Browne Jacobson

Shared insights: The Paterson Inquiry: learning for the healthcare system

25 May 2021

These insights were shared at our fortnightly online forum for NHS professionals on 25 May 2021. To find out more please visit our Shared Insights hub.

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In this Shared Insights session, we discussed the learning from the Paterson Inquiry and the implications for in-house legal teams, patient safety, clinical governance, workforce culture and large-scale reviews.

We were delighted to be joined by Jacqui Atkinson, Partner Browne Jacobson; Kathryn Fearn, Associate Director of Legal Services at University Hospitals of Derby and Burton NHS Foundation Trust; and Alison Bell, Advocacy and Improvement (Freedom to Speak Up) Senior Manager at NHS Improvement.

The Shared Insights were:

- Jacqui Atkinson began by providing an overview of the Kennedy Review and the report of the Bishop of Norwich highlighting that one of the issues identified was that there was too much focus on HR and not enough focus on patient care. There are a number of key areas where organisations can take steps to minimise the risks:
- **Recruitment** – it is vital that organisations are careful about who they recruit:
  - Look carefully for any evidence of potential issues and any red flags prior to an individual joining the Trust.
  - Ask to look at the individual's surgical logbook etc. and read references carefully - look for what may be implied but not said. Follow up on any concerns.
  - Once someone has joined the Trust, what does the buddying system look like?
  - How is the team functioning - there is more and more research on the detrimental impact of team breakdown on patient care. Red flags include individuals whom colleagues don't want to or cannot work with. Specialist area for HR to tackle.
- **Resources** - a key issue in Paterson, the way the recall was handled.
  - What resources will you put into a recall? Following on from the criticism in Kennedy and the Paterson inquiry, processes which are done well are those where the HR process runs separately to the patient and governance issues. It is possible to run two processes simultaneously dealing with the respective need to keep patient care central and deal with risks in managing doctors in difficulty.
  - In some circumstances, external rather than internal eyes can give better scrutiny. Please see attached checklist on commissioning external reviews from a previous Shared Insights session.
  - Set up your swat team at the beginning – what experience have you got around the Executive/Non-Executive team – hold regular strategy meetings with key stakeholders – and professional advisors - different departments can and sometimes do work in silos so you need a really strong oversight and scrutiny lead to make sure everything that should be looked at is examined.
  - Be curious – ask questions, join the dots on the emerging patient care and intelligence picture that is presenting.
  - Ensure the board has oversight, is updated and takes control of what processes need to happen in order to deal transparently and candidly with patient issues.
- **Culture**
  - You can have all the policies and committees in the world; but these are only as good as the culture set within the organisation.

- Trust Boards need to be sighted on these issues and committed to changing cultures where it is needed – a top down approach is needed with boards demonstrating that staff can feel safe about raising concerns.

- **Kathryn Fearn** spoke from a Trust perspective and shared her experiences having been at the centre of external reviews into patient care.
  - It is vital that patients are kept at the centre of the process
  - Be curious – the Trust needs to look at the bad as well as the good to make sure the recall process was robust.
  - All roads lead back to the terms of reference (TOR) – make sure the TOR include everything you need to cover, such as speaking with patients and making sure their views are fed into the review process.
  - Patients need to be able to contact someone who knows about the review when they call to ask questions about it. The Trust therefore have previously set up a specific team with administrative support, a project lead and an independent specialist to speak with the patients as the review progresses.
  - Patients should be written to prior to the review taking place – each letter needs to be carefully written, ensuring all details are correct (asking GPs to confirm if necessary). It is so important to get this initial correspondence right and give the right impression, as it sets the tone for the relationship with the patient going forwards.
  - Individual letters should be sent by recorded DX (courier) so the Trust can track who has received the letter and when, and any returned undelivered are followed up.
  - The letter needs to give a personalised number for the patients to call. Lots of patients may come forward and share their experiences in writing and this needs to be passed to the reviewers to consider when looking at their care.
  - When the review is concluded, a bespoke letter should be written to each patient by an independent consultant with their individual outcome – someone from the Trust should telephone the patient prior to the letter being sent so it wasn't sent out cold.
  - An independent Consultant should have a consultation with each patient to go through their case, the outcome of the report and to answer any questions. As a result of the pandemic these can be done via Teams, although it may be preferable for this to be face to face.
  - A bespoke counselling package should be arranged for the patients to self-refer onto. If they need further follow up, this could be arranged directly rather than going via their GP and having to wait.
- **Alison Bell** discussed the role of a healthy speak up culture in patient safety.
- **Culture and listening**
  - It is clear from the Paterson inquiry and Kennedy review that the culture was wrong. Make sure people know how to speak up and are aware of the role of the Freedom to Speak up (FTSU) Guardians. Trusts can also use anonymous reporting.
  - FTSU is everyone's responsibility but needs to be led from the top:
    — As well as people speaking up, senior leaders and the Board need to listen up, including to the everyday smaller issues which may indicate a wider problem.
    — The Board and senior leaders set the tone and need to be living those values and seen to be doing so. The overall culture then flows throughout the rest of the organisation.
    — Guardians are not solely responsible for FTSU. The Board holds overall responsibility.
    — Every NHS organisation in England needs an Executive and a Non-Executive lead for FTSU – culture is led from the top. It trickles down. Make sure your board and senior leaders are able to drive that agenda.
- **Triangulation of data**
  - The Paterson inquiry identified a lack of corporate memory. Corporate memory needs to be fed into any other data that comes in. Systems such as Datix or Ulysses can help with lack of corporate memory.
  - Many Trusts have setup a monthly forum to compare issues and whether there is a problem in a particular area. That triangulation can identify hot spots. These meetings should include a range of people who have access to key metrics to spot things that might be happening, such as representatives from HR, those responsible for staff engagement/surveys, chaplaincy, for soft intelligence, EDI leads, Clinical Governance, Patient Safety Teams, Complaints team and Unions, who have insight into what is happening on the ground.
  - Act upon any issues/concerns. Trusts need to move from looking for someone to blame and focus on just culture.
- **Listening up**
  - Trusts have to listen, no matter how hard it is. There may be nothing to it but you must check so patients can have the best care.
  - Take action to investigate and address dysfunctional teams. Make sure the Board is fully sighted about dysfunctional teams because dysfunction in teams leads to worse patient outcomes.
- **Speaking up is everyone's responsibility**

- Many people in Paterson said they didn’t speak up because they thought someone else had. Clinical staff have a professional duty to raise their concerns. They will only do that if the culture is right in the first place.
- Permit confidential and anonymous reporting if you think people aren’t speaking up.
- Encourage everyone to raise concerns – it is better to hear the same thing too often than not at all
- Use Champions in lots of locations as a listening ear.
- Listen, be curious and act.

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