Meeting in common of the South Gloucestershire Health Scrutiny Committee and the Bristol People Scrutiny Commission

Wednesday, 23rd November, 2016 (from 4.30pm)

South Gloucestershire:

Present
Councillors: Kaye Barrett, April Begley, Janet Biggin, Robert Griffin, Paul Hardwick, Shirley Holloway, Sue Hope, Marian Lewis, Sarah Pomfret, Toby Savage (Chair) Ian Scott and Maggie Tyrrell

Apologies for Absence
Apologies for absence were received from: Councillors Gloria Stephen (replaced by Maggie Tyrrell) and Erica Williams

Officers in Attendance
Gill Sinclair (Deputy to the Head of Legal & Democratic Services), Claire Rees (Health & Well Being Partnership Support Officer) and Karen King (Democratic Services)

Bristol:

Present
Councillors: Lesley Alexander (Vice-Chair for this meeting), Eleanor Combley, Anna Keen and Celia Phipps.

Apologies for Absence
Apologies for absence were received from: Councillors Mark Brain, Jos Clark, Gill Kirk, Cleo Lake, Brenda Massey, Liz Radford and Ruth Pickersgill.

Officers in Attendance
Karen Blong (Policy Advisor – Scrutiny) and Hilary Brooks (Interim Service Director Care and Support Children & Families)

Others in Attendance:
University Hospitals Bristol NHS Foundation Trust: Dr Sean O'Kelly (Medical Director) and Ms Bryony Strachan (Clinical Chair, Obstetrics and Gynaecology)

51 WELCOME AND INTRODUCTIONS (Agenda Item 1)

In accordance with previously agreed arrangements, Cllr Toby Savage (South Glos) took the Chair and Cllr Lesley Alexander acted as Vice-Chair*

The Chair welcomed everyone to the meeting and outlined the roles and responsibilities of health scrutiny and the arrangements for holding a meeting in common.

*(*NOTE: Bristol People Scrutiny Commission was inquorate at the start of the meeting, however at 4.40pm, the Commission became quorate and from that point Cllr Lesley Alexander acted as Vice-Chair of the meeting.)*

52 EVACUATION PROCEDURE (Agenda Item 3)

The Chair drew attention to the evacuation procedure.

53 DECLARATIONS OF INTEREST UNDER THE LOCALISM ACT 2011 (Agenda Item 4)

There were no declarations of interest.

54 SUBMISSIONS FROM THE PUBLIC (Agenda Item 5)

The meeting received two submissions from the public, as follows:

- Allyn Condon
- Daphne Havercroft (not present)

Details would be added to the Table of Public Submissions for review.

55 ITEMS FROM MEMBERS (Agenda Item 6)

Cllr Ian Scott asked what was the current position concerning a question set out in Min. No.6 of the last meeting in common held on 12th August 2016 which stated:

"Q.2 Will they make a commitment for a financial provision of legal support to family within next two months?
m. Confirmed they were happy to do that."

Dr O'Kelly answered that the Trust had taken legal advice on this matter, which related to the release of a report centred on an employee. The advice was that the Trust had a duty of confidentiality to the employee and could not release all of the report to the family, however the Trust had released as much as it could. There was no precedence for the Trust to fund legal advice to a member of the public through the use of public monies.

Dr O'Kelly was asked whether this had been discussed at Board level and whether the Board had said no to legal support for the family. Dr O'Kelly said that this was the case.

56 MINUTES OF THE MEETING HELD ON 12TH AUGUST 2016 (Agenda Item 7)

The minutes of the last meeting in common were received for information, for Members to refer to.

57 INDEPENDENT REPORTS RELATING TO THE BRISTOL ROYAL HOSPITAL FOR CHILDREN 2016 - THREE MONTH REVIEW (Agenda Item 8)

The Chair reminded Members of the purpose of the meeting which was to hold a 3 month review since the 12th August 2016 meeting in common. The meeting would receive an update on the UHB Trust's progress on implementing the recommendations set out within the Verita Report, commissioned following the death of a baby at the Bristol Royal Hospital for Children in April 2015.

Dr Sean O'Kelly, Medical Director and Ms Bryony Strachan, Clinical Chair, Obstetrics and Gynaecology (UHB) attended the meeting to report back and to answer questions from members.

A report from the Trust stated that seven of the nine recommendations in the Verita report had now been completed. One action had been completed to the extent possible (R3) and one further action (R9) remained in progress while meetings with the family continued. A number of the Trust Standard Operating Procedures, produced through the work to complete the Verita report's recommendations, had been circulated with the report presented to the meeting.

Dr O'Kelly reported on further action taken by the Trust, namely that following meetings with the family, a list of 80 questions had been formulated, to which the Trust would now begin to provide responses. The target date for completion of this process was the end of January 2017.

Members then questioned the Trust and received replies as follows:

Q.1 What happens when telephoning through results from the Pathology Laboratory to the ward?

A.1 If a result is phoned through to the ward it will be electronically recorded that this has happened, providing an audit trail. Individual wards also had their own procedures. It was important to go through the records on the ISystem to avoid any 'hidden' reports as had been referred to.

Q.2 When was the senior clinician referred to in R9 appointed, was there a gap before the clinician started work with the family, what was the Trust's view on the family's view that R3 is not completed; was it reasonable to

stretch the response time to the 80 questions to the end of January and what resources were the Trust putting in to resolve matters quickly?

A.2 A clinician was appointed shortly after the last meeting and there was a short time before the clinician began work with the family; R9 allows for residual questions on actions to be addressed and provides a 'safety net' for any outstanding issues to be addressed; there was a lot of work involved in answering the 80 questions and a second clinician had been appointed to undertake the necessary work; given the work involved it was not unreasonable to set a response time of January.

Q.3 Imparting news to the family does not seem to have been given enough weight; was it not disappointing that there had been no contact with the family since 7th October?

A.3 There have been meetings over several months resulting in the formulation of the 80 questions; the outcomes are being considered by the additionally appointed clinician and the Trust had been in contact with the family more recently than October, for example Dr O'Kelly had exchanged emails with them.

Q.4 If the Trust had only just formulated the questions why did they not indicate that this meeting was premature, in that they were not providing much updated information or answers to members?

A.4 The Trust had provided a 3 month update report as requested at the last meeting in common, had held 4 constructive meetings with the family and agreed the 80 questions with them, which the Trust saw as their progress.

Q.5 R1 is marked as complete in the progress report, however the family dispute that; how do the Trust respond to this?

A.5 The Trust is grateful for the family for spending time to cross-reference where existing questions are outstanding and in understanding the rationale for clinical decisions; a further clinician was appointed to help the family and the Trust reach a common understanding and the Trust was committed to continuing this journey; Dr O'Kelly represented the Trust in this process and Robert Woolley, Chief Executive, was also fully involved and reported to the Trust's Board.

Q.6 Noting the discrepancy over the date of the last communication with the family, the Trust was asked to explain how the 80 questions were arrived at and indicate when it would next be meeting the family?

A.6 The Trust stated that it had discussed the way forward with the family face to face, there have also been interim communications such as emails; they have worked around six themes so they can understand this difficult, complex story; they have gone slowly according to advice in order to address the needs of the family; a senior experienced person is in place to

work with the family and the Trust to reach a shared and common understanding of events.

Q.7 Will the disagreement on whether R1 is complete be picked up in the 80 questions?

A.7 Yes and if not, the Trust will ensure that the family's concerns are picked up. **(ACTION: UHB)**

Q.8 Would the Trust explain the roles in the reviewed Child Death Review (CDR) process?

A.8 There are two new posts in the bereavement team, with three core people all having a nursing and/or hospice background; it is recognised that every family has its own needs if there is a sudden death or death as a result of a long term condition; the team works with medical and palliative care teams; the Trust holds workshops and reviews around this work; when a child dies there are a number of investigative processes, including the Parliamentary and Health Service Ombudsman (PHSO), child safeguarding board, NHS England and the Coroner.

Q.9 Is it correct that some inquests take place in Southampton?

A.9 There is involvement from the Avon Coroner, however when it is a Coroner post mortem (as opposed to a hospital post mortem), this may have to be performed outside the Avon area in which case Southampton and Great Ormond Street Hospitals are options.

Q.10 Would accommodation at the hospital have been made available to the family if it had been known how ill their child was, and was it assumed that it was not a serious case of need?

A.10 There is a big challenge in providing accommodation to parents at the hospital; charitable efforts have improved provision; the Trust would need to check what the circumstances were in this case regarding family accommodation. **(ACTION: UHB)**

Q.11 What does the Trust mean when it says that the work on R2 is complete?

A.11 There was a task and finish group to refresh the pathways across the whole hospital and new family support (i.e. a wider provision than solely for bereavement) is underway.

Q.12 Recognising that there is a balance between a duty to staff and to the family in releasing certain information requested as part of R3, do the Trust feel that they have got the balance right or could they have considered trying to anonymise parts of the report; is naming staff the legal issue; is it not the case that there is no closure for the family as things stand and will this be picked up in the 80 questions?

A.12 Data subjects are entitled to confidentiality under the Data Protection Act (DPA); the Trust has tried to include as much as possible about the findings without contravening the DPA; the Trust is exploring ways of addressing the family's concerns and if this aspect is not in the 80 questions the Trust will pick this up. **(ACTION: UHB)**

Q.13 What was the outcome of the audit that was due in August and when was it completed?

A.13 There was an internal South West audit as Verita had identified issues with documents concerning their order and lack of dates; the audit report was presented to the Trust last week; the Trust would need to check the date the Audit was undertaken and would respond after the meeting on dates and what the outcomes were. **(ACTION: UHB)**

Q.14 How often does the Trust review its policies?

A.14 New policies are reviewed after 1 year and established policies after 3 years.

Q.15 In accordance with R6, how many senior leaders had been trained and were there any 'mop up' training sessions planned for those not able to attend?

A.15 The training rate is around 90% and monthly monitoring of training takes place; specific figures were not to hand and would be reported back after the meeting. **(ACTION: UHB)**

The Chair noted that many of the issues of concern were being picked up in the 80 questions and expected to see feedback on that at the next meeting on 27 February 2017.

Cllr Eleanor Combley said that she felt there had been significant progress if someone had been working with the family and welcomed that a degree of trust had been rebuilt, sufficient to formulate the 80 questions.

Cllr Ian Scott said that the meeting had an important duty and responsibility to hold NHS bodies to account, particularly in the context of the Mid Staffordshire case. He considered it a disgrace when reading the agenda reports, particularly that there were finances available to protect staff and the Trust's reputation but not for the family. He did not have confidence in the Trust and felt there were issues that needed to be highlighted nationally. As such he planned to move a motion adding to the recommendation that the matter be brought to the attention of the Secretary of State for Health

Cllr Anna Keen said that although she respected the reasons for requesting a referral to the Secretary of State, she felt that a decision should be delayed until the impact of this action could be considered and suggested that this be an item for a future agenda.

The Chair clarified that the decision making process would involve South Glos and Bristol members taking separate decisions, reflecting that the committees were meeting in common rather than as a joint body.

South Gloucestershire resolution:

Upon a proposal by Councillor Ian Scott, seconded by Councillor Sue Hope, it was UNANIMOUSLY*

RESOLVED:

(1) To note the progress achieved with the implementations of the recommendations contained within the Verita report, with a further meeting planned for Monday 27th February 2017, to include an update on progress with the Verita recommendations, an update on the 80 questions formulated with the Condon family and the planned 6th month review of the Independent review of Children's Cardiac Services in Bristol; and

(2) To write to the Secretary of State for Health to advise of the recent scrutiny of the Verita report and the UHB Trust's response/action plan, in order to bring this matter to the government's attention and ensure that there is local and national awareness of the matters raised and lessons are learned.

*(*NOTE: Cllrs Sarah Pomfret and Maggie Tyrrell took no part in the decision as they had not been present during the whole item)*

The Vice-Chair clarified the decision taken by South Glos members and sought the views of Bristol members.

Cllr Celia Phipps asked the Trust whether the Care Quality Commission (CQC) was informed of all child deaths. The Trust advised that not all deaths were notifiable to the CQC, although statistical information on mortality rates was provided to the CQC. There was however, a requirement to review all child deaths internally. A CQC inspection of the children's hospital was currently underway.

Ms Strachan reported that the response to the Verita report was an interim document and much work was underway. She apologised that she had not been able to attend the August meeting and noted that an offer had been extended to members to visit the hospital to see first-hand some of the changes that had been put in place. Ms Strachan extended the offer of a visit before the February meeting. **(ACTION: SGC/BCC/UHB)**

Bristol resolution:

The Vice-Chair proposed that the Bristol members support the recommendation in the Report, as amended by South Gloucestershire resolution and agreed by the South Glos Health Scrutiny Committee, to include a update on progress with the Verita recommendations, an update on the 80 questions formulated with the Condon family and the planned 6th month review of the Independent review of Children's Cardiac Services in Bristol.

Upon a proposal by Cllr Lesley Alexander, seconded by Cllr Anna Keen, it was UNANIMOUSLY

RESOLVED:

To note the progress achieved with the implementations of the recommendations contained within the Verita report, with a further meeting planned for Monday 27th February 2017, to include an update on progress with the Verita recommendations, an update on the 80 questions formulated with the Condon family and the planned 6th month review of the Independent review of Children's Cardiac Services in Bristol.

The meeting closed at 5.45pm

Chair…….

Date……..

South Gloucestershire Council

The Rt Hon Jeremy Hunt MP
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Public Enquiries Unit
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By email to: mb-sos@dh.gsi.gov.uk

Date: 7 December 2016
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Dear Secretary of State for Health

Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital by Verita

The purpose of this letter is to bring to your attention the above named report regarding University Hospitals Bristol NHS Foundation Trust (UHBT), which has recently been scrutinised by the South Gloucestershire Health Scrutiny Committee. In discharging its functions the Committee unanimously resolved that the report and UHBT response be brought to your attention so that you can ensure there is national awareness of the issues raised and learning takes place to minimise such a situation arising again. The Scrutiny Committee is mindful of its responsibility to undertake rigorous scrutiny of the services. To date it has scrutinised two independent reports, UHBT's action plan and it has required the attendance of a number of senior UHBT officers at its meetings to answer questions and to provide information. As can be seen from the Committee reports, the Scrutiny Committee recognised the importance of working collectively with the Scrutiny Committee of Bristol City Council. This has resulted in the Committees meeting in common maximising and strengthening the effectiveness of their individual scrutiny functions.

In addition the Committee is mindful of the Mid Staffordshire Inquiry and your comments in the Foreword of 'Patients First and Foremost – The Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry'. You state that there are four key groups that are essential to creating a culture of safety, compassion and learning that is based on cooperation and openness, and local scrutiny bodies are part of the external structures surrounding each individual organisation to ensure that all hospitals deliver good care, they raise concerns and ensure action is taken. Extract below:

"There are four key groups that are essential to creating a culture of safety, compassion and learning that is based on cooperation and openness.

First, and most importantly, patients and service users, and their families, friends and advocates – these are the people who know immediately if something is not right and who must feel welcome and safe in every part of our NHS and care and support system.

Second, the frontline staff who can foster change through their individual responsibilities, behaviours and values, and by working effectively together in strong teams – we know that those organisations that treat their staff well provide better care for patients.

Third, the leadership teams and, in particular, the boards of each organisation – they have the principal responsibility for ensuring that care in their organisations is safe and that those who use their services are treated as individuals, with dignity and compassion.

Fourth, the external structures surrounding each individual organisation, including commissioners, regulators, professional bodies, local scrutiny bodies and Government – they are there to ensure that all hospitals deliver good care, to raise concerns and to ensure action is taken. The system must get its structures, accountabilities and ways of working right to support this and to tackle any areas of poor performance rapidly and decisively."

Background

On 12 August 2016 the South Gloucestershire Health Scrutiny Committee held a meeting in common with Bristol City Council People Scrutiny Commission to consider published independent reports relating to the Bristol Royal Hospital for Children.

In relation to Children's Cardiac Services in Bristol, the following reports were received:

- The Report of the Independent Review of Children's Cardiac Services in Bristol, Eleanor Grey QC and Professor Sir Ian Kennedy, June 2016;
- Clinical Case Note Review: A review of pre-operative, peri-operative and postoperative care in cardiac surgical services at Bristol Royal Hospital for Children, Care Quality Commission, 23 June 2016; and
- The UHBT response and action plan.

In addition the Committee received the report by Verita entitled 'Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital'; and the UHBT response and action plan.

The agenda papers and approved minutes are enclosed for reference.

The Committees agreed to hold a further meeting in three months to receive an update from the Trust on its progress with the recommendations set out in the Verita report; and another meeting in six months to follow up actions in relation to children's cardiac services.

The Committees met on 23 November 2016 to receive the three month update on the Trust's response to the recommendations in the Verita report. The agenda papers and draft minutes are enclosed for reference.

At the meeting on the 23 November, the Committees learned that since the meeting in August UHBT had held meetings with the family and agreed a list of 80 questions requiring a response. The Committees asked that a further progress report, including the Trust's response to the 80 questions be submitted to the six month update meeting (which is scheduled for 27 February 2017). In addition, the South Gloucestershire Scrutiny Committee unanimously resolved that a letter be sent to the Secretary of State for Health to inform you about the existence of the reports referred to and are aware of the issues raised therein; and that you give consideration on a national basis of the need for further awareness raising and dissemination of lessons learned.

South Gloucestershire Council Health Scrutiny Committee will continue to scrutinise the action plan of the Trust and work to secure service improvements, it does however recognise that a number of the issues raised in the reports will not be restricted to UHBT alone and where this is the case it considers it is important that it raises these issues at the earliest opportunity.

I hope you find this information helpful, and that you are able to take appropriate action to ensure that lessons are learned and the actions of this Trust are not repeated elsewhere.

Yours sincerely

Councillor Toby Savage Chair Health Scrutiny Committee	Councillor Sue Hope Lead Member Health Scrutiny Committee	Councillor Ian Scott Lead Member Health Scrutiny Committee