
Investigating Concerns Over Children's Cardiac Surgery in Bristol:

Terms of Reference for the Investigation

Introduction:

Recent concerns over the children's cardiac service at Bristol have been expressed by a number of families who have had experience of using the service. These concerns gave rise to a meeting between Sir Bruce Keogh, Medical Director for NHS England, and a group of concerned families on 14th February 2014. At that meeting, Sir Bruce listened to the concerns and responded by making the suggestion that an Independent Review might provide a process for both exploring the concerns and indicating where opportunities for improvement may lie. The broad sweep of concerns expressed at the meeting has been incorporated into the terms of reference below.

In addition, in a process which will take place independently of this review, the Chief Inspector of Hospitals of the Care Quality Commission (CQC) will:

- Request the National Institute for Cardiovascular Outcomes Research (NICOR) to carry out a further assessment of outcomes after surgery;
- Undertake a clinical case note review, to consider the cases of a number of the children who have received care from the service. The scope of such a review may be guided by the findings of NICOR's examination of the service. A mechanism for ensuring that this investigation may recommend that particular cases be reviewed will be established.

Preamble:

The Review will not determine questions of liability in respect of individual cases, or matters of professional discipline. Normal processes for dealing with these continue.

The responsibility for providing the service to a good standard rests with the Trust. The responsibility for commissioning it rests with NHS England.

Terms of Reference:

1. To gather evidence from a range of families about their experience of using the Bristol children's cardiac service, from the publication of national standards for children's cardiac surgical service in March 2010, to the date of the Review.
2. To gather evidence from present and past members of staff of the Trust, and other relevant witnesses, regarding the provision of the service during the same period, including its quality and safety.
3. To explore the candour and quality of communication, and the explanation and support made available, to families using the service.
4. To assess the degree to which progress has been made in implementing those recommendations relevant to this review contained in the Report of the Bristol Royal Infirmary Public Inquiry published in 2001.
5. To establish an understanding of the service in sufficient depth to:
 - a) Describe both achievements and any shortfalls by reference to published standards and any other relevant recommendations for change or improvement;
 - b) Assess the extent to which any such achievements and shortfalls were made apparent to the Trust Board, and the adequacy and candour of the reports made by the Trust to those with responsibilities to commission the service provided; and to
 - c) Describe the response of commissioners to the information provided.
6. To contribute, by investigation of the matters outlined above, to emerging National Standards for this service.
7. To make recommendations as appropriate.

Suggested Lines of Enquiry:

Building on the Note of the meeting with families on 14th February 2014, four lines of enquiry suggest themselves:

A. The Environment of Care - to cover issues of staffing, skills, record-keeping, communication between staff (especially when handing over responsibility), equipment, the physical setting, the management of pre-

and post-operative care, the demands on the service, and the capacity to meet those demands in a manner which was safe and of an appropriate quality. Such enquiries may be directed at any venue at which care was provided, including at Outreach Clinics, admission through the Accident and Emergency Service, or care and treatment in the paediatric intensive care unit and Ward 32.

B. Communication - to cover the candour, quality, continuity and consistency of communication with families. This will include the quality of explanations of events, uncertainties and risks, including communication over matters such as critical incidents, root cause analyses, and child death reviews.

C. Care and Compassion - to explore the quality of the care and compassion extended to families at the various stages in the journey of care, with a specific focus on support, immediate and longer term, in cases of bereavement.

D. The Culture of the Trust - to cover the access of patients to information within the Trust, and the operation of reporting and the use of information within the Trust at, and below, the level of the Board, including the reporting of information to relevant bodies at a regional or national level and the response of commissioning bodies to the information made available to them.

Method:

The review will be led by Eleanor Grey QC, an independent barrister who was formerly Counsel to the Bristol Royal Infirmary Public Inquiry. Sir Ian Kennedy has agreed to act as a Consultant Advisor, available to advise generally on the gathering of evidence and issues arising, and upon the contents of a draft report and its recommendations. Ms Grey will be further assisted by independent experts who will be asked to advise on clinical matters and other issues arising.

The Review will be independent. At the conclusion of its work, it will deliver a report which will publish its findings and recommendations. NHS England, the Chief Inspector of Hospitals for the Care Quality Commission, and other relevant bodies with responsibilities for the delivery and regulation of services will consider these findings and recommendations, through the normal mechanism provided by guidance from the National Quality Board.

The Review will have access to communications support (including a website), legal advice, a secretariat and expert opinion on specific

topics.

The Review will organise its work under the four lines of enquiry suggested above.

The Review will proceed without legal powers to compel witnesses and obtain documents, in the expectation that parents, members of staff of the Trust and others are willing to take part. This is the basis on which the terms of reference proceed. The Review will advise its commissioners if, in its view, its progress has been impeded by an inability to secure evidence on this basis.

Interviews conducted by the Review may take place on a confidential basis (subject to any obligations that may exist under the Freedom of Information Act), or be held on the record if the witness so wishes. A record of the interview will be made, which the witness will be able to review and agree.

The Review would seek to complete its work with all due speed.