Date: **5 December 2001**

Venue: **Committee Room 3, National Assembly for Wales**

Title: **Issues flowing from the Kennedy Report**

Purpose

1. To provide the Committee with an overview of the Kennedy Report and invite members to discuss specific aspects of the report

Action

2. You are asked to note that the Administration proposes to publish a full response to the Kennedy Report shortly. You are asked in the interim to consider in detail two of the central themes of the Report:

- the way children's services are managed / delivered;
- the generic issues of culture change in the NHS

Background

3. The Kennedy Report was published on 18 July. The Inquiry, chaired by Professor Ian Kennedy, was asked to look at children's heart surgery at the Bristol Royal Infirmary between 1984 and 1995 and to draw wider lessons for the health service as a whole.

4. In examining events at the Bristol Royal Infirmary between 1984 and 1995 the Report describes 'a tragedy born of high hopes and ambitions'. Between 1991 and 1995 the Report makes clear that between 30 and 35 more children, aged under one year, died after open heart surgery in Bristol than was typical of similar heart units elsewhere in England. This was not due to differences in the severity of the cases. While mortality rates fell throughout the rest of the country this did not happen in Bristol.

5. The Report exposes considerable flaws in the systems, culture and management arrangements in place at the time; and highlights a culture where little account was taken of the views and concerns of parents, there was a shortfall in clinical audit practices, management actively discouraged open discussion and

resolution of concerns raised by staff and early warnings were brushed to one side.

6. The recommendations are wide ranging and many will require a fundamental cultural shift.

7. The Report concludes that there was a tragic combination of key clinicians failing to reflect on their practice (the senior staff concerned got things wrong not least because they assumed that in time things were bound to come right); senior management failing to grasp the seriousness of what was going wrong; and people in a range of capacities failing to act. It was left to a whistleblower, an anaesthetist in the hospital, Dr Stephen Bolsin, to trigger the chain of events, which led eventually in 1996 to the suspension of children's heart surgery.

8. The Report makes 198 wide ranging and challenging recommendations about the organisation and culture of the NHS to ensure that if implemented a tragedy such as Bristol cannot happen elsewhere.

9. The Kennedy Report places the patient at the centre of its view of how the health service should be organised and the recommendations flow from the guiding principle that the patient should be entitled to expect:

- Respect and honesty;
- Care in a setting which is well led;
- Competent healthcare professionals;
- Care which is safe;
- Care of an appropriate standard; and
- Inclusion and Involvement in the NHS, both as patients and members of the public.

10. The recommendations are a considered attempt to shift the culture of the NHS to one where it can be acknowledged that medicine is not a perfect science and that even the best people can make mistakes. It describes a future culture where appropriate systems and relationships are in place to provide a safe framework within which clinical care can be provided to a high and recognised standard; outcomes can be monitored and evaluated; staff are well regulated, trained and supported for the tasks expected of them; error is minimised but when it does occur lessons are learnt and shared; and above all where patients are genuine partners in the decision making process.

Recent Developments

11. Whilst the events which took place in Bristol were tragic, in the intervening years a number of new organisations and mechanisms have been introduced which focus on the quality of care provided by the NHS which have helped to begin a cultural shift within the NHS by investing management time and focus on quality of care. It is essential that when considering the Kennedy recommendations we look at them in light of these developments which include:

- **The National Institute for Clinical Excellence (NICE)** - was set up as a Special Health

Authority for England and Wales on 1 April 1999. It is part of the National Health Service (NHS), and its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". NICE guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.

- **The Commission for Health Improvement (CHI)** was set up on 1 April 2000 to improve the quality of patient care in the NHS across England and Wales. For many years it has been apparent that the standard of care offered by the NHS in England and Wales has varied greatly, for example, between hospitals, between departments in the same hospital and between general practices. CHI aims to address this issue of variation and has a programme underway which aims to ensure that every NHS patient receives the same high level of care.

- **National Service Frameworks (NSFs)** are designed to ensure the NHS delivers top quality services for everybody, no matter where they live. They spell out the standards of care patients can expect to receive for their condition / illness regardless of where they live in Wales.

- **The National Patient Safety Agency (NPSA**) A new agency is to be set up to boost patient safety in the NHS by introducing a national system for reporting failures, mistakes and near misses in the health service. It will run a mandatory reporting system for logging all mistakes to ensure that lessons are learned when things go wrong.

Consideration

12. It is essential that thinking around the recommendations and their implementation be linked to "Improving Health in Wales" and its implementation. The aims of the plan and of the report are entirely compatible - delivering a people centred and participative service which should:

- Be simpler for patients to understand;
- Be accountable for the actions it takes and the services it delivers;
- Have a stronger democratic voice in the way it is governed.

13. In Wales we already have a Children’s Commissioner and a Cabinet Sub-Committee on Children and Young People which I chair. The Cabinet Sub-Committee’s role is to promote health, well being, educational, social and personal development of all children and young people. In addition we are also developing a National Service Framework for Children in Wales.

14. The Kennedy Report is only one piece of work ongoing in Wales that bears upon children's services and it must be considered alongside others, such as the Tertiary Services Review and the Carlile Inquiry.

15. For the most part, I am content with the recommendations, either wholly or in principle. There are several which require ongoing discussions with colleagues in the Department of Health as they relate to,

for example, jointly sponsored bodies such as the National Institute for Clinical Excellence and the Commission for Health Improvement. Our response will be a first step in a longer process. While in many cases there is work ongoing to take forward the recommendations, there are areas, which require significant development. These are:

- Ensuring that we deal fully with the issue of consent to treatment. I propose to issue guidance on this before the end of the year.
- Children's services including the development of a National Service Framework

Culture within the NHS

Current position

16. Although events have moved on from the circumstances described in the Kennedy Report there is a wider, but by no means universal recognition within the NHS that:

- Patients must be involved in the design, planning and delivery of the services they, their families and carers rely upon
- Early warning systems should be in place to ensure that those providing NHS services are competent and that those who fall short of this are assessed for further training to bring them up to standard
- Systems must be in place to ensure that those consistently failing to provide competent services, despite corrective and supportive measures, are unable to practise within the NHS
- Stronger leadership is exercised over and within the NHS with organisations being brought to account for failing to deliver services
- Greater consideration of the training and development needs of all those responsible for provision of NHS services, including managers
- There should be a more robust framework for securing informed consent from patients, ensuring that patients receive all the information they require to make an informed decision about their care and treatment.

17. A recent study of Hospital Staff Cultures in Wales is being finalised. The project focuses on 4 areas:-

- Mapping clinical governance strategies in 5 trusts
- Analysis of staff perceptions of clinical governance
- Analysis of how staff assess their organisation and affiliate with it
- Analysis of professional subcultures

18. The project is due for completion in March 2002. The Members of the Committee are asked to consider:

- What culture do we wish to support and develop in NHS Wales and what are the guiding

principles that will underpin this culture?
- How can we change culture in the NHS and what supportive measures can be put in place?
- What should we do when people work against a positive culture shift? How do we move from a culture where blame flourishes to one where patients views and experiences are actively encouraged, engaged with and acted upon?
- Strong leadership is key to culture change, how can we strengthen leadership in Wales?
- Whether they would like to receive a presentation of the results of the study into hospital cultures in the future?

Children's Services

Current position:

19. The Specialised Health Service Commission for Wales is undertaking a comprehensive review of tertiary children's services available to children resident in Wales. The review will take account of the BRI recommendations and will be completed by 2002.

20. The National Paediatric Cardiac Services Review Group was established in March this year to develop national standards for all aspects of the care and treatment of children with congenital heart disease. Wales is represented on this Group. The Group is due to report to Ministers in early 2002.

21. The National Paediatric Cardiac Services Review Group was established in March 2001 and is due to report to Ministers early 2002.

22. The Review will take account of the findings of the Brompton and Alder Hey inquiries, carefully consider the Bristol Royal Infirmary inquiry report and build on the significant preparatory work already undertaken by the British Paediatric Cardiac Association, as well as similar reviews in other countries and make recommendations for change.

23. Information has been gathered from all Trusts with paediatric and congenital cardiac units in England, Wales and Northern Ireland via a questionnaire sent to Chief Executives. A programme of structured visits to each of the units is following up the questionnaire, giving the units a chance to participate in the review, to validate the information provided in the questionnaire and to listen to the views of parents.

24. A user / carer involvement and consultation strategy is included in the work programme. As well as meeting local parent groups on the visits, this includes meetings with national parent groups at events organised by the Children's Heart Foundation.

25. The members of the Committee are asked to consider how they might wish to become involved in pulling the various strands of work already underway in relation to Children’s services together.

Next Steps

26. I will ensure that the Committee has a copy of the Administration's response as soon as it is fully completed.

27. I expect the monitoring and evaluation of the implementation of the response to fall under the banner of the Performance Assessment Framework and the accountability processes within the Assembly. I will update the Committee on progress during September 2002.

Jane Hutt
Minster for Health and Social Services

Annex A

Work already underway

Respect and honesty - a series of recommendations around a partnership with patients, communicating, supporting, using feedback and what to do when things go wrong

- in 2001, a review of health information for the public, to enable the production of more user friendly information
- in 2002, a health and social care charter for children and young people which will address participation and access to information
- by 2003, a "patient awareness" training programme for front line staff to focus on effective communication with patients
- by 2003, a network of "expert patients" to support individual patients
- by 2004, a formal; procedure for patients to receive copies of correspondence between clinicians about themselves
- by 2002, proposals to make the NHS complaints procedures more independent and easier to understand

A health service which is well led - recommendations about the quality and the safety of healthcare and the management of the NHS at a local level

- modernising the contractual arrangements for consultants
- review of the distinction awards scheme
- formal review of the work of the newly appointed non-executive directors from a personal and organisational perspective and to identify any support and developmental needs

The competence of healthcare professionals - recommendations around leadership, continuous professional development, information needs and audit

- To develop a Lifelong Learning Strategy that would be applicable to all NHS staff.
- Chief Executives in Wales are signed up to the Institute's code of conduct and will be developing codes of practice and management standards.

Safety of care; building safety into systems, a national reporting system for sentinel events, care of an appropriate standard

- establishment of the National Patients Safety Agency

Public involvement through empowerment: transparent and supported processes to involve patients and the public

- in 2001, all patients leaving hospital will be invited to complete a questionnaire
- NHS organisations will be required to incorporate a range of public involvement mechanisms into their health service planning and service reviews
- In September 2001, a resource guide was published which offers practical help to NHS organisations on how to effectively involve and engage patients and the public.

The care of children; the planning and staffing of children's' services to ensure a child centred approach

- The Specialised Health Service Commission for Wales is undertaking a comprehensive review of tertiary children's services available to children resident in Wales. The review will take account of the BRI recommendations and will be completed by 2002.
- The National Paediatric Cardiac Services Review Group was established in March 2001 and is due to report to Ministers early 2002.

Healthcare services and treatment for children with congenital heart disease; recommends the development of national standards for all aspects of the care and treatment of children with congenital heart disease [CHD].

- The National Paediatric Cardiac Services Review Group was established in March this year to develop national standards for all aspects of the care and treatment of children with congenital heart disease. Wales is represented on this Group.