in particular he stated that a member of staff had been ‘reduced to tears’ as a result of the Chief Nurse’s ‘unprofessional behaviour’.

336. It should be noted that the Chaplaincy Team Leader provided no specific examples of any of the incidents referred to, though we were told that this was to preserve those individuals’ anonymity. In addition, it is unfortunate that the Chaplaincy Team Leader did not feel able to escalate the general themes of the concerns that were raised to senior leaders within the Trust, which may have enabled action to be taken.

337. One interviewee stated that in their view bullying was a subjective experience for individuals rather than a ‘culture’ within the organisation. This interviewee had not witnessed any bullying by most members of the Leadership team although did state that some could be “straight-talking and forthright”, and this contrasted with the approach of the previous leadership team. This interviewee did, however, say that they had witnessed bullying and unprofessional behaviour by the Chief Nurse. This had been raised with the Chief Executive but the interviewee was not aware of any formal action having been taken in response. Again, no specific evidence in support of this allegation was provided to the investigators.

338. A significant number of other interviewees commented on their interactions with the Chief Nurse. She was described by one interviewee as not being very self-aware and displaying a somewhat dictatorial style of leadership. Interviewees did not always feel that the Chief Nurse listened to them during their interactions. One interviewee described the Chief Nurse as being “*unrestrained in comment and behaviour*.” Whilst the interviewee felt that this behaviour could come across as being bullying and harassment, they did not think that the Chief Nurse intended this.

339. Another interviewee said that the Chief Nurse could adopt a condescending manner and be critical of others while not appreciating

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the impact of doing so. However, this interviewee said that the Chief Nurse's approach had changed in the last few months and that she was now more calm and measured.

340. Other interviewees were more critical, saying that they had experienced the Chief Nurse shouting at staff and that people avoided her because of her reputation for shouting. We put this to the Chief Nurse in our interview with her and she said that she does not shout.

341. It should be noted that no evidence was provided in support of the concerns about the Chief Nurse described above, and there is no indication that they were reported through any of the Trust's formal routes for raising concerns.

342. The Chief Nurse described herself as familiar with and supportive of speaking up, and proud of how approachable she is. She did however acknowledge that there may have been occasions where she has highlighted to staff that existing standards and practices within the Trust fell below what was acceptable.

343. The Chief Nurse stated that she had numerous difficult conversations to address situations where services at the Trust fell below an acceptable standard. These conversations included frequently having to hold staff to account, addressing poor outcomes and insisting that timely action was taken to resolve issues. We accept her view that addressing significant concerns which have gone unchallenged for some time is not easy and bringing about necessary change is not something which all staff will have found easy to accept, particularly if they feel they have been criticised for how things have been run in the past.

344. It should also be noted that some individuals did comment during their interviews with the Investigative Team that the Chief Nurse was good for the Trust; that her honesty, enthusiasm and passion were

appreciated, and that they did not recognise the allegations of bullying and intimidation that had been levelled against her.

345. In addition, the Chief Nurse told us that she received numerous requests to meet with staff and visit their wards and was respected for her engagement and focus on improving patient experience.

346. Some members of the Leadership team also commented on the Chief Nurse's behaviour. The Chief Operating Officer identified that the Chief Nurse's 'style of management' was potentially challenging for some individuals. The COO stated however that she had not witnessed any behaviour from the Chief Nurse that she considered bullying or intimidating.

347. The Director of Human Resources said that he was aware that the Chief Nurse had had 'difficult conversations' with consultants who didn't like to be challenged. He did however identify one instance in which he witnessed the 'fallout' of an argument between the Chief Nurse and an ED consultant, although he did not witness the argument itself. He stated that the Chief Nurse was behaving "in a troubling manner" and that he was concerned for her. Although a mediation-type meeting was arranged between the Chief Nurse and the Consultant in question, the Director of Human Resources stated that he did not think this meeting would be successful because the Chief Nurse was 'very angry' and 'not objective' during that part of the meeting when he was present. The Chief Nurse told us that in fact the meeting ended positively and that she subsequently worked well with the Consultant.

348. The Director of Human Resources was asked what he had done about the Chief Nurse's behaviour in view of his role as a corporate director. He stated that he raised the issue with the Chief Executive, and that she told him that she would take it forward. However to his knowledge no formal action was taken.

349. The Chief Executive confirmed that the Trust had received 2 undated anonymous letters regarding the behaviour of the Chief Nurse and she had also personally witnessed an "over-zealous" approach by the Chief Nurse to a receptionist in ED.

350. The first anonymous letter indicated that the author wished to remain anonymous as they feared:

"that the culture within the Trust and nursing in particular is one of "blame and intimidation"

351. The author said that they had been subject on a number of occasions to behaviours by the Chief Nurse which caused offence, including being undermined in front of colleagues, and via e mail, and being talked over in meetings. The author described the Chief Nurse's management style as a "dictatorship".

352. The second letter raised similar concerns, stating that the author did not feel they could approach the FTSU guardian as the guardian "worked for" the Chief Nurse. The letter referred to at least 5 people who had said they were bullied by the Chief Nurse, not allowed to do their work, consistently criticised, and treated with verbal aggression and attitude.

353. The Chief Executive explained that these matters had resulted in candid discussions between her and the Chief Nurse about the latter's behaviour but she 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 is difficult to investigate them further.

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354. The Chief Executive said that she advised the Chief Nurse to source a coach and offered support to her to discuss difficult issues when these arose.

355. The Chief Nurse's account of this discussion is somewhat different but she points out that no formal action was taken, or notes put on the Chief Nurse's file. As part of the leadership development programme the Chief Nurse had access to a coach and she took up this opportunity.

356. The Chief Executive observed that the Chief Nurse's behaviour had subsequently "settled down". The Chief Executive stated that no other concerns about the Chief Nurse were raised with her, and also told us that both the Director of HR and Trust Chair were supportive of the Chief Executive's response to the two anonymous letters.

357. The Chief Nurse was appointed to the substantive role after the Trust received the first anonymous letter which suggests that notwithstanding the concerns raised in that letter the Trust was satisfied that she was fit to hold a substantive Director role.

358. In conclusion, we find that there are a number of allegations of bullying and intimidation of staff, primarily by the Chief Nurse but also by the Medical Director. These 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. It was in any event beyond the scope of our terms of reference to investigate specific allegations.

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

359. Some interviewees reported that they believe members of staff are afraid to report incidents.

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360. Several interviewees cited the Chief Nurse’s behaviour and alleged unpredictability as a reason why staff were reluctant to raise concerns or report incidents. One said that the Matrons were very anxious about the Chief Nurse’s behaviour, and that this in turn impacted on what they raised in meetings.

361. One interviewee stated that people were worried about losing their jobs, and that this was placing a strain on the whole organisation, commenting that “If I say anything they'll come after me”. Another interviewee described a reticence within the organisation to raise concerns. They said they had witnessed senior managers being intimidated, browbeaten and reduced to tears, although we were not given details of specific incidents. Furthermore, most of the views expressed by interviewees were that other staff (rather than the interviewees themselves) were afraid to report incidents.

362. We also noted a view expressed in the Non-Executive Directors’ focus group that the approach of the Leadership team to tackling the challenges that the Trust faces has promoted a degree of fear in the organisation. Some Non-Executive Directors indicated that even they were not encouraged to offer challenge to the Leadership team, although this was not the view of the whole group.

363. This view was not shared by members of the Leadership team, who referred to significant and at times robust challenge during Board meetings. We saw evidence of this challenge in Board minutes. They also pointed out that Non-Executive Directors are publically accountable members of the Board whose role is to oversee the executives and seek independent assurance of the effective functioning of the Trust. As a result, they should not need to be encouraged to provide appropriate challenge.

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364. Whilst some interviewees provided anecdotal evidence that incidents may be downgraded and concerns minimised, as considered in further detail below, we did not find evidence that there had been inappropriate downgrading or closing of incidents.

365. The Chief Nurse told us that she introduced and encouraged benchmarking, looking outside of the Trust to determine what the Trust's performance was. She played a key role in the introduction of the new Annual Quality Metric, designed to increased and improve reporting.

366. We also noted from the documents that were reviewed that the new Leadership team has in fact focussed on the reporting and prompt investigation of incidents and that this has been reviewed at CQSPE and Board level.

367. By way of example, in September 2017 the Board received a report by the Director of Governance/Board Secretary in respect of Serious Incidents. This reported on never events; numbers of reported serious incidents and the extent to which the Root Cause Analysis (RCA) for serious incidents was being completed within 60 days. The report noted that extra training was being arranged and delivered to Trust staff to assist with the better production of RCAs. The number of open incidents was noted, and it was reported that the vast majority were "no harm" incidents, but without them being closed in accordance with the prescribed process and timescale the Trust could not be confident all learning and feedback had been extracted. It was noted that the Divisions had been given a trajectory to close incidents.

368. The national Serious Incident Framework published by NHS England in March 2015 notes that:

Whilst a serious outcome (such as the death of a patient who was not expected to die or where someone requires on going/long term

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treatment due to unforeseen and unexpected consequences of health intervention) can provide a trigger for identifying serious incidents, outcome alone is not always enough to delineate what counts as a serious incident. The NHS strives to achieve the very best outcomes but this may not always be achievable. Upsetting outcomes are not always the result of error/ acts and/or omissions in care. Equally some incidents, such as those which require activation of a major incident plan for example, may not reveal omissions in care or service delivery and may not have been preventable in the given circumstances. However, this should be established through thorough investigation and action to mitigate future risks should be determined.

369. Therefore, incidents that result in no harm should nevertheless be investigated appropriately in order to ensure that relevant learning is extracted from them. Incidents should only be closed once an investigation has been completed and relevant lessons learnt. It is not clear from the evidence we considered whether the imposition of a trajectory to close incidents had any negative impact on the quality of learning extracted from “no harm” incidents.

370. One aspect of the incident reporting process that we were told was challenging for the Trust was the amount of time taken by the CCG to close down RCAs. The report referred to above noted that the Trust Chair would raise this with the CCG Chair, and this was subsequently done.

371. The board minutes for September 2017 also noted that the Chief Nurse had requested that benchmarking data should be added to the incident reporting paper to compare the Trust against the best organisations, which are the highest reporters of incidents. The Board approved this amendment to the data that would be presented in subsequent reports.

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372. Incident reporting was considered again by the Board in February 2018. At that time it was noted that the Executive Team had agreed further resource for the Incident Team so that it would be able to business partner the divisions in closing incidents in a more timely manner and directly extract learning to enable learning to then be cascaded across the Trust. It was noted that the report of learning reported and applied suggested some improvement against that seen previously. The Board noted that the Trust was not a high reporter of incidents overall and that continuing work was needed to improve the Trust's incident reporting culture.

373. The documentary evidence in respect of incident reporting was corroborated by comments from members of the Leadership team. The Chief Executive explained that prior to her arrival the Trust had not used the Datix electronic system for reporting incidents, and she and other executives remarked on the lack of patient safety data that was available within the Trust at that time.

374. Having considered all of the evidence presented to us on this issue we have concluded that whilst there has been a drive from the leadership team to close down incidents, this has been in an effort to comply with good practice in respect of the timely reporting and analysis of those incidents rather than in order to suppress information. We are satisfied that the leadership team has shown an interest in encouraging a reporting culture within the Trust. We do not find that there have been attempts to minimise reporting of patient safety concerns.

375. It is however, concerning that on the basis of comments received from some interviewees there may be some staff who are afraid to report adverse incidents. We have not been able to assess whether these comments are accurate, or the extent to which reportable incidents may not have been reported.

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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

376. Some of the staff that we interviewed have serious concerns about the effectiveness of the Trust's bullying and harassment and whistleblowing policies, but this does not provide a clear indication that Trust staff generally do not trust those policies.

377. As noted earlier in this report, the Trust Board receives quarterly reports from the FTSU Guardians and these include comparative data for the Trust and other local Trusts. The data do not suggest that the Trust is an outlier in respect of the incidence of FTSU concerns being raised.

378. In the 2017 National NHS Staff Survey (the most recent survey results that are available) the percentage of Trust staff experiencing harassment, bullying or abuse from staff in last 12 months was reported as 21% (up from 20% the previous year). This was not a statistically significant increase. It was also below the benchmarking figure for acute and community trusts of 24%.

379. The survey also reported the percentage of staff/colleagues reporting their most recent experience of harassment, bullying or abuse. The Trust's result for 2017 was 46%, which is an increase of 2% on the previous year, and compares with a benchmarking figure for combined acute and community trusts of 47%.

380. It should be noted that the Trust staff survey response rate was 36%, which was a reduction of 8% compared with 2016, and also below the benchmark of 43%.

381. Some interviewees did, however, tell us that staff did not have confidence in the Trust's processes for addressing bullying,

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harassment and whistleblowing. Interviewees said that when concerns are raised there is no evidence that they are dealt with. This results in a loss of confidence in the process and a feeling of 'What's the point'? They said that this is exacerbated by a lack of trust that those raising concerns will be treated fairly and without reprisals.

382. This view may in part be due to the fact that not all managerial interventions are visible to Trust staff generally. For example, the Chief Executive told us that she had intervened when allegations of poor behaviour by the Chief Nurse had been made in anonymous letters by discussing them with her on a 1:1 basis.

383. Similarly, the CQC report in April 2018 noted that all of the concerns raised with the FTSU Guardians in respect of bullying and harassment were resolved without any requirement for a formal investigation.

384. Particular concerns were raised by some interviewees in respect of the neutrality of the FTSU guardians, and the perception that they were managerially accountable to the Chief Nurse. This in turn was said to inhibit staff who may wish to raise concerns about the Chief Nurse. In fact, as noted earlier in this report, the FTSU Guardians had direct access to the Chief Executive, and the perception that they were accountable to the Chief Nurse was due to the fact that they were nurses by background.

385. We heard from the Trust's chaplaincy team that they spoke to people who were in tears as a result of the treatment they had received and felt that they had no-one else to turn to. However, these people often asked the chaplains not to escalate their concerns any further within the Trust.

386. In conclusion, we find that 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. This is consistent with the comments made by the Chaplaincy Service that some staff approached the chaplains instead of the established channels for raising concerns.

v. the Trust has taken sufficient steps to ensure that the leadership team display role model behaviour

387. Some of those we interviewed did not feel that the leadership team displayed role model behaviour, although this was not a universally-held view. Issues cited in support of this view were that the leadership team did not listen to staff; imposed its own views without discussion and displayed behaviour that was disrespectful.

388. As noted earlier in this report, several interviewees cited the behaviour of the Chief Nurse as causing upset and distress although these allegations were not substantiated and have not been investigated further.

389. In the Non-Executive Director focus group a view was expressed that the new Leadership team's approach had promoted an aggressive blame culture. One of the NEDs described the Leadership team as defensive.

390. Members of the Leadership team acknowledged that it had been necessary to deliver some difficult messages to staff upon their arrival at the Trust. Specifically, a number of issues were identified by the new leadership team where the Trust was not achieving acceptable standards of performance, quality or safety. The Medical Director commented that a large number of safety issues related to safeguarding, sepsis, the deteriorating patient, breast screening and histopathology had crystallized since the new Leadership team arrived, and these have had to be addressed.

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391. An example of behaviour that was raised with us by several interviewees that was not felt to set a good example was members of the Leadership team executive team regularly parking in disabled bays because these were located closer to the Trust HQ.

392. We raised this with all members of the Leadership team. The Chief Executive explained that parking on the site is often difficult, and can be particularly so if returning from a meeting in the middle of the working day. She had therefore agreed with the facilities management team that she would be provided with a pass for using a disabled bay when other parking spaces were not readily available. Subsequently, other members of the executive team also parked in disabled bays. Matters came to a head when one of the consultants took photographs of whose vehicle parked in a disabled bay. At this point the Chief Executive spoke to her colleagues, and it was agreed that in future they should use the peripatetic parking area that had been designated to the front of the hospital.

393. The Chief Operating Officer explained that consultants at the Trust had raised the issue of parking in the disabled bays with her and that she had shared this with her executive colleagues and explained that it was not the right thing to do. Following this, the decision had been made that Executives should not use disabled bays in future but that appropriate alternative provision should be made.

394. The Chief Nurse confirmed that members of the executive team frequently parked in disabled bays outside of Trust HQ. She had been provided with permission to park in the disabled bays due to special circumstances.

395. We did receive evidence that members of the leadership team display role model behaviours. Specifically, we noted that Chief Officer for Adult Social Care acknowledged the honesty, openness and

resilience of the Chief Executive. In addition, the Chief Nurse provided us with documentary evidence that showed that some staff considered her to be a role model for the organisation.

396. In the light of the information we received, we conclude that there is a view amongst some Trust staff and NEDs that the style of the Leadership team is not always consistent with role model behaviour and may not promote a positive culture. However, the only specific example provided of behaviour that did not set a positive role model concerned parking in disabled bays.

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

397. As noted earlier in this report interviewees were generally aware of the channels available for speaking up, and the evidence indicates that the Trust is not an outlier in respect of staff raising concerns with the FTSU Guardians. Some interviewees told us they were reluctant to raise concerns through these channels because they were unsure who their comments would get back to. Another commented that there had been a positive change of culture on paper, but in reality there had been no change.

398. One individual told us that they and a group of their colleagues had been addressed by a member of the Trust senior management (although not an Executive Director) on this matter and had been told 'not to bother raising things with the Freedom to Speak Up Guardian as it just gets back to us anyway'. The individual was not clear whether this message was intended to be a threat or a comment that their concerns are listened to by the senior team (and that as such they should be willing to bypass the freedom to speak up guardian and approach the leadership team directly). Whatever the intention, the interviewee was clear that the people that they had spoken to who had

received that message had been left with doubts as to the safety and validity of raising concerns through the Trust's speaking up channels.

399. We were also told that there had been an occasion where support had been sought from an Executive Director in order to address FTSU concerns that had been raised and the response had not been helpful. In contrast, the Chief Executive provided details of cases that had been raised with the FTSU Guardians where she had intervened to achieve a successful resolution.

400. Both the Chief Executive and the Chief Nurse emphasised their commitment to promoting a speak-up culture. The Chief Executive told us that she has regular meetings with the FTSU guardians, and also personally became involved in resolving issues that are raised with the Guardians. More generally, we noted from the various Board and committee papers that we reviewed that the Executive team expressed an interest in promoting the reporting and analysis of incidents.

401. We also noted when we attended the Trust that posters advertising the FTSU Guardian service were prominently displayed, and we understand that the national FTSU Guardian attended the Trust on 11th October 2018 for a meeting with staff.

402. 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 FTSU process has increased under the current Leadership team and is in line with local comparators. However, that some staff have reservations about the Leadership team's commitment to this culture.

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

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403. Soon after the appointment of the Chief Executive in April 2017 the Trust engaged Deloitte to devise an Executive Team Development Programme. This comprised 10 workshops together with executive coaching. A further development programme aimed at the divisional leadership teams was devised by Deloitte in November 2017.

404. The Deloitte report of the Trust's Well Led Review in December 2017 noted that:

The Board and, in particular, the Executive team has undergone a number of changes in recent months with a number of posts refreshed following the current Chief Executive Officer's (CEO) appointment. Whilst this represents significant turnover at Board level, the changes have generally been positively received by staff, senior managers and fellow Board members (BMs). The new team are seen to have brought increased rigour and pace to the organisation and, whilst this has proved challenging at times, the different style is recognised as being beneficial to the Trust and we concur with this view.

405. The report identified the need for clearer succession planning for key leadership roles alongside a review of corporate functions. Board Members confirmed to Deloitte that there was scope for improved succession planning at Board and senior leadership levels, with an historically reactive approach combined with a significant lack of investment in this area. Interviewees also commented on the previous lack of leadership development and talent management which compounded succession planning concerns across the layers of organisational leadership. The COO portfolio was cited as an example where the organisation has experienced challenges in this regard. Specifically, this Executive post had been without deputy support for a number of years, with unsuccessful attempts made to recruit to this role.

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406. The turnover of the executive team was also noted by CQC in its report dated 18th April 2018. This stated that:

"The chief executive (CEO), the chief operating officer (COO), the chief nurse and the medical director had all been in post less than nine months at the time of our inspection. The capacity of the executive team was impacted on due to either no deputy structure being in place or individuals who did not have the capacity or expertise to take the issues forward. This had resulted in the executive team taking on multiple roles to try to resolve issues in a timely manner, it was recognised this could not continue and key areas of responsibility needed to be transferred to those who were accountable. We saw that the executive team had already addressed and prioritised many issues and that they were actively recruiting to strengthen the capacity of the team.

407. None of those we interviewed referred us to any impact assessment or risk assessment being undertaken in connection with the turnover in leadership. However, we were told that 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.

408. As noted earlier, whilst several interviewees questioned whether proper recruitment procedures had been followed in respect of some senior appointments our enquiries satisfied us that appropriate recruitment processes were followed for all Executive appointments.

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

409. The Trust commissioned Deloitte to undertake an independent review of its governance arrangements against NHS Improvement's

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Well-led Framework between September and November 2017. The final report following that review was presented on 21 December 2017. This noted the progress that the Trust had made in improving the dynamics between the leadership and staff, but acknowledged that further work was needed. The report contained the following findings in this regard:

"The Trust's values are known by staff and we have noted an open, transparent culture under the current leadership. However, the Board must ensure it balances increased pace and rigour with consideration of the impact of this on staff. Leadership and organisational development have been lacking historically, and whilst recent improvements have been made, these remain a work-in-progress. Staff are able to raise concerns, though subsequent feedback on action taken could be improved. The Board has recognised shortfalls in relation to incident and complaints investigation and response times, and the Chief Nurse is ensuring a focus in this area."

"The Board is focused on improving internal and external stakeholder engagement. However, there are areas where further improvements could be made, specifically in relation to: patient experience; the communication of changes made as a result of staff feedback; Governor training and exposure to the Non-Executive Directors (NEDs); and external stakeholder mapping to ensure co-ordinated and appropriate levels of engagement."

410. The Deloitte Well Led Review included a recommendation to establish a broader Board development programme that should include a focus on cohesion; assurance; and challenge and debate.

411. There was a Board Workshop on 7th December 2017 where the Trust's action plan in respect of the Well Led review was presented. This included an action to undertake formal board development. Board Development was also discussed by the Board in January 2018.

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412. There was a further Board workshop on 15th February 2018 to consider feedback from CQC on its well led findings. Between April and May 2018 there were further discussions and emails, including scoping discussions with Deloitte around the content of the board development programme. It was not possible to commence the programme in May due to the availability of the Deloitte team.

413. A Board Development planning session with Deloitte took place on 19th July 2018. At this session, Deloitte presented the following suggested content for Board Development:

1. *Building effective Board debate and challenge*

- *Dynamics and cohesion;*
- *Board member values and behaviours*
- *Operating as a unitary Board and the role of a corporate director*
- *Board debate*

2. *Strategy*

- *Balancing stewardship and supervision*
- *Clarifying priorities and approach to monitoring progress*
- *Aligning supporting strategies*
- *Linking to QI initiatives*

3. *Board Committees and the BAF*

- *Committee focus and effectiveness*
- *Committee reporting to the Board*
- *BAF*
- *Board and committee papers*

4. *Culture*

- *Establishing the culture from the top*
- *Building alignment across the Trust*
- *Board visibility and connection to SLT and the Trust*

414. This was followed by Board Development Sessions with Deloitte on 2nd August and 8th November 2018, with 3 further workshop sessions planned as well as calls with individual Board members; a Board survey and Board observations.

415. We received feedback from the Non-Executive Director focus group that some Non-Executives feel that the Board is not currently functioning as an effective unitary Board. We were told that the committee structure is not working effectively and that there is a lack of communications and trust. Some NEDs believe that this is due to lack of a coherent and clear strategy which makes it difficult to judge success. It should, however, be noted that the Trust has an existing strategy which is being refreshed, and there is also a clinical strategy, an annual business plan and a link between strategic objectives and actions within the yearly business plan from which individual objectives flow.

416. Some Non-Executive Directors also felt that there is insufficient challenge in meetings, despite this being an important element of the NED role, although this was not the view of the whole group. They said that sometimes it was hard to see where problems might arise as they were contained in lengthy reports which it can be hard to pick through.

417. Interviewees had mixed views as to whether Board development could address the perceived dynamics between leadership and staff. Some felt that the relationship between Executives and clinicians had broken down irretrievably. They mentioned that some senior consultants had already resigned, and others were due to leave soon and that this reflected a loss of trust in the leadership team. However,

the Trust is continuing to have successful recruitment to both consultant and nursing posts, and whilst the number of consultant leavers between November 2017 and November 2018 was 16, new consultant joiners in the same period totalled 30.

418. Other interviewees 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.

419. It was concerning to us that the Medical Director considers that he has been systematically bullied by a group of consultants prior to and following his appointment. The relationship between the Medical Director and the consultant body is crucial if the Trust is going to be able to move forward in a positive way.

420. We note that the Trust has already committed to engaging in a mediation process with True North Organisational Consulting in order to facilitate a dialogue between members of the Consultant medical staff and the Trust Executive. The aim of this facilitation is to help build a stronger space of common ground and trust between the signatories to the anonymous letter and the Trust Executive. This mediation is intended to focus on improving relationships for the future, and conclude with agreements on the improvements that are jointly sought by the Executive Team and the Consultants, how trust between them will be enhanced, and how any future tensions will be approached by the parties through these improved relationships.

421. Alongside this mediation the Trust should proceed with the planned Deloitte Board Development programme, and we note that the content of this programme includes working as a unitary Board and establishing organisational culture from the top. We recommend that this report should inform the delivery of these elements of the Board Development programme.

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.

422. We make the following recommendations in respect of Phase 2 of the investigation:

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

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

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

- 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.