Meeting in Common
South Gloucestershire Health Scrutiny Committee
Bristol City People Scrutiny Commission

Tuesday, 30th January, 2018
Held at the Civic Centre, Kingswood

Present for South Gloucestershire:

Councillors: Marian Lewis (Chair), Kaye Barrett, April Begley, David Chubb, Robert Griffin, Shirley Holloway, Sue Hope, Trevor Jones, Sarah Pomfret and Ian Scott

In Attendance: Claire Rees (H&WB Partnership Officer) and Gill Sinclair (Deputy to the Head of Legal, Governance & Democratic Services)

Present for Bristol City:

Councillors: Brenda Massey (Vice-Chair), Tony Carey, Eleanor Combley, Celia Phipps and Liz Radford

In Attendance: Louise de Cordova (Scrutiny Advisor)

Others in Attendance:

University Hospitals Bristol NHS Foundation Trust: Robert Woolley (Chief Executive), Carolyn Mills (Chief Nurse) and Ian Barrington (Divisional Director, Bristol Royal Hospital for Children)

Apologies for Absence:

South Gloucestershire Councillors: Janet Biggin (replaced by Trevor Jones), Keith Burchell, Katherine Morris and Gloria Stephen

Bristol City Councillors: Mark Brain, Clare Campion-Smith, Gill Kirk, Cleo Lake and Ruth Pickersgill

83 WELCOME AND INTRODUCTIONS (Agenda Item 1)

In accordance with previously agreed arrangements, Cllr Marian Lewis (South Glos) took the Chair and Cllr Brenda Massey (Bristol) 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.

84 EVACUATION PROCEDURE (Agenda Item 3)

The Chair drew attention to the evacuation procedure.

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

There were no declarations of interest.

86 SUBMISSIONS FROM THE PUBLIC (Agenda Item 5)

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

- Allyn Condon
- Kelly Marlow (not present)

(Details would be added to the South Glos Table of Public Submissions for review.)

In addition, the meeting noted 114 submissions relating to matters on the agenda, which had previously been received by the Bristol Overview & Scrutiny Management Board on 1st November 2017 and referred to this meeting.

87 ITEMS FROM MEMBERS (Agenda Item 6)

There were no items from Members.

MEETING APPROACH

The Chair reminded Members that, as a 12 month review since the last meeting in common, the purpose of today was to receive an update on the progress of University Hospitals Bristol NHS Foundation Trust (UHBristol) in implementing recommendations set out within, firstly, independent reviews of children's cardiac services at the Bristol Royal Hospital for Children and, secondly, an independent investigation into the management response to allegations about staff behaviours related to the death of a baby at the Children's Hospital. Cllr Lewis invited Mr Woolley and colleagues from the Trust to present their reports.

88 INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SURGICAL SERVICES AT BRISTOL ROYAL HOSPITAL FOR CHILDREN (Agenda Item 7)

Carolyn Mills (UHBristol) presented the report of the Trust which gave a summary of the work undertaken to date in relation to recommendations made by an Independent Review and CQC report. She gave information on

key milestones and identified actions and learning that had been taken forward throughout the organisation.

Ms Mills paid tribute to the families and the children and young people who had taken part in the Trust's work to effect change and improve the way it listened to patients and their families, particularly by participating in the Steering Group overseeing delivery of recommendations. The Trust believed it had fully evidenced what it had achieved, and in some cases surpassed, in terms of the recommendations. It had been a challenging year but there had been learning in line with the spirit of the recommendations and this would continue after the action plan was complete.

Ian Barrington (UHBristol) added that the Cardiac Services review group also had regular reviews and sought continual improvement.

- Patient information leaflets were available on the Trust's website; they had been revised to take account of feedback from patients and families
- Contact had been made with the Cardiac network in Wales and communication had improved
- The website now also included information on palliative care
- Improvements to the website had been tested to obtain feedback, for example at Ward coffee mornings
- There was recognition that families would need different support and information depending on their views and circumstances
- Reporting of patient safety incidents had been broadened through training with the aim of achieving consistency in reporting by staff
- Although the option to record conversations had been implemented, there had not been a great take up of this option
- Benchmarking had involved surveys with and visits to other paediatric cardiac centres and useful information had emerged, notably regarding the satisfactory number of staff involved in outpatient clinics and in the identifying the low number of cardiac specialists and psychology support being provided
- The Children's Quality Assurance Committee was a sub-committee of the Divisional Board and had a remit for overseeing improvement actions arising out of the benchmarking exercises

The report of the Trust and information provided as above, was noted.

89 INDEPENDENT INVESTIGATION INTO THE MANAGEMENT RESPONSE TO ALLEGATIONS ABOUT STAFF BEHAVIOURS RELATED TO THE DEATH OF A BABY AT BRISTOL ROYAL HOSPITAL FOR CHILDREN (BY VERITA) (Agenda Item 8)

Robert Woolley (UHBristol) addressed the meeting and said he was conscious of how inadequate his words would be to Mr Condon and his family and was sorry for the length of time it had taken for the Trust to issue an apology to the family.

Mr Woolley reminded Members of the circumstances relating to the death of a baby, Ben Condon, at the Children's Hospital on 17th April 2015. He also detailed the ways in which the organisation had lost the family's trust. A specialist organisation (Verita) had been asked to undertake an independent investigation into the circumstances of the management response to allegations about staff behaviours. The written report circulated with the agenda papers set out how the Trust was addressing the recommendations by Verita.

The report also summarised key concerns Mr Condon had raised with the Trust and detailed the Trust's responses and actions so far. The 4 main concerns were summarised as:

- Clinical staff failed to disclose information and/or lied to the family
- Senior management had engaged in a cover-up
- Consultants gave contradictory evidence at the inquest and in other statements
- Ben died without appropriate treatment/ with the wrong treatment

Since the last meeting, the Trust had commissioned a further expert opinion on the question of whether and when antibiotics should have been given to Ben. The Trust found that this latest opinion cast a greater doubt on the reasonableness of withholding antibiotics compared to previous expert opinion that the Trust had relied on. The Trust had therefore decided it was right to apologise to the family and accept that the lack of anti-biotics was a material contributing factor in Ben's death. A public apology had been made.

The Trust was deeply sorry for serious mistakes it had made in managing the complaint and in communicating with the family. Whilst accepting that it would offer little comfort to the family, the case had led the Trust to make a number of improvements in clinical care and in how it communicated and engaged with bereaved families.

Members were also advised that Mr Condon had recently taken action to make a complaint to the Parliamentary and Health Service Ombudsman (PHSO) and had already lodged a claim for clinical negligence. He had also asked the General Medical Council (GMC) to investigate 7 doctors involved in Ben's case.

The Committees were asked to note the developments in the case since their last consideration, the learning and improvements inside the Children's Hospital and the Trust as a result of its review of Ben's care. They were also asked to note the continuing dissatisfaction of the Condon family and the Trust's hope that this would be addressed by an independent review by the PHSO.

Members asked a number of questions about the report and received the following information:

- The Trust acknowledged that the process was far from over in terms of implementing recommendations and in terms of the legal processes
- NHS Resolutions would be the responsible body dealing with the terms of the settlement; it was not known for certain whether a confidentiality clause would be included; information on the settlement terms would be reported to Members in due course

- If a child with a viral illness was a patient today, it was not necessarily appropriate that anti-biotics would be routinely administered; clinicians were aware that administering anti-biotics in the case of a viral infection could cause harm in itself and could contribute overall to the breeding of drug resistant bacteria; as in Ben's case, clinical opinion was divided on the issue and the hospital had to trust the doctors' professional judgement in each case to weigh up whether there was an undiagnosed bacterial or viral infection; with the actions taken by the Trust following Ben death, the chances of the issue recurring had been minimised

- In terms of how quickly the type of infection could be identified, if an identical case presented itself today, tests would be done to determine the type of infection but it was important to note that the tests themselves could be risky and invasive especially for very small children; awareness of the risk of a secondary infection had been heightened since Ben's case

- Accepting that the report not address the issue of identifying blame or identifying a single person as responsible, the Trust felt it had set out the issues as openly as possibly in the summary in appendix 1 to the report; this set out the allegations against clinicians and the Trust and described the approach taken by the Trust in response; the family said they wanted the truth and this was understandable however their truth was to apportion blame to doctors and to Mr Woolley as Chief Executive; it was a complex issue to which explanations had been given and while that might look like confuscation to the family, nonetheless there were more innocent explanations for the inconsistencies; some behaviours, though, had clearly been wrong, for example suggesting the deleting of a recording

- A small number of complaints had been received since 2015 from parents about failures of care in the intensive care unit; some would be the subject of inquests; the Trust's representatives did not recall anything similar to Ben's case

- There were a range of ways of dealing with complaints; issues included whether dissatisfaction was expressed on the ward; there was a service called Liaise to deal with concerned parties; and there was a formal thorough complaints process

- The cost of litigation costs was not yet known and actions were on-going; it would be a cost to the public purse; the Trust subscribed to a negligence scheme and NHS Resolution would pay any compensation awarded

The Chair made closing comments. Both Scrutiny Committees were satisfied that the review of services had been conducted thoroughly and in great depth by the CQC and through the independent specialist investigation by Verita. They were also satisfied to see that families had taken part in the Steering Group and through an on-line virtual group. The Committees noted the progress in implementing the recommendations identified in the Trust's report and noted that many of them had been completed and were already part of standard practice. Many lessons had been learned and the service had moved forward with improvements both in the standard of care for patients and in the communication with the patients' families.

The Committees would await the outcome of the various processes outlined in the report, including the progress of litigation, professional review by the GMC and independent investigation by the PHSO. The Committees requested that they be kept informed of the outcomes of these processes.

Whilst having every sympathy with the bereaved families, it was felt that the two Committees had done all they could within the scope of their powers and it would not serve any useful purpose to convene the meeting in common again. There was in fact no role for the meeting going forward and she suggested that the meeting now be brought to a close.

In response, other South Glos members felt that as the matter had not been concluded, there would be a benefit in reconvening a meeting in common in a year's time.

Upon a PROPOSAL by Cllr Ian Scott, SECONDED by Cllr April Begley, and being put to the vote it was

RESOLVED by the South Glos Health Scrutiny Committee: That the meeting in common be reconvened in a year's time to review progress.

VOTING: 7 FOR
0 AGAINST
3 ABSTENTIONS

Upon a PROPOSAL by Cllr Brenda Massey, SECONDED by Cllr Tony Carey and upon being put to the vote it was

RESOLVED by Bristol People Scrutiny Commission: To receive a progress written report from the UHBristol Trust in a year's time, reserving the option to convene a further meeting if appropriate.

VOTING: 5 FOR

0 AGAINST
0 ABSTENTIONS

The meeting closed at 3.40pm

Chair……

Date……..