

TERMS OF REFERENCE

INDEPENDENT REVIEW

Trust Background

Heart of England NHS Foundation Trust (HEFT) provides general and specialist hospital care for the people of east Birmingham, Solihull, Sutton Coldfield and South Staffordshire, serving a population of circa 1 million. It provides these services through three hospital facilities (Good Hope, Heartlands and Solihull), the Birmingham Chest Clinic and Solihull Community Services. It employs approximately 11,000 staff and has a turnover in excess of £600 million.

The Trust's corporate strategy and primary focus centres upon providing acute and community healthcare services for its local communities. It believes that its success as an organisation should be judged by patient perceptions, with trust, confidence and pride being the three key criteria for measurement. This perspective has been used to develop the Trust's mission, vision, values and key strategic priorities. These are summarised as:

Mission: 'Healthcare at the heart of our communities'.

Vision: To provide services that inspire confidence, trust and pride within the communities we serve.

Value: Openness.

This mission and vision are underpinned by four strategic priorities:

- Safe and Caring
- Locally engaged
- Efficient
- Innovative

In terms of achieving the Trust's vision the Board has agreed 16 goals one of which specifically underpins its core value of 'openness'. This is the aspiration to be known as one of the most open organisations within the NHS.

Context

In 2007 Heart of England NHS Foundation Trust began an investigation into the breast surgery practice of one of the Trust's Consultant Surgeons, Mr Ian Paterson, following serious concerns raised by colleagues regarding a form of incomplete mastectomy. The investigation, which included external expert opinions being sought, resulted in the surgeon undergoing a period of retraining, agreeing to change his mastectomy practice and a targeted recall of patients, based upon information and advice available at that time.

Concerns from patients, external agencies and colleagues continued to be raised following this investigation and in 2011, as a consequence of this, a number of further measures were implemented including:

- Mr Paterson was excluded from practice at the Trust (May 2011) whilst the further concerns were investigated;
- a new confidential HR investigation was initiated, with Terms of Reference focused upon the concerns raised in 2011;
- A full recall of all of Mr Paterson's patients who had undergone a 'mastectomy' at this Trust, was started;
- Regular meetings were held between patients who raised complaints, and the Medical Director and the Breast Team
- The Trust co-operated with the (ongoing) investigation into Mr Paterson's Fitness to Practice, explored by the GMC;
- The Trust collated data through the recalled patients, to submit to the West Midlands Cancer Intelligence Unit, in order to understand whether the data could inform clinical understanding as to any impact on prognosis, of the procedure in question.

As part of meetings held with patients and carers to respond to their complaints, concerns were raised generally about the length of time this procedure may have been carried out by the surgeon, and specifically about the time scale between the concerns being raised internally, and the decision to conduct and complete a full recall, sharing information with the patients involved. The Trust considers that it is necessary and appropriate to respond these concerns and, following consideration at Board level as to how to explore such issues, has decided to undertake a retrospective, reflective independent review into the events surrounding the incomplete mastectomy procedure concerns, including analysis of the precise sequence of events based upon what is now known, and the Trust's response to those events as information became available. The review will consider the concerns raised by its staff, patients and the public, the subsequent investigation and actions taken to ensure patient safety, to see whether any further learning is required.

Rationale

The Trust's principle aim and purpose is to ensure that it delivers high quality safe acute and community care for the patients its service in all of its local communities. As an organisation, success is determined by how patients perceive the Trust, in terms of how well they feel cared for and how well the Trust run services on their behalf. Not only is this the Trust's aim, it is also the aim of the NHS as a whole.

Whilst it is clear that the organisation has taken steps to investigate concerns regarding Mr Paterson's surgical practice, the Board fully recognises the concerns expressed by patients around the length of time taken to complete this investigation and take action. Whilst there may be valid reasons for this, the Board feels that, in the interest of providing high quality services and its duty to safeguard both staff and patients, there may be lessons to be learned about how the organisation might improve its response to concerns raised by staff about clinical practice in the future.

This review will be conducted in a spirit of both transparency and learning recognising that it will be carried out with the benefit of hindsight. It will seek to be inclusive of patients,

the public and staff in understanding their perspectives and experience, so that the organisation can capture as much learning as possible and improvements can be made to services and governance systems where necessary. It is also anticipated that learning from the Trust's experience will be shared as widely as possible so that lessons relating to the complex matter of raising and acting on concerns about professional practice can be learned across the NHS.

Outcomes from the Review

The principle objective of this review is to provide a formal report to the Trust Board which will provide an independent assessment of the organisation's response to these concerns and capture the learning from the Trust's response. The report is to be published and provide a comprehensive understanding of the organisational systems, and processes which the Trust employed to discharge its duty of quality and safety to its staff and patients. This will need to incorporate the following:

- a detailed timeline of events and actions taken;
- an independent assessment of the processes used to investigate concerns that were raised and action taken to address those concerns, identifying both good practice and areas for improvement;
- identify clear recommendations which help to define the future direction and any changes to improve and enhance the Trust's quality and safety culture; and
- clear recommendations which can support the NHS in improving its response to concerns raised by clinicians into another clinician's practice.

Where there are areas for improvement, steps will be taken to develop the Trust's services and strengthen organisational systems. In line with the Trust's values of openness and transparency, this Review is to be overseen by an Independent Chair.

It is essential that patients and members of the public are given the opportunity to contribute directly to this review. Patients will be given the opportunity to tell the review team about their experience in terms of how their concerns were handled and what was done to address them. Consideration is to be given to the patient support including offering different methods for presenting comments to ensure patient views are represented.

As with patients, all members of staff that were involved in the delivery of breast care services will be invited to contribute to this review. Staff involved with the Trust investigations and the management response will also be invited to participate and give an account from their perspective. Additional support will be provided to ensure that staff are confident and able to bring forward their views.

This Review is expressly charged with being delivered within a no blame culture, to ensure that information is received in as open and constructive way as possible. It is key to the Review that those who contribute feel that doing so they will be helping to achieve a positive contribution to setting a course for the future within an organisation (and an NHS).

Terms of Reference

1. To provide a detailed chronology of events from the time of the Trust's appointment of Mr Paterson within the breast service, to the Trust Board's decision to conduct an independent review, encompassing:
 - The development of the Trust's breast care services, including the appointment of Mr Paterson, and of the organisational arrangements for providing these services to patients;
 - The raising of concerns about Mr Paterson's mastectomy practice, who raised them and to whom, including the senior management of the organisation;
 - The Trust's investigation of these concerns within the various established processes;
 - The action taken by the organisation to safeguard patients and prevent harm.

To examine the nature of the organisation's working environment, culture, systems, particularly regarding the collection, analysis and reporting of information about relevant surgical procedures and their outcomes and the role of audit, and arrangements for decision-making, generally, and particularly in relation to the breast care service.

2. Once concerns were raised, to establish what action was taken to investigate them, the timeliness of such action, and the measures taken and to ensure that the safety of patients was maintained within the breast care service.
3. To identify and evaluate the steps taken by the Trust to ensure that relevant external agencies/bodies were alerted and engaged in supporting the organisation in its response to the concerns raised.
4. To evaluate the effectiveness of the organisation's systems for ensuring the safety of patients, for clinical governance and for responding to whistle blowing by staff, throughout this period, in relation to the breast care service.
5. To identify lessons that can be learnt from these events: both examples of good practice and areas where improvement is required,
6. To make recommendations which will aim to ensure that lessons are learnt and steps taken to prevent any re-occurrence of the circumstances giving rise to the Review. The recommendations should include measures which can support the NHS in improving its response to concerns raised by clinicians into other clinicians' practices and concerns raised by staff into standards of care. Such recommendations should take account of initiatives across the NHS and professional bodies regarding whistle blowing.