Report from the Medical Director

Author: Medical Director

Trust Board paper H

1. Context

The purpose of this report is to describe UHL's current position in relation to the failings detailed in the Jack Adcock case, as identified in the Trust's Serious Incident Investigation report, the Inquest, the court proceedings and the Medical Practitioner's Tribunal that followed.

Whilst it is more than seven years ago that Jack died in our care, we acknowledge the on-going heartbreak for his parents and seek to constantly challenge ourselves on safety and quality matters.

2. Topics Covered in this report

- Organisational failings detailed in the JA investigation reports;
- The trust measures and actions which have been implemented to mitigate these failings;
- The current position and proposed UHL Quality Strategy;
- Suggested recommendations.

3. Questions

1. Is the Board satisfied that we have taken sufficient actions to mitigate the failings described in the report?
2. Are our governance arrangements sufficiently robust?
3. Are we rigorously tracking and responding to safety concerns?

4. Input Sought

The Trust Board is invited to consider the actions and improvements described in this paper and discuss if sufficient measures have been taken in respect of the system failings identified. Specifically the Board is requested to support the following further actions:-

1. To establish an active surveillance mechanism regarding issues with the new paediatric single front door;
2. To undertake a formal evaluation of the new paediatric single front door service model in April 2019;

3. The Executive Workforce Board to receive regular reports on doctors-in-training supervision and concerns raised through the GMC survey;
4. The EQB / EPB to receive a report on winter planning arrangements specifically relating to paediatrics, detailing how capacity can be flexed to accommodate the peaks in bronchiolitis admissions;
5. Ensure robust governance processes regarding listening to and acting on concerns raised via the Freedom to Speak Up, 3636 and Junior Doctor Gripe Tool processes;
6. The Medicines Optimisation Committee to review practices regarding the self (or parent) administration of medicines.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Yes
Consistently meeting national access standards	Yes
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	No
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	No
Enabled by excellent IM&T	Yes

2. This matter relates to the following governance initiatives:

Organisational Risk Register	Yes
Board Assurance Framework	Yes

3. Related Patient and Public Involvement actions taken, or to be taken:

4. Results of any Equality Impact Assessment, relating to this matter:

5. Scheduled date for the next paper on this topic: TBC

6. Executive Summaries should not exceed 2 pages. Yes

7. Papers should not exceed 7 pages. Yes

UNIVERISTY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT BY: **MEDICAL DIRECTOR**

DATE: **4TH OCTOBER 2018**

SUBJECT: **CURRENT POSITION ON SYSTEMIC AND TRUST ISSUES IDENTIFIED THROUGH THE JA CASE**

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1. INTRODUCTION

1.1 The purpose of this report is to describe UHL's current position in relation to the failings detailed in the Jack Adcock case, as identified in the Trust's Serious Incident Investigation report, the Inquest, the court proceedings and the Medical Practitioner's Tribunal that followed.

1.2 Whilst it is more than seven years ago that Jack died in our care, we acknowledge the on-going heartbreak for his parents and seek to constantly challenge ourselves on safety and quality matters.

2. BACKGROUND

2.1 Jack Adcock (JA), a six year old boy, was admitted to the Childrens' Assessment Unit at LRI on 18th February 2011. Jack died later that evening and the investigations which ensued revealed that early recognition and treatment of his sepsis were identified as significant failings. This case, and the criminal and professional tribunal case of Dr Bawa-Garba have been widely reported on since 2011, both internally and in the media.

3. ORGANISATIONAL FAILINGS

3.1 Following Jack's death a series of investigations took place. These included an internal Trust root cause analysis (RCA) investigation, an organisational learning report, a police investigation, medical and nursing expert witness reports, and reports prepared ahead of the inquest and criminal trial. Over the years, the findings of these investigations have been reported through the Trust's safety and quality committees as well as to executive team meetings, and periodically to the Trust Board.

3.2 In summary the failings identified included:-

- IT system failures which led to abnormal laboratory test results not being highlighted.
- The failure of medical staff to understand and communicate the significance of abnormal blood results.
- The failure of nursing staff to recognise the significance of abnormal observations and record and monitor according to clinical need.
- Ambiguity of the observation and escalation tools in use in Children's Hospital.
- Poor communication of clinical condition between staff because of an absence of effective systems for handover (medical and nursing).
- Failure to fully appreciate the child's overall clinical picture and underlying medical history due to a failure to engage a timely cardiology review.
- Failure to follow guidelines (Leicestershire Medicines Code) for non-prescribed medication because of custom and practice for administering non prescribed regular medication.
- Accessibility of clinical information at the bedside.
- Medical and nursing staff shortages.

- The absence of a mechanism for an automatic consultant review.
- Weak systems for induction and re-orientation of staff returning to work following prolonged periods of leave or absence.
- Not all medical staff at all levels allocated having an educational supervisor on immediate commencement of post or return from prolonged leave.
- Weak visual aid prompts to alert staff of abnormal blood parameters.
- Inconsistent consultant supervision and presence on the Children's Assessment Unit including ensuring that the CAU consultant reviews the all patients remaining on CAU.

3.3 The action plan of the Trust's internal RCA has been monitored both within the Women's and Children's CMG and at Trust committees for assurance that sustainable actions for improvement on these issues have been implemented and embedded.

4. TRUST QUALITY AND SAFETY IMPROVMENTS

4.1 Since 2011 and the death of JA there have been very considerable organisational improvements which have addressed the failings identified or have mitigated the risk. These include:-

4.2 Recognition of sepsis and deteriorating patients:

Significant improvements have been made in the detection and management of sepsis within UHL. UHL now uses an electronic track and trigger system (e-obs, NerveCentre) to automate calculation of a Paediatric Early Warning Score (PEWS) based on nursing observations. This score is informs the nurse inputting the observations of necessary escalation actions. This ensures that sepsis is accurately identified from the available observations and that the correct level of escalation is chosen for each individual child. Escalation to the correct level of doctor is carried out using the task management function within NerveCentre which alerts doctors to the need for review via mobile hand-held devices. The trust gains assurance that the necessary actions have been taken by regular audit. There is a team of dedicated sepsis nurses employed by the trust to ensure that cases of sepsis are picked up early so that intravenous antibiotics and other critical interventions can be administered within one hour in line with NICE guidance on managing paediatric sepsis. Automated red-flag sepsis alerts are planned for the near future. Sepsis boxes have been introduced and are accessible on all wards. These include all the necessary antibiotics and equipment required to deliver the Sepsis 6 actions within an hour to avoid delays in finding the correct equipment and drugs.

4.2.1 The full hospital-wide roll out of electronic observations (e-obs) and the NerveCentre electronic platform have given us considerable traction and reassurance on the timing and quality of observations undertaken and the response to these in terms of treatment. The consequence of this has been a reduction in avoidable harm relating to the deteriorating patient and sepsis. Responses to the deteriorating patient are monitored at the sepsis and deteriorating patient boards which report into the Executive Quality Board.

4.3 Arrangement of paediatric urgent care services within UHL:

4.3.1 Since 2011 there have been a number of improvements made to the paediatric urgent care pathway:

- CAU has now closed and all children enter the Children's Hospital through a single front door. The team that manage this are known as the Children's Acute Team. This area is staffed with Emergency Department (ED) and Paediatric Consultants and is the single point of access for all children. The care here is consultant-led with a consultant rostered to be present between 9 to 5 pm every day. Outside of these hours consultant presence is dictated by clinical need with an innovative "sliding-scale" of attendance based on the acuity of patients in the department based on their needs and PEWS scores and seasonality. In practice a paediatric consultant is usually present until late

into the night; and available to re-attend immediately if required. This is a marked increase in levels of consultant supervision compared to those in 2011.

- E-obs is now rolled out throughout the Children's Hospital (see above) which allows timely recognition of children who are at risk of sepsis or who are deteriorating
- Near patient testing in the Children's ED has improved markedly with blood results now available within 1 hour.
- Improved handover documentation between the Children's ED and ward areas.
- The Children's Hospital has a Matron lead for sepsis and a lead consultant. The Head of Nursing meets regularly with the Sepsis lead to ensure SEPSIS recognition remains a priority
- The introduction of formalised regular safety huddles in the ward areas has improved situational awareness within the paediatric teams. Conversations at these huddles are facilitated using handover on NerveCentre. They serve as a meeting during the day for the teams to get together to share information about the patients in that area – with particular emphasis on safety and sick patients. The huddle also serves as a defined point in the day when staffing levels can be reviewed and staff flexed between the areas that need them most to ensure safety of patients. Huddles are attended by senior managers and clinicians.

4.4 Information technology:

- IT to support clinical pathways has improved since 2011 with introduction of ICE as the repository of all diagnostic tests including blood results. Currently there is a parallel system called iLab which means that if one system fails that there is always a back-up available to access lab results. There are clearly defined protocols that define when abnormal results will be urgently communicated to clinical teams verbally in order to alert them of seriously significant findings. The thresholds for alerting clinicians have been reviewed and, in some cases, set to a lower threshold as a result of this case. All blood results on ICE have a visual prompt to highlight if they are abnormal. The introduction of NerveCentre has proved a powerful tool to aid handover, to assign tasks to the correct grade of doctor, and to alert clinicians to patients who are deteriorating.
- Both ICE and NerveCentre are technologies that are available at the patient bedside using either handheld devices (NerveCentre) or mobile Computers on Wheels.
- There is an ICE Programme Board which oversees the systems for handling the results of diagnostic tests. The Acting on Results work-stream in the Quality Commitment reports to the Executive Quality Board on a quarterly basis.

4.5 Staffing levels:

- Nursing vacancies remain a challenge with particular gaps on ward 11, ward 30 and PICU/CICU. The use of safe staffing tools means that the trust is well-sighted to staffing levels throughout all of our wards. The Chief Nursing Officer reports regularly into the Executive Quality Board with a summary of staffing levels.
- A bespoke recruitment campaign is being planned for the Children's Hospital to fill vacant positions.
- Medical rotas and consultant presence have improved since 2011 and there is better oversight of the medical rots with a forward-planning meeting that proactively identifies future gaps so that shifts can be filled. Despite this gaps do occur from time to time and on occasion consultants have to "act down" to fill registrar shifts to ensure that the unit is safely staffed. Using this approach, over the last four years only two night shift posts have remained unfilled.
- All staff shortages are discussed at the daily Operational Command Meetings which occur at 9am, 1pm, 4pm and 6 pm. These means that the trust executive are well-sighted to critical staffing shortages and that the operational team are working hard to fill any gaps in real time using all available resources.

4.6 Supervision of trainees and how concerns are raised:

All junior doctors in the Children's Hospital have both an assigned Educational Supervisor, and an assigned Clinical Supervisor. As detailed above, the level of consultant supervision in the Children's Hospital has been increased since 2011.

4.6.1 Since 2011 many initiatives have been introduced to ensure that the concerns of junior doctors can be raised within the organisation. These include strengthened guidance to junior doctors about how to raise safety concerns including introduction of a Junior Doctor's Gripes Tool for less urgent concerns. There is a refreshed algorithm for the Escalation of Concerns that has been developed by the Children's Hospital. The trust has appointed a Freedom to Speak Up Guardian who is an independent individual who reports directly to the Chief Executive. During the recent heightened media coverage surrounding the death of JA, the trust's Medical Director met regularly with paediatric trainees in the trust to address any new or on-going concerns about trainee supervision within paediatrics. Matters relating to junior doctor concerns are overseen by the Trust Medical Education and Workforce Group which reports regularly into the Executive Workforce Board. The GMC survey from 2018 demonstrates particularly good results for paediatric emergency medicine which has improved since 2017 and there are now 4 green flags (1 in 2017). The score for local teaching has increased from 71 to 90. Paediatric Emergency Medicine scores for supportive environment, induction, local teaching and rota design are the highest, for the specialty, in the UK. In paediatrics there is one new red flag for out of hours supervision of paediatric higher specialist trainees at the LRI. The new CAT model and single front door have been put in place since then and there are plans to further increase senior supervision out of hours by improving consultant presence.

4.7 Supervision and induction for staff returning to work after a long absence:

- All new staff are orientated to the ward areas in the Children's hospital and bank staff in nursing are asked to sign the green induction book as evidence that this has happened.
- For medical staff, those on maternity leave receive ongoing supervision whilst on leave (if in training) and have regular Keep In Touch days with the department. On return from leave a bespoke phased reintroduction is implemented for each individual in order to meet their unique needs.
- UHL as a Learning Organisation:
- Learning is shared through EQUIP which happens on a Monday every week. Actions from SIs/ Datix are shared with the teams in Children's.

4.8 Administration of medicines:

4.8.1 UHL's current policy on the self-administration of medicines makes it clear that medicine should not be self (or parent/carer) administered on in-patient wards. However, there remains a grey area for patients who are waiting in the ED and have not yet been admitted or had their medicines prescribed. Some of these patients will need administration of time-critical medications in order to prevent harm, and therefore self-administration would be acceptable under such circumstances. There is a need to review practices around self-administration in these situations to ensure that a pragmatic policy can be developed and adhered to. This issue will be taken up by the Medicines Optimisation Committee.

5. CURRENT POSITION

5.1 Notwithstanding all the environmental, professional, system and organisational improvements described above, the Trust is by no means complacent about patient safety. We recognise that reduced nurse staffing, junior doctor rota gaps and demand and capacity pressures provide daily challenges within the Trust. We are, however, getting better at picking up safety concerns from staff, organising ourselves around safety and quality improvement, and triangulating data to inform our actions.

5.2 The seriousness with which we hold patient safety demands that we pay great attention to governance processes as well as actively listening and responding to concerns raised. We have, therefore suggested further actions in the recommendations below.

6. UHL QUALITY STRATEGY

6.1 At the UHL Leadership event in September, the Chief Executive outlined proposals to build a culture of continuous quality improvement that enables improvements in quality, efficiency and productivity of services across the Trust. These plans are currently being worked up into a UHL Quality Strategy which will assist the organisation to organise itself better for safety and quality improvement. This may provide a further opportunity to scrutinise our governance arrangements around safety and ensure that we have sufficient detective mechanisms to pick up and act on concerns early.

7. RECOMMENDATIONS

7.1 The Trust Board is invited to consider the actions and improvements described in this paper and discuss if sufficient measures have been taken in respect of the system failings identified. Specifically the Board is requested to support the following further actions:-

1. To establish an active surveillance mechanism regarding issues with the new paediatric single front door.
2. To undertake a formal evaluation of the new paediatric single front door service model in April 2019.
3. The Executive Workforce Board to receive regular reports on doctors-in-training supervision and concerns raised through the GMC survey.
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6. The Medicines Optimisation Committee to review practices regarding the self (or parent) administration of medicines.

Colette Marshall, Deputy Medical Director
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September 2018