Bristol City Council
Minutes of the People Scrutiny Commission

12 August 2016 at 10.00 am

Bristol City Council Councillors and Officers

Members Present:-
Councillors: Brenda Massey (Chair), Lesley Alexander, Eleanor Combley and Anna Keen, Gill Kirk, Cleo Lake, Liz Radford and Clare Campion-Smith

Officers in Attendance:-
John Readman (Strategic Director - People), Hilary Brooks (Service Director, Care and Support - Children & Families) and Nancy Rollason (Service Manager Legal), Karen Blong (Scrutiny), Louise deCordova (Democratic Services)

Others in attendance:-
Dr Jo Copping

South Gloucestershire Councillors and Officers

Members Present:-
Councillors: Toby Savage, (Chair), Kaye Barrett, April Begley, Robert Griffin, Paul Hardwick, Shirley Holloway, Sue Hope, Trevor Jones (substitute for Janet Biggin), Ian Scott

Officers in Attendance:-
Claire Rees (Public Health)

Others in attendance:-
UHB: Robert Woolley, Sean O'Kelly, Carolyn Mills, Ian Barrington (substitute for Bryony Strachan)
CCG: Jill Sheppard, Guy Stenson, Tony Jones
NHS England: Linda Prosser, Vaughan Lewis

1. Apologies for Absence

Apologies for absence were received from, Councillor Jos Clark, Councillor Mark Brain, Councillor Celia Phipps, Councillor Ruth Pickersgill, Councillor Sarah Pomfret, Councillor Erica Williams, Councillor Gloria

Steven, Bryony Strachan – UHB Clinical Chair, Division Women's and Childrens, Mark Pietroni – Director of Public Health, South Gloucestershire.

2. Declarations of Interest

There were no declarations of interest.

3. Welcome, Introduction and Safety Information

In accordance with previously agreed arrangements, Councillor Brenda Massey, (Bristol), took the role of Chair and Councillor Toby Savage (South Gloucestershire), took the role of Vice-Chair.

The Chair led welcome and introductions and outlined the Health Scrutiny requirement and Meeting in Common powers in full as outlined in the agenda papers.

4. Public Forum

The Committee considered the public forum statements received as follows with Daphne Havercroft and Allyn Condon in attendance:

Statement 1	Yolanda and Steve Turner	The Bristol Review into Cardiac Services at Bristol Royal Hospital for Children 2010-2014
Statement 2	Daphne Havercroft	Children's Cardiac Services – Risk Management
Statement 3	Allyn Condon	UH Bristol Trust Progress of the Verita recommendations
Statement 4	Katharine Tylko	The Bristol Review – improvements in the safety of children's congenital heart surgery nationwide

5. Independent Reports Relating to the Bristol Royal Hospital for Children, 2016

The Committee considered the report presented by Robert Woolley, Chief Executive University Hospitals Bristol NHS Foundation Trust, accompanied by Sean O'Kelly, Medical Director, Carolyn Mills, Chief Nurse, Ian Barrington.

Which set out the Trust's response, to the Independent Review of Children's Cardiac Services in Bristol and the Trust's response to the two independent reports published on 30 June 2016, namely the report of the Independent Review of Children's Cardiac Services in Bristol and a Review of pre-operative, peri-operative and postoperative care in cardiac surgical services at Bristol Royal Hospital for Children. And presented the University Hospitals Bristol NHS Foundation Trust's Cardiac Review Action Plan.

Robert Woolley (RW) summarised the UHB response to failings identified in the report and made the following points.

a. Clarified that the CQC have stayed involved and have carried out random sample cases with audits targeting most complex cases. Separate independent clinical experts have been used to analyse case notes. Eleanor Grey had sight of the findings before she concluded her review. CQC did a comprehensive inspection in September 2014 with 70 inspectors. Review found services for CYP at UHB in 2014 were good overall, specifically good for safety.
b. In April 2016, NICOR published audit of all specialised children's cardiac centres and found outcomes and standards of care were comparable with standards in other UK centres.
c. In 2016 new a national congenital heart disease review announced results of assessments of all units against the new standards. Announced intention to cease commissioning from three units in England. UHB was not one of these and would receive support to comply with all commissioning standards (which came in from April 16).

RW read out the independent review conclusions and CQC conclusions and concluded with the following points:

d. Recognition that UHB fully accept findings, got things wrong in a number of ways. Care feel below acceptable standards, did not respond to parents concerns, apologised unreservedly and repeat this today.
e. Pleased that upon review standards now found acceptable, but must get it right for every parent every time. Have already taken number of actions and will describe significant improvements in response to questions later.
f. Referred to Chapter 14 which set out actions already taken and Appendix A3 which sets out the action plan against recommendations. Thirty-two recommendations apply in the main to the Trust and also to NHSE and DoH.
g. Issue of consent is one area that is being looked at – how can parents know exactly what they are consenting to; the way that incidents are dealt with. Grieving parents should not be expected to navigate the system of complaints handling– CDR, CQC, ombudsman, etc.
h. The result has been a confusing picture for all, UHB was inefficient in communications.
i. Staffing is major theme and paediatric cardiac intensive care provision across country needs to be addressed.
j. Failings in the report are not ones that persist now. Great deal of external assurance in place. Acknowledged the role parents played improvements made nationally and confirmed willingness to bring progress reports back to Committee. Agreed to facilitate visits by Councillors to the units.

Action: Officers to facilitate visits for Councillors to the units

Members' questions

Q1. What are the current staffing arrangements and are there sufficient staff and are bank or agency staff being used?

a. RW confirmed that as soon as CQC came in in 2012 they responded immediately to ensure ratio of staff to beds was correct. Subsequently invested significantly in staffing, dedicated HDU with 5 beds, 1 nurse to 2 patients on remainder of ward is 1 staff to 3 patients. £3m invested.
b. Ian Barrington (IB) confirmed that staff had been under significant pressure, had believed that using bank and agency staff to relieve this was acceptable at the time, but have now realised was not acceptable. Full establishment of staff, fully recruited to post. Additional challenge faced around staff retention. Significant effort invested and have developed faculty of nurse education and clinical skills base on the ward. Occasionally use agency staff for annual leave or sickness cover, but have full complement of permanent staff.

Q2. When parents raised the issue of staffing through complaints, was resources an issue at the time? Did NHSE have to release funding to address staff issues?

c. RW confirmed that there wasn't a resource issue in terms of staffing numbers on the ward – genuinely believed staffing model operating was safe, but knew it wasn't sustainable. With hindsight realise this wasn't the case. There was recognition that volumes were growing in terms of demand and complexity was increasing. Chapter 11 of report states that there wasn't a resource constraint in 2012. After CQC inspection, commissioners responded immediately with the resource to create HDU.

Q3. Is there now a robust process in place to manage complaints?

d. Reflected long and hard on how to manage complaints. The review outlines that they regrettably used the process to serve their own needs and on a number occasions lost sight that a grieving family was at the end of a complaint. Has been confusion between processes (CDR, etc) and it was not clear how to involve parents and keep them informed throughout the process.
e. Need to present a single face to family. Need a case manager to be the single POC for the families. Reviewed complaints policy and amended guidelines for staff about which procedure should follow.
f. IB – more done to address parents' concerns straight away. Every bed space has a chart for parents to say if unhappy with any aspect of child's care. Concerns are included in documentation on daily basis and addressed by a Matron who speaks to any family who is not happy each day.

Q4. How do we as a whole health service respond to potential issues in terms of service delivery?

g. NHSE has carried out a thorough review of congenital heart services nationally. It includes an agreed set of standards, developed with families, for every aspect of care for the children. Concerns raised by parents have informed the detail in the commissioning and monitoring standards.

Q5. With reference to paediatric intensive care unit beds and responsibility for coverage of the south west for planned admissions and emergencies. This is expensive. What do you feel you need to do or can do to minimise risk?

h. Invested in another intensive care bed and staff to go with it through agreement with commissioners. NHSE now needs to do a national review of capacity set against likely future demand. There are times of the year (winter) when availability of IC beds is low, a poor service meaning families need to travel 50-100 miles for intensive care. The Review asks NHSE to do a national review of IC bed availability.
i. Vaughan Lewis (VL) confirmed that a review was planned to start this month and carried out rapidly with initial outcomes delivered by the end of 2016. Review of numbers of beds, look at the split between HD and IC beds, so NHSE can make judgement.
j. Cover transport of critically ill children and also look at service for children with cardiac and respiratory disease.

Q6. Previously at committee we asked about why the HDU was not put in place in time and UHB said that had asked for one, but NHSE said no. However, looking at the Review report, (p43, section 1.95) it makes it clear that the Trust had not provided commissioners with right information. Feels UHB had not been honest with the committee before. What wold have happened if CQC not done an inspection?

k. RW apologised that the impression was given that they were passing the buck to commissioners previously. Confirmed that UHB was accountable for anything it did. They genuinely didn't believe there was a safety concern before. The Division and the Trust had been planning ahead appropriately to secure resources to get the HDU.
l. Confirmed that they got it wrong in that they did not work at sufficient pace and the pressures on the ward had been greater than they appreciated at that time.

Q7. Consent process and policy review? How linked together? (p284 and p283)

m. Sean O'K (SO) There will be representatives from the general surgical division as well as children's division, plus parents. Linking with Association of Anaesthetists regarding consent

around anaesthesia as well. IB – have also been working with parents on consents within cardiac unit.

Q8. Have there been any changes in the Trust senior leadership team since 2012 and if so why?

n. Have been changes but no disciplinary reasons for changes. There is now a strong connection between Management Board and Clinical leaders with departmental lead clinicians and department managers going to Management Board.

Q9. Please confirm parent experience for out patient's appointments, proposals for psychological support, and links with Wales.

o. IB – a high volume area. Working to increase number of clinics and staff. Confirmed it was not easy to recruit consultant cardiologists, but appointments have been made recently.
p. Recruited new full time psychologist working purely with paediatric surgery service. The further recommendations in the Review report will be addressed.
q. In April established a formal network for congenital heart services that covers Wales and South West, which includes a network and a board with parental representation to reduce fragmentation.

Q10. Provide detail of staff training regarding engagement with parents / families and how developing further, for example recent Kings Fund re. collaborative partnerships

r. CM – communication is a key challenge. Staff training in place for two professional groups, nurses and doctors. Key part of registration phase is communication skills. Have put support in place in children's service around psychology for staff and families. Above this is process about how we engage strategically, not easy to see from high level data.
s. IB – families involved in consent pathway. Also, involved families in rewriting of info sent out to families' pre and post hospital.
t. Planning a conversations week in September whereby all senior staff touring the hospital to talk to patients/families.
u. The goal is for every patient and family to know who to go to if want an answer or want to contribute.

Q11. The Vice Chair asked for both oral public statements to be addressed by UHB. What is UHB's response?

v. RW confirmed he would respond to Daphne Havercroft's risk management points during this section of the meeting, and then respond to Allyn Condon's oral statement as part of his opening remarks on the Verita report.

(The Vice Chair agreed to that approach)

w. RW – confirmed that the risk in question was analysed in detail in chapter 11, section 12. With reference to analysis of risk in NHS. Every risk is classified for its inherent risk, this is why risk '1901' was rated as high. Once mitigations were considered for example the use of temporary staff, the residual risk was then assessed, which resulted in a medium risk rating.
x. The risk was around sustainability not safety. Eleanor Grey concludes that the effectiveness of the mitigations was not being tested sufficiently robustly at the level at which the risk was assessed. An opportunity was missed in 2011 when a risk assessment was missed. Confirmed there was increased focus on how they manage risk in the organisation. It was very complex. Stated a personal determined to improve on it. External people have been invited in, problems were found in 2011 and 2014. Continue to work on this area. Had a review in 2015 by Deloitte which was reported to Fdn Trust regulator and they found that there was openness and transparency in the organisation. Received recommendations on how to keep focus, which UHB is following through.

Q12. Question for NHSE and its response to recommendations in the Action Plan

y. VL has been in discussion with RW. NHSE Director of SC will receive action plan. Timescale for completion by the end of the calendar year.

Q13. Don't think timescales are good enough?

z. NHSE gone through rigorous assessment of 12 key standards across country. Implementation Group been set up from each of regional teams and meets weekly regarding action plans to meet standards.

Q14. Patient groups involved in developing standards?

aa. Implementation group has patients on it. Congenital heart disease network board will have parent representation. Integral involvement of parent and user involvement throughout the whole process.

Q15. Staffing contingency plans re. Brexit and changes to nurse bursaries?

bb. Ongoing challenge, UHB in good position regarding registered nurses, strong across England but have a few hotspots. Each division has plans for staffing.
cc. Bursary changes impact – difficult to predict. Been in discussions with UWE to determine figures for 2017. Limiting factor at the moment is placement capacity. Working collaboratively with UWE to make UHB an attractive place to train.

Q16. How is UHB complying with recommendation around having a database manager?

dd. IB – Do not yet have a full time data manager (part time 0.8 at moment). Looking at how they can work with other areas to pool the Data Management resource and create resilience.

Q17. The Vice Chair referred to para 1.78 and 1.79. How is Robert Whoolley and his senior team now being informed of concerns?

ee. There is a far greater connection between Board, the senior leadership (clinicians and managers coming together with executives) and the push of standards for risk assessment and management deeper into the organisation. There is a clear process for reporting concerns.
ff. Currently refreshing the 'Speaking Out' Policy for Whistleblowers. Last staff survey showed that they are fastest moving trust in terms of improving staff engagement.

(The Committee broke for recess at 11.40am and reconvened at 11.55am)

6. Verita Report - University Hospital Bristol Trust Response Appendix B

The Committee considered a report presented by Robert Woolley on the Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital.

The points below were noted in the question and answer session that followed:

Summarised the key points that triggered the Veritas investigation and management response to the conclusion's detailed in the Veritas summarised as follows:

a. Staff behaviour; a meeting where parents were given inaccurate information about the timing of tests; an episode in a CDR feedback meeting, (during a recess the consultants continued to discuss matters after parents left the room and when they realised they were still being recorded, one suggested it be deleted). The Trust investigated this and as stated p297.
b. An allegation in an email from a parent about a cover up by staff which linked to a deeper allegation that clinical staff had been responsible for Ben's death on IC unit. That is why Verita was commissioned to do the investigation into the management response to the allegations.
c. The Trust were keen that Ben's family was able to influence the Terms of reference for the investigation and feed their concerns into the investigation.
d. The Report is the management response to staff behaviour subsequent to Ben's death. Confirmed that that there had been a formal inquest a few weeks ago, it did not find that failings in the care given to Ben, had caused Ben's death. Confirmed that Ben's family do not accept this finding and there are differences in opinion.

e. Acknowledged that Ben's family feel consultant staff have lied, but this was not the conclusion of the Trust. Nonetheless the investigation shows that the Trust has let Ben's family down in a number of ways. The Trust missed a number of opportunities to engage proactively and candidly with Ben's family. Delays in complaints being investigated, contributed to a sense of mistrust and suspicion. The senior management team failed to get a grip of the complaint at first, and then subsequently the complexity of the investigation and response required.
f. Veritas report states that the Trust hadn't explained sufficiently what they had found. Thereby the Trust's responses have compounded the issue with its poor responses and communications.
g. The Trust had begun to deliver the 9 recommendations, p300, the action plan demonstrates the progress made. This was shared with Ben's parents, who disputed the contents, before it went to the Trust's Board. This was discussed openly in a Board meeting. In response to recommendation 9 the Board agreed to identification of a senior clinician within the Trust from a different division to meet with Ben's parents and to understand the outstanding concerns and endeavour to agree a plan to answer those concerns. So it is a work in progress.
h. Ben's father has raised concern that the Trust is trying to lump in other matters to Reccommendation 9 but this is not the intent.
i. With reference to Reccomendation 3 – undertook a formal investigation 'through maintaining high professional standards' process and shared broad conclusions with Ben's parents. The Trust's interpretation is that there is a need to share more information on this to demonstrate that the investigation was robust but was unable to share the whole report due to a duty of care to the staff concerned. Legal advice is pending on this.

Members Questions:

Q1. There is acknowledgement of the apology for failure and that recommendations are being worked on but no mention of disciplinary actions. Noted that some dates outstanding , for example recommendation 9 has no date against it. This family has gone through a terrible tragedy, are they getting any help with their legal costs?

j. The formal investigation previously described is a preliminary to any disciplinary action if this is required, and the Trust concluded that this was not required. Recommendation 9 completion timescale remains open until both parties agree that as much as possible has been done, hence this attempt to reengage via a senior clinician form other area.
k. Question on legal advice is fair challenge – Trust didn't anticipate that there would be a legal obstruction in terms of releasing the report mentioned at recommendation 3, but this is position the Trust is in. Confirmed that he is determined to find a way to prove the investigation was robust.
l. Success of reengagement depends on the Trusts ability to answer questions to the family's satisfaction. There are avenues for independent investigation by the family which won't incur legal costs, but this is a consideration that could be needed at later date if warranted.

Q2. Will they make a commitment for financial provision of legal support to family within next two months?

m. Confirmed that they were happy to do that.

Q3. With reference to Recommendation 30 keeping families informed and provision of opportunities to be involved in design changes.

n. There is a review of cardiac improvements and revision of complaints provision families are involved .

Q4. Has there been a change in practice?

o. Current process - issues are addressed in a letter to parents. The Trust Have strengthened the process for complex complaints to include table of issues and actions. Under pinning this, representatives from all divisions meet so that parents can be involved in the specifics of progressing an action. Parents have named contact for who to approach regarding further involvement.

p. Wider PPI activity – confirmed that there are a number of complainants who want to be more involved via a Patient Public Network.

Q5. What are the representatives from UHB and NHSE each going to do personally to ensure that what has been heard and read today won't happen again?

q. RW – absolutely accept his accountability for the failings in these reports. Entirely incumbent on him to deliver recommendations in all the reports that they are taken forward at speed and done well and as far as possible are delivered with parents (if they wish) and it is done publicly with reports to board and future HOSC meetings. Personal commitment given to do everything in power to ensure done well and at pace.

r. LP confirmed that in NHSE and in commissioning community the absolute commitment to ensure recommendations and actions plans are implemented.

Q6. A personal response?

s. VL referred to the standards document previously discussed and confirmed as clinical director that he will be working with directly with Trusts and to ensure with Trust via regular meetings that there are clear action plans in place to meet standards and read the paragraphs relating to the two specific standards i) for Level 1 units (like UHB) and the ii) palliative care and bereavement. These are both standards that are difficult to measure but the NHSE already have a number of processes in place to draw on. A dashboard is being developed and should

include these areas. NHSE will pursue these areas with Trusts and confirmed that he would feed back to colleagues in other areas to ensure they meet standards too.

Q7. Recommendations 2 and 8 have completion dates against them of September this year. Are you confident these will be met?

t. RW – yes.

Q8. There is a need to move forward not back. What date should we come back?

u. Confirmed that the Trust would comply with a timescale that the committee felt appropriate. Suggested 3 months to can update us on action plans and the same frequency going forward to update in entirety.

Q9. Concerned that community learning could be forgotten. How do we ensure learning is embodied going forward?

v. RW agreed. There is a constant struggle to demonstrate learning. This report calls for a partnership across the NHS with patients and families which is still not embedded fully in the service. UHB is committed to developing this partnership and that level of holding to account by the very people they serve. Need to address concerns at time occur, driving responsiveness and learning.

Q10. Reference to 5c Discharge planning? Progressing repatriation policy to regional hospitals?

w. RW confirmed strategy they have and the new congenital standards put in place. As regional, tertiary centre have responsibility across network of hospitals to assist local hospitals to have ability to care for patients where appropriate closer to their homes and where appropriate travel to Bristol for specialist care.

Q11. Support for bereaved families - training and dissemination of guidance to staff?

x. IB – a palliative care team is in place and have developed bereavement support in place. Now trying to bring both together in comprehensive way.

The Committee briefly discussed the appropriate timescales for an update on both reports.

The Committee agreed that the Trust return to committee in 3 months to provide a progress report on the Veritas report (Item 5) and return to committee in 6 months to provide an update for the cardiac (Item 6).

Action: Officers to facilitate dates for further meetings.

Date of Next Meeting (to be confirmed)

The meeting closed at 12.40pm

CHAIR _____