MILLS & REEVE

briefing

July 2016

Bristol - another report 15 years on

The report of the Independent Review of Children's Cardiac Services in Bristol was published on 30 June 2016. We supported the Review working alongside Eleanor Grey QC and Professor Sir Ian Kennedy.

Summary

Readers will see that 32 recommendations have been made. These are set out in the Executive Summary at pages 1-17.

The Review particularly noted that a CQC clinical case note review was not critical of the standard of surgery in any individual case. However it also observes that, at the time of finalising the report, the outcome of the PHSO's investigations were not available to the Review. They acknowledge the possibility that, at times, they may have reached differing conclusions on similar issues. If this is the case the Review acknowledge that this is because they have worked independently, dealing with complex issues, both with the benefit of expert advice but from different individuals and using evidence that will overlap but will not be identical.

Although a lot of the report and many of the recommendations are specific to Bristol Royal Children's Hospital there are points for others to take away. Particularly other Trusts with paediatric cardiac services but also providers more generally (and not just those in the acute sector). It is those more general points we will focus on in this note.

A very substantial number of those who contacted the Review reported good experiences of the service. Many spoke highly of the care received and dedication and professionalism of those who provided it. Where there were negative experiences there were recurring themes.

The points of general application from the Review cover:

- Consent
- Serious Incidents/Risk Management
- Complaints
- Staffing
- National issues

Consent

There were five points relating to consent:

- Firstly, the Review heard a range of concerns regarding the process of obtaining consent to their child's treatment. The Review considered that most, if not all, families would now readily be able to record discussions with clinicians by using their mobile phones. In light of this the review recommended that clinicians encourage an open and transparent dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment or prognosis is being discussed. (It is noted that the tape recording of discussions was something that the Bristol Public Inquiry had recommended back in 2001 but had not been accepted nationally and is an approach provided for in GMC guidance…)

- Secondly, it was recommended that there be a review of the consent policy and training of staff to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought.

- Thirdly, a review of the consent policy was also recommended to take account of recent developments in the law in this area, emphasising the rights of patients to be treated as partners by clinicians and to be properly informed about material risks.

- Fourthly, there is no clear guidance nationally about what information should be given about who will be involved in a procedure, when there may be more than one person involved. The consent policy recording "I understand that you cannot give me a guarantee that a particular person will perform the procedure" slightly conflicted with a) the reality of team working and b) parents' wishes and expectations. The Review received evidence that, at times, parents attached a great deal of faith in the relationship built up with the person they had met pre operatively.

- Finally, the Review endorsed CQC's clinical case note review recommendation that there is a need to review the recording of the percentage risk of mortality or other major complications discussed with parents or carers on the consent forms.

It is of note that the Bristol Public Inquiry emphasised the importance of communication between children and families and that good communication provides a bedrock for effective and informed consent. The need for better communication between patients and carers and clinicians is a theme that has run through public inquiries and reviews since that time. This Review makes the very valid point that because of the confusion and differing recollections relating to consent this was a potential source of distrust between clinicians and families. Once distrust like this starts the likelihood of unresolved complaints increases leaving families to look to third parties to assist them in investigating their concerns.

Serious Incidents/Risk Management

Chapter 12 covers Governance and Leadership.

An audit or other means of review has been recommended to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked.

It notes that staff were confused about the need to raise an incident report when staff levels fell below the safe level. There was also confusion about whether such issues should be reported to wards where the gap existed or it should be reported as a corporate risk. The Review notes that it is concerning that this confusion existed in 2014

after the focus on safe staffing levels at Mid Staffordshire Public Inquiry. The Review concludes that if more attention had been given these matter could have received attention earlier (see staffing section below).

This is because the Review concluded that there were weaknesses in the system for the review of “low risk” or “no harm” incidents. They felt that attention was concentrated on higher risk incidents, coupled with high level reports. If delegation of responsibility to consider “low risk” incidents was to be effective then the Patient Safety Team/clinical governance groups had to discharge their responsibilities rigorously. It also depended on effective oversight from Divisional leaders who needed to detect and then challenge any failings or weaknesses at that level. The Review was not satisfied that this occurred. Further the Review were concerned that there was a risk that staff may place undue reliance on the patient safety team and not take responsibility themselves for risk management.

Ultimately the Review felt that if more sustained attention had been given to reviewing “low risk” or “no harm incidents” or to developing the draft risk assessment of Ward 32 these matters could well have been detected and received attention earlier.

Paragraph 6.8 at Chapter 13 of the report is quite damning. It states that “ the Trust’s senior leadership should have taken much greater care to avoid giving the impression that documents which set out critical comments, such as [this] RCA, were not welcome. Their behaviour was crucial in setting the tone or “culture” of the organisation so as to ensure that the Trust was a “listening” organisation.”

The Review noted evidence of RCAs taking too long as well.

Complaints

While the Review saw examples of good handling of complaints they noted that in the difficult and complex situations which lay at the heart of the Review investigations and handling of complaints had not succeeded in resolving concerns. The approach taken had actually deepened suspicions and rifts.

Their review of complaints files did not give the Review confidence that the team members had the authority or capacity to carry out effective “arms-length” investigations. The Review observed that they tended to function by asking staff to give a written response to those aspects of a complaint which touched on their particular work and that the answers were incorporated into a draft letter of response for approval by Trust executives. The Review felt that there were occasions when the tone or sensitivity suffered as a consequence, as did the ability to identify and focus on key areas of concern.

The Review found that families were confused about the different investigations initiated, especially after a child had died. The process of a complaints investigation, a Root Cause Analysis investigation and a Child Death Review was confusing and could, on occasion, lead to an over analysis. The Review noted the previous recommendation of a “one stop shop” with respect to dealing with concerns from the Bristol Public Inquiry but that families did not experience this. Instead there were overlapping processes that did not have a clear relationship with each other.

In light of this the Review has recommended:

- There should be an integrated process for complaints and all related investigations after the death of a child or serious incidents and this should take into account the work that NHS England Medical Directorate is carrying out relating to standardisation of the Child Death Review process.

- In designing complaints processes account should be taken of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.

- Guidance should identify when, and if so, how, an “independent element” can be introduced into the handling of those complaints or investigations which require it.
- Serious consideration be given to offering as early as possible alternative forms of dispute resolution, such as medical mediation.
- Patients and families should be offered not only information about any changes in practice introduced as a result of a complaint or incident involving them but also the opportunity to be involved in designing those changes and overseeing their implementation.

Staffing

Staffing levels of course are topical and feature in the report at Chapters 10, 11 and 13. The Review is critical of the fact that a proper risk assessment on the cardiac ward was not carried out in late 2011 and that concerns of a Consultant about staffing did not prompt re-consideration of that risk assessment. Instead steps were taken to reassure him rather than to analyse the concerns themselves. Strong risk management processes should ensure that concerns such as this are fully investigated before such reassurance is given.

The cardiac ward is noted as suffering from a lack of strong and stable leadership for some time. There is particular reference to a private meeting of the Board in 2012. The Review note that a more thorough discussion and review of the history of concerns about staffing and of the most recent investigations into deaths or untoward incidents in the ward, would have contributed to a fuller and more complete understanding of the pressures on the service and the effectiveness of the measures taken to mitigate risks. This would have led to a more qualified or nuanced discussion with the Board and better informed communication with some of the key families concerned.

One recommendation emphasises the importance of the early use of, in particular, a nationally recognised paediatric staffing tool for acutely ill children. The Review goes on to emphasise the importance of the availability of a senior nurse to meet senior medical colleagues and regularly discuss the care of patients in order to develop the team and share accountability for setting and maintaining standards.

Nationally

Recommendation 24 states that urgent attention should be given to developing effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations. This came about because the Review concluded that organisations within the NHS, and more particularly NHS England, failed to engage consistently with families throughout 2013 and to develop and deliver a strategy for reporting on what had been done to investigate or to address concerns. The Review felt that these failings played a part in creating the situation which eventually led to the commissioning of the Review.

In addition, Recommendation 25 highlights that, when structural changes are made, adequate resources are devoted to organising and archiving records in a way that will enable them to be retrieved and studied at a later date.

Due to limitations on capacity of the Bristol Paediatric Intensive Care Unit, the Review recommends that NHS England commission a review of Paediatric Intensive Care services across England and we understand that NHS England have already agreed to do this.

Conclusion

This report comes only six months after the Mazars' report into Southern Health. As always these reports provide food for thought and opportunities for change and improvement.

We would recommend that Boards review the report in detail and measure themselves against the points raised above.

If we can assist in any way, particularly around training or risk management workshops please do not hesitate to get in touch.

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