NHS
University Hospitals Bristol
NHS Foundation Trust

Report to the Council of Governors meeting to be held on 31 October 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

		Agenda Item	7.2
Meeting Title	Council of Governors	**Meeting Date**	31 October 2017
Report Title	Independent Review of Children's Cardiac Services – Final Report		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status	Open		

Governor Responsibility (please tick any which are impacted on / relevant to this paper)	
Holding the Non-Executive Directors to account	☐
Non-Executive Director appointments (appraisal review)	☐
Constitutional/forward plans	☐
Member/Public interests	☒
Significant transaction/private patient increase	☐
Appointment of External Auditor	☐
Appointment of the Chief Executive	☐

Action/Decision Required
(please tick any which are relevant to this paper)

For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose: The purpose of this paper is to share with the Council of Governors assurance provided to the Board and a high level overview of the actions taken to deliver practical changes and service developments at the Trust in response to the publication of the Independent Review of children's cardiac services in Bristol in 2014, to support formal closure of the improvement action plan by the Board.

Key issues to note: The assurance document (Appendix 1) details the original recommendation, the responsible delivery group, the key actions taken to meet the requirements of the recommendation, details of the evidence to support actions completion, the timescales that the actions were completed in, any future developmental actions and the governance group for assuring delivery of these.

Recommendations

Governors are asked to

- **Note** the report.

Intended Audience
(please tick any which are relevant to this paper)

Board/Committee Members	☐	Regulators	☐	Governors	☒	Staff	☐	Public	☐

Date papers were previously submitted to other committees

Nominations & Appointments Committee	Quality Focus Group	Governor Strategy Group	Constitution Focus Group	Public Trust Board 31 October 2017

Independent Review of Children's Cardiac Services at the Bristol Royal Hospital for Children (BRCH)

1.0 Introduction

The purpose of this paper is to provide board members with assurance and a high level overview of the actions taken to deliver practical changes and service developments at University Hospitals Bristol NHS Foundation Trust in response to the publication of Independent Review of children's cardiac services in Bristol in 2014, to support formal closure of the improvement action plan by the Board.

This paper provides the following:

- A summary of the work undertaken;
- For each of the recommendations it provides details of the activities undertaken and milestones achieved through to completion;
- For each of the recommendations it identifies work that will continue as part of business as normal activity and the means by which this will be monitored within University Hospitals Bristol and the Bristol Royal Children's Hospital;
- Identifies where actions and learning have been taken forward throughout the organisation.

Underpinning the delivery of the recommendations has been a commitment to change, and an understanding that when we listen to the views and experiences of our patients and their families we can provide services that people need in the ways that they want. Some of the families involved in the Independent Review have joined us on that journey and continue to contribute in the co-design of children's services for the future. Our strategy is one of continual improvement; we recognise that there is always more work and that to not recognise this would be complacent.

2.0 Background

In February 2014, the Medical Director of NHS England commissioned an independent review of the children's cardiac service at the Bristol Royal Hospital for Children, in response to the continuing concerns expressed by families regarding the care that they had received.

NHS England worked with the families to develop and publish terms of reference for the review and asked Eleanor Grey QC to lead it, with Sir Ian Kennedy acting as an advisor.

At the same time, the Care Quality Commission conducted an independent audit and review of the medical records of a sample of children who were cared for by Bristol children's cardiac services between January 2012 and December 2014.

The reports of the Independent Review of children's cardiac services and the CQC expert review were published on 30 June 2016. The Trust fully accepted the findings of both these reports and welcomed their publication as a way to learn from mistakes. Although the reviews focused on children's cardiac services, the Trust, where possible, has implemented learning and service changes throughout the organisation, as we recognise the benefits this will bring to patients and their families.

3.0 Recommendations

There were 38 recommendations in total for implementation, 32 from the Cardiac Review and 6 from the CQC report. The majority of the recommendations (30) were for the Trust to implement, with the responsibility for delivery of the remaining recommendations being with South West and Wales Congenital Heart Disease Network, Department of Health and NHS England.

A schedule of all the recommendations, along with proposed organisational/individual ownership, proposed governance and details of initial actions and timescales was approved by the Trust Board on 28 July 2016. The recommendations were broadly spread across four categories:

- Women's and children's services;
- Consent for surgery;
- Supporting families and staff through incidents and complaints;
- National and local recommendations for services that the Trust is not directly responsible for but which have an impact on the experience of children and families.

The Trust has fully achieved, and in some cases, exceeded delivery of actions to address the 30 recommendations.

4.0 Governance of programme

The Board of Directors received the outcome of the Independent Review of Children's Cardiac Services in Bristol at the Board Meeting in July 2016. At that meeting, the Board agreed that Carolyn Mills, Chief Nurse, would be the Senior Responsible Officer and Board sponsor of the work programme. A time limited Steering Group which was accountable to the Board of Directors was established to oversee the implementation of the recommendations.

The Board of Directors agreed to receive performance reports against the delivery of the recommendations at each meeting. The Council of Governors also agreed to receive monitoring reports at each meeting of the Council of Governors.

The monthly report to the Board of Directors has provided assurance to the Board that:

- The implementation plan described detailed actions, timescales and responsibilities to ensure the recommendations were fully responded to
- The actions being taken fully addressed the body and spirit of the report
- All actions were completed in a timely and well-coordinated way, and if this was not achievable why.
- There were comprehensive and auditable processes established to enable scrutiny of performance and the delivery of actions
- Stakeholders were involved and engaged as appropriate in the governance and delivery of actions.
- There was a defined process to establish and build a comprehensive portfolio of evidence in support of actions taken and the improvements in place.

To assure the Board that the views of parents and young persons have been heard and that the development of the actions to implement the recommendations reflects what is important to patients and families, the Board have received a monthly update on parents and young person's involvement. Families and young persons have been involved in a number of different ways including:

- Membership of the Steering Group overseeing delivery of the recommendations
- Membership of the Cardiac Parents and Young Persons Reference Group
- Co-designing and involvement with specific work they are interested in
- Showcase of improvement: families have been invited to come and see what has been done to date via open days or 1:1 meetings.

The approach to the governance of the programme has been consistent with the priority given to the programme by the Trust Board and its commitment to transparency in reporting progress. This has provided the Board with a high level of assurance in terms of the delivery of the recommendations from the review.

5.0 Service improvements

For a summary of key actions taken to meet the requirements of the recommendations, evidence to support action completion, additional developmental actions still to be taken, timescales for completion of these and the assurance group for these actions, please see Appendix 1.

A family friendly document summarising the improvements that have taken place following the review has been developed with families which is available via the Trust website.

6.0 Next steps

The Board has recognised the need for improvement and has made a number of service changes/developments. To provide additional assurance to the Board regarding the delivery of the outstanding developmental actions and the sustained delivery of the improvements made, the delivery programme will be subject to internal audit in 2017/18.

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 1: Board Assurance Framework for the delivery of Independent Cardiac Review Recommendations

Recommendation 2: That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.	
Reference from original report/CQC review resulting in recommendation: Points 1.19 – 1.21	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales	Additional Actions	Assurance group	Completion/ Update timescales
Review of the paediatric cardiac data team staffing in relation to workload to identify any gaps in capacity Results and recommendations of the review reported at Women's and Children's Delivery Group in Sept. '16. Requirement for additional staff fed into Trust business round 2016-17 however additional posts were not funded at that stage. Divisional review of roles and responsibilities as well as additional staff resource agreed.	Staffing review report and terms of reference produced Women's and Children's Delivery Group Agenda and minutes 20.09.16 Expression of interest form and Women's and Children's Operating Plan Mar'17 added to Independent review risk register in view of concerns over ability to meet recommendation requirements due to lack of support for additional resource Apr'17 review complete, additional resource funded by division – recruitment progressing	Planned Completion Date: April 2017 Actual Completion Date: May 2017	To undertake a further review of team establishment and skill mix once the impact of additional fetal reporting requirements is confirmed.	Children's Quality Assurance Committee	September 2017 once additional reporting requirements are confirmed.

Recommendation 3: That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to

ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Specialist Clinical Psychologist, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of patient information leaflets (discharge, cardiac surgery and cardiac catheterisation) in collaboration with parents and families. Development of website information with visual diagrams displaying pathways of care (Medical, Fetal, Surgical, Cardiac Catheterisation) in collaboration with parents and families. External contractor commissioned, to design pathways that are both interactive and engaging for all ages. Cardiac information pages on hospital website updated to reflect improvements and signpost to virtual patient pathways. Links to signpost patients and families to relevant information added to patient clinic letters copied to families.	Copies of revised patient information leaflets (Links to recommendation 16 and CQC 1) Screenshots of visual pathways of patient journeys (fetal, surgical, medical with others pending) Copy of patient letters demonstrating links present	Planned Completion Date: April 2017 Actual Completion Date: May 2017

Additional Actions	Assurance group	Completion/ Update timescales
Link Congenital Cardiac Network website to BRCH website.	Children's Quality Assurance Committee	November 2017

<u>Recommendation 4:</u> That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an

expectation that their baby will be transferred to Bristol at some point following the birth	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Congenital Heart Disease Network Clinical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
English and Welsh commissioning, University of Hospital of Wales (UHW) and University Hospitals Bristol (UHB) developed an agreement to establish: 1. Commissioner oversight of network 2. Commissioner support for independent review recommendations (4,5 &11) 3. Establishment of working groups to address the specific changes in practices required in relation to the network standards and the independent review. Specifics of recommendation defined (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); Congenital Heart Disease (CHD) standards that relate to this recommendation; examples of practice from other centres Fetal survey to gather patient feedback undertaken between UHB and UHW established a plan to deliver additional fetal working group established to progress work.	Meeting minutes confirming discussion Agreed pathway of care in line with new CHD standards and in line with patient feedback. Patient counselling and Clinical nurse specialist cover reviewed and aligned. Offer in place for families to visit Bristol when antenatal diagnosis made. Description of South Wales Fetal Cardiology Service; 3rd fetal session commenced. Fetal survey completed and collated with outcomes shared with all relevant teams for actions. Working group in progress. Network annual plan 2017/18	Planned Completion Date: April 2017 Actual Completion Date: June 2017

Additional Actions	Assurance group	Completion/ Update timescales
In view of vacancies across main sites the final elements of the work planned in this area will move to the Network work plan going forward. Establish fetal patient working group – to be led by new psychologist with responsibility for fetal services	Children's Quality Assurance Committee	Complete July 2017 March 2018

Implementation of new pathways for families with a baby with fetal abnormality.		

Recommendation 5: The South West and Wales Network should regard it as a priority in its development to achieve better coordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Congenital Heart Disease Network Clinical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales	Additional Actions	Assurance group	Completion/ Update timescales
Meetings between Network Leads, English and Welsh Commissioners, UHW and UHBristol established to discuss terms of working and commitment to the new CHD standard to be driven by the Network Joint working group with Network Team facilitating. UHBristol, UHW and commissioners set up to deliver improvements required for service. The opportunities and actions for improvement in coordination agreed. A patient engagement exercise (e.g. focus group, survey, online reference group) undertaken to test the proposed options for improvement. Actions to improve co-ordination agreed and delivered.	CHD Network terms of reference and governance structure Minutes of meeting and action plan Jointly agreed action plan Proposal sent to virtual parent's reference group, responses received and incorporated into plans. Quarterly network report to the Trust's senior leadership team and the Network annual plan 2017/18	Planned Completion Date: April 2017 Actual Completion Date: June 17	Network to gain commitment to provision of CHD services from each centre in the form of a statement of intent from the hospital, backed by commissioner support, to include: • headlines from baseline self-assessment • current workforce and intentions • service risks & facility issues Develop mechanisms to improve access to members of the specialist team	Children's Quality Assurance Committee	December 2017 December 2017

Recommendation 7: The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with

the intended treatment plan, including with regards to the timing of follow-up appointments	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Conduct 1st annual audit into follow up care for paediatric cardiac patients Report findings of the audit to the Women's and Children's IDR Delivery Group Ensure that paediatric cardiac waiting lists are visible and managed through regular reporting and review at monthly Cardiac Business meeting. Additional steps: – Validation of follow up backlog waiting list; capacity gap analysis; trajectory and action plan for achievement of backlog clearance. – Investigation of alternative plans to address the capacity gaps and space utilisation.	Audit proposal and report Audit presentation and W&C delivery group Agenda and minutes November 2016 meeting Agenda and discussion notes of monthly Cardiac Business meeting Action plan to address follow up backlog with associated actions completed and demonstrable delivery of additional capacity	Planned Completion Date: Jan 2017 Actual Completion Date: Septem ber 17

Additional Actions	Assurance group	Completion/ Update timescales
Repeat Annual Audit Include annual audit in BRCH annual audit cycle from November 2017.	Children's Divisional Board	November 2017 From November 2017

Recommendation 8: The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatients completed Put systems in place for regular and monitoring, review and acting on results of family experience of outpatients.	Outpatients and Clinical Investigations Unit Service Delivery Terms of reference Outpatients and Clinical Investigations Unit Service Delivery Group Agenda (3.10.16) Outpatients and Clinical Investigations Unit Service Delivery minutes of meeting (3.10.16) OPD Patient Experience Report (October 2016) Project on a Page: Outpatient Productivity at BRHC	Planned Completion Date: Oct 16 Actual Completion Date: Jan 17

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 9: In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the

Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.

<u>Recommendation 11:</u> That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)

Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34

Responsible Delivery Group: Women's and Children's	**Lead Officer: Women's and Children's Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Undertake benchmarking exercise with other CHD Networks, reviewing a defined list of criteria including aspects such as: job planning, IT and imaging links, information governance. To include site visits as appropriate Identification of actions required to address the gaps Progress to implementing any changes in practice that are deemed necessary	Comparison of specific concerns identified in the IDR against relevant published standards of care to inform benchmarking criteria. Benchmarking data collection analysis completed; Site visit completed May 17 Gaps identified from completion of analysis; actions held by Cardiac business group. Minutes and action log from Cardiac Business Group	Planned Completion Date: Jan 17 Actual Completion Date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Specific improvement actions identified from benchmarking review to be added to paediatric cardiac benchmarking group action log. Annual benchmarking review to be completed for specific service areas	Children's Quality Assurance Committee	November 2017 Annual

<u>Recommendation 12:</u> That clinicians encourage an open and transparent dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment, or prognosis is being discussed.

Reference from original report/CQC review resulting in recommendation: Points 1.39-1.42	
Responsible Delivery Group: Consent	**Lead Officer: Medical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Guidance to be developed for medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed. Review of new/existing guidance to reflect the recommendation and include recommendation in updated consent policy, guidance notes and links to e-learning Incorporate new guidance into existing Children's hospital documentation	Copies of guidance produced and published Consent policy (Making clinical decisions in partnership with patients: A Policy for Consent to Examination and Treatment - Section 1.2) Parent/patient information booklets- Preparing for heart surgery and Cardiac Catheterisation	Planned completion date: Dec 16 Actual completion date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Explore options to improve management and storage of recorded conversations on Medway. Internal audit team to be tasked with finding a method of gauging patient understanding and satisfaction of consent process as part of annual audit.	Clinical Quality Group	November 2017 By April 2018

<u>Recommendations 13:</u> Review of consent policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought.

<u>Recommendation 14:</u> That the Trust reviews its Consent Policy to take account of recent developments in the law in this area, emphasising the

rights of patients to be treated as partners by doctors, and to be properly informed about material risks.	
Reference from original report/CQC review resulting in recommendation: Points 1.39-1.43	
Responsible Delivery Group: Consent	**Lead Officer: Medical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Set up Trust-wide Consent delivery group to meet monthly for the duration of the programme - final format of meetings, post IDR, to be agreed but likely to be virtual. Review the consent policy and agree a re-write policy or amend existing policy to ensure patients and clinicians are supported to make decisions together Develop training and communication plan Advice from legal team and safeguarding on revised consent policy and e-learning Update e-learning for any changes to consent policy and process	Terms of Reference for Trust Wide Consent Group Minutes and actions from meeting Revised and renamed Consent policy (Consent policy (Making clinical decisions in partnership with patients: A Policy for Consent to Examination and Treatment) ratified by Clinical Quality Group January 2017 Training and communications plan Multi professional Consent workshop 6th April 2017 Legal and safeguarding agreement and comments on consent policy and e-learning Updated E-learning package for consent Use of scenarios in workshops allows staff involved in the consent process to practice their skills and challenge ideas	Planned completion date: Jan 17 Actual completion date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Add links to scenarios/pod casts into online consent training	Clinical Quality Group	April 2018

Recommendation 16: As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members.	
Reference from original report/CQC review resulting in recommendation: Points 1.39-1.42	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Enhance existing guidance to describe team working and in particular, the involvement of other operators, team members in patient care and the virtual parent reference group. Review by the Trust-wide consent group and Cardiac Clinical Governance for approval and then implement.	Revised 'Preparing for Surgery' and 'Cardiac Catheter/Intervention' leaflets. In addition - Revision of ward 32's leaflet to replicate changes made to the above leaflets.	Planned completion date: Dec 16 Actual completion date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Cardiac governance group to collate feedback and comments regarding the leaflets and amend accordingly	Children's Quality Assurance Committee	April 2018

Recommendation 17: That the Trust carry out a review or audit of (I) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent	
Reference from original report/CQC review resulting in recommendation: Points 1.39-1.42	
Responsible Delivery Group: Consent	**Lead Officer: Deputy Medical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Anaesthetic group to be set up to review current practise in pre-op assessment in relation to consent for anaesthesia and how they can implement a consent for anaesthesia process Trust-wide Liaise with Royal College of Anaesthesia and other appropriate professional bodies with regarding national policy Implementation plan for Trust-wide consent process	Minutes and actions from meeting Correspondence with Royal College of Anaesthetists and Associations AAGBNI Guidance on Consent January 2017 Business case for paediatric pre-operative assessment successful, cover provided ad hoc whilst recruitment ongoing to provide permanent solution.	Planned completion date: May 17 Actual completion date: May 17

Additional Actions	Assurance group	Completion/ Update timescales
Audit impact of anaesthetic input into pre-operative assessment at 6 months following implementation	Children's Hospital Quality Assurance Committee	November 2017

Recommendation 18: That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services.	
Reference from original report/CQC review resulting in recommendation: Points 1.44-1.51	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented	Current process review report Reviewed meeting agenda and cancelled operations report for the Joint Cardiac Conference (JCC). Standard operating procedure (SOP) for cancelled operations and next steps reviewed and redistributed. Email correspondence confirming team's commitment to the process Records of the JCC discussions of cancelled patients	Planned completion date: Actual completion date: September 2017

Additional Actions	Assurance group	Completion/ Update timescales
Quarterly audit of compliance with the Joint Cardiac Conference Standard Operating Procedure	Children's Hospital Quality Assurance Committee	January 2018

Recommendation 20: That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	
Reference from original report/CQC review resulting in recommendation: Points 1.60-1.62	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
End-of-life care and bereavement support pathway developed Implementation and roll out of new pathway	End of life and bereavement support pathway SOP including input from families who have experienced a bereavement Paediatric palliative care and bereavement support service leaflet Monitoring templates to capture effectiveness of the 'core offer' Minutes of Palliative Care and Bereavement Service Delivery Group Communication and presentations for roll out of bereavement core offer	Planned completion date: Nov'16 Actual completion date: Feb'17

Additional Actions	Assurance group	Completion/ Update timescales
Long term: Review opportunities to improve bereavement pathways in maternity services. The Congenital Cardiac Network team and Trust palliative care lead nurse to work towards a consistent approach to palliative care and bereavement across the network.	Children's Hospital Quality Assurance Committee	April 2018 Quarterly report from the Network

Recommendation 21: Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of

psychological support.	
Reference from original report/CQC review resulting in recommendation: Points 1.60-1.62	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Commissioners**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Previous submission to commissioners for psychological support updated. Expression of Interest for increased resource to be submitted as part of business planning	Submission to commissioners Expression of interest completed and supported; Recruitment completed and start dates confirmed	Planned completion date: Nov'16 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
Annual report from psychology team to demonstrate value added by increase in service provision	Children's Hospital Quality Assurance Committee	April 2018

Recommendation 22: That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should routinely report on this matter to the Board.	
Reference from original report/CQC review resulting in recommendation: Points 1.63-1.82	
Responsible Delivery Group: Other	**Lead Officer: Commissioners**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Trust Secretary review of current arrangements and processes to ensure that the needs of the child are a focus of the Trust Board	Executive Lead Role description April 2015 Board annual report BRCH 2015/2016	Planned completion date: March 2017 Actual completion date: March 2017

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 23: That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked.	
Reference from original report/CQC review resulting in recommendation: Points 1.63-1.82	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review results of Trust-wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety incident reporting and management Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff	MAPSAF presentation to W&C Divisional Board – Sept 2016 Briefing paper on training plan Training plan and attendance information from June 2016 onwards	Planned completion date: Dec'16 Actual completion date: Feb'17

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 24: That urgent attention be given to developing more effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations.	
Reference from original report/CQC review resulting in recommendation: Points 1.83-1.88	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Discussion with commissioners about the issues and agreement to mitigate a similar occurrence	Quality Surveillance Group - How to be make your quality surveillance group effective. Mar 14 Document Agenda Clinical Commissioning Group/United Hospitals Bristol Quality Sub Group, Feb 17 Bristol, North Somerset & South Gloucestershire Clinical Commissioning Groups Quality Surveillance Group Report, Feb 17 National guidance on learning from deaths, Mar 17	Planned completion date: Jan 17 Actual completion date: May 17

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 26: That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS England's Medical Directorate on this matter. Clear guidance should be given to patients or parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon.

Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99

Responsible Delivery Group: Incidents and Complaints	**Lead Officer: Chief Nurse**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Develop an appendix to the Serious Incident policy defining "link" between Child Death Review (CDR), complaints and serious incident investigations / reporting, includes adults and children. Develop and implement guidance for staff in children's services on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement. Develop and implement guidance for staff in adult services on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement. **Supplementary to the requirements of the**	Serious incident policy reviewed/updated and appendix document added - Link between serious incidents and other investigatory procedures' Guidance document produced and approved by the Quality Assurance Group. Usage/effectiveness monitored weekly at the Bereavement Group, Audit Apr 17 completed; action plan sits with bereavement group Guidance for Supporting and Working with patients/families after unexpected death of an adult or a serious incident involving an adult – referenced as an associated document in	Planned completion date: Jan '17 Actual completion date: May'17

Additional Actions	Assurance group	Completion/ Update timescales
To review the opportunities to improve information/processes for supporting young person's 16-18 year olds involved in a serious incident.	Children's Quality Assurance Group Clinical Quality Group	April 2018 May 2018

recommendation. Develop 'guidance' / information for families in children's services how the x3 processes of CDR / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate Develop 'guidance' / information for staff in children's services on how the x3 processes of CDR / SI / RCA investigation inquests and complaints are initiated / managed and integrate. Develop the above staff guidance for staff in adult services (minus CDR) Develop the above family guidance for adult patients and families (minus CDR). Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options (FI). Implement a process for gaining regular feedback from patients / families involved in a SI RCAs process to understand what it felt like for them and how we can improve the process for them	Evidence 1 SI policy. What review processes might happen when my child dies? Information leaflet –Guide For Patients And Families About Patient Safety Incident Standard operating process - Communication to staff following a clinical event likely to require further investigation (Paediatrics) Standard operating process - Communication to staff following an incident likely to require further investigation (Adults) Staff briefing on investigatory processes following an incident/event involving a patient - referenced as an associated document in Evidence 1 SI policy. Guide for adult patients and their families about investigations of unexpected events and incidents. Information and guidance for patients and families for reviewing an incident investigation (Root Cause Analysis) report/ Letter to accompany item / diagram to describe options				

	for patient / family involvement in SI process, has been incorporated into Draft Minutes of BRHC Quality Assurance Committee, April 2017	

Recommendation 27: That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.	
Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Design Guidance for the Preparation and Conduct of Meetings with Parents / Families to discuss concerns and / or adverse event feedback; Completed and signed off at January 2017 I&C meeting Bespoke training opportunities to be considered in light of development of staff guidance by Children's Services – bespoke training programme designed with a plan to utilise in the event of a significant patient safety incident in order to support staff through the process	1) BRHC recorded meeting consent form - internal recording 2) BRHC recorded meeting consent form - external recording 3) PowerPoint presentation showing training on 'Responding to Complaints with Confidence 4) PowerPoint presentation showing training on the 'Link between complaints, incident and mortality investigations' used at Trust-wide induction and root cause analysis training 5) Training records for Trust-wide induction dated February and March 2017	Planned completion date: June 2017 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
Align patient safety training programmes in paediatric and adult services to ensure consistency.	Clinical Quality Group	April 2018

Recommendation 28: That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or investigations which require it.	
Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review UH Bristol's previous use of independent review / benchmarking from other Trusts to inform • Complaints • RCAs Develop guidance for when to access 'independent advice / review' for • Complaints • SI RCAs Some actions required to complete this recommendation are replicated in recommendation 29	Review of practice re independent complaints investigation document Independent element - serious Incidents benchmarking document Cover sheet and amendments to Serious Incident Policy Email to divisional patient safety managers, divisional directors, clinical chairs and heads of nursing advising of changes to SI policy Extracts from updated Complaints and Concerns policy for CI delivery group Dec 16 Email to all divisional directors, clinical chairs and heads of nursing re. independent investigation, support and mediation	Planned completion date: December 2016 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
Ongoing audit / review of the extent to which divisions are taking up the options for independent review, as outlined in the Complaints & Concerns Policy. This will be discussed at each division's annual complaints review panel. The Trust is also working in collaboration with the Patients Association to develop a 'toolkit' which will provide staff with guidance about triggers for obtaining an independent/objective view about a complaint and where that input might appropriately come from.	Clinical Quality Group	April 2018

	Email between Trust and Patients Association confirming arrangements for focus group Finalised invitation letter to the focus meeting planned for May 17	

Recommendation 29: That as part of the process of exploring the options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation.

Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99

Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of options pertaining to dispute resolution. Representatives from the Bristol Royal Hospital for Children (BRHC) and the Trust's Head of Quality met with a representative from the Medical Mediation Foundation (MMF) to gain a better understanding of the services provided. MMF services discussed by the BRHC Quality Assurance Group. Further review required and a funding request to be sought from the Grand Appeal and/or Above and Beyond. **Supplementary to the recommendation** Head of Quality (Patient Experience and Clinical Effectiveness) to undertake further investigation into the market for medical mediation or alternative options; next steps would require executive agreement and a procurement process to ensure	Summary of the visit to the Trust of Medical Mediation Meeting minutes from BRHC Quality Assurance Committee where the report was considered for next steps on 21/04/2017 High risk complaints SOP Divisional escalation pro-forma Email from Head of Quality (Patient Experience and Clinical Effectiveness) to divisional directors, clinical chairs and HON dated 6th Feb 17, 'Independent investigation support and mediation' Extracts from CC policy	Planned completion date: April 2017 Actual completion date: May 2017

Additional Actions	Assurance group	Completion/ Update timescales
Divisional Governance Group to Evaluate trial of the Medical Mediation Foundation's dispute resolution training.	Clinical Quality Group	April 2018

consistency and appropriate Some actions required to complete this recommendation are replicated in recommendation 28		

Recommendation 30: That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in practice introduced as a result of a complaint or incident involving them or their families and seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation.

Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99

Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Develop a clear process with timescales Trust-wide for feedback to families / patients outcomes involved in SI panels / review and actions ongoing from this and staff. Serious incident policy updated and information sheets produced for patients / families providing information about feedback to patients/families with regard to serious incident investigations and actions arising from these. Ensure complainants are routinely asked whether and how they would like to be involved in designing changes in practice in response to the concerns they have raised The following elements were added to the work of the group to meet this recommendation however they sit outside of the true detail of the recommendation. Use of process for asking patients how they would like to be involved in designing changes in practice in response to the concerns they have	Revised Serious incident policy – 1 Cover sheet and amendments; 1a full policy Rapid response duty of candour pro-forma Staff Being open policy Proforma of questions used in the formal complaints management process Proforma of questions used in the informal complaints management process Report to I&C group from Head of Quality (Patient Experience and Clinical Effectiveness) summarising changes made for asking patients how they would like to be involved in designing changes in practice in response to the concerns they have raised Family information sheets	Planned completion date: December 2016 Actual completion date: June 2017

Additional Actions	Assurance group	Completion/ Update timescales
Patient Support and Complaints Team work plan to undertake as part of annual audit a question regarding whether complainants are being asked about involvement, what their answers are and whether and how this has led to any involvement opportunities.	Clinical Quality Group	April 2018

raised to be audited at the end of February 2017, including review of survey replies. Regular complainant focus groups to be held, rescheduled to May 2017 to maximise attendance, as part of routine follow-up of people's experience of the complaints system. Ambition is for these focus groups to eventually be facilitated by previous complainants. Supplementary to the recommendation requirements	advising on processes that may be followed following a death – child Family information sheets advising on processes that may be followed following a death – adult Minutes of the April 2017 BRHC Quality Assurance Committee Minutes of the May 2017 Clinical Quality Group Patient / family involvement in SI process Key associated documents to the Serious Incident Policy updated Draft information and guidance for parents and families for reviewing an incident investigation Letter to accompany parent and family guidance				

Recommendation 31: That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care.	
Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Paper submitted to Trust Board to acknowledge parental roles in change Assurance visits by local councillors Trust attendance at the Overview and Scrutiny Committee	Trust Board papers and agenda July 2016 Meeting minutes from the overview and scrutiny committee August 2016 and February 2017 2 Visits by local councillors in February 2017 Minutes of BSCB	Planned completion date: October 2016 Actual completion date: march 2017

Additional Actions	Assurance group	Completion/ Update timescales
Further attendance at the overview and scrutiny committee planned Further visits by local councillors invited by BRHC	Quality Assurance Committee	December 2017

Recommendation 32: That the Trust re-designate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care.	
Reference from original report/CQC review resulting in recommendation: Points 1.100	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Terms of Reference for the Trust Patient Safety Group and associated governance groups revised so that references to 'patient safety' have been replaced with the term 'safety of patients'. Role descriptions for members of staff with corporate or divisional roles in patient safety have been revised so that references to 'patient safety' have been replaced with the term 'safety of patients'. Training and development activities led by the Trust's Patient Safety Team and associated resources have been reviewed and the term 'safety of patients' has been adopted as described above.	Patient Safety Group minutes record the discussion and decision to amend terms of reference and role descriptions as described.	Planned completion date: December 2016 Actual completion date: March 2017

Additional Actions	Assurance group	Completion/ Update timescales

CQC 1: Recording the percentage risk of mortality or other major complications discussed with parents or carers on consent forms	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Trust Consent forms 1-3 have been amended to include percentage risk of mortality. BRHC produced bespoke consent information sheets including percentage risk.	Amended Trust-wide consent forms 1-3 including percentage risk 33 Paediatric Cardiac Information Sheets with % risk.	Planned completion date: January 2017 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales

CQC 2: Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Initial audit December 2016 Further audit February 2017.	Initial audit results Copy of new Echo form implemented demonstrating Evolve filing guidance Re-audit Email from clinical chair following March deliver group Further audit of compliance may 2017	Planned completion date: November 2016 Actual completion date: June 2017

Additional Actions	Assurance group	Completion/ Update timescales
Annual audit of compliance both with completion of the form and accurate filing in the Evolve system	Children's Hospital Quality Assurance Committee	June 2018

CQC 3: Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Documentation developed to enable easy collection of pain data Audit of nursing documentation completed monthly on existing practice and findings reported. Targeted training based on audit findings. The nursing audit collection document amended to include question about reassessment 30 mins after pain relief has been administered.	Clinical protocol for recording and acting upon physiological observations in paediatric in-patient areas within UH Bristol NHS Foundation Trust. Nursing Observation Chart (example 0-12months) Nursing Daily Assessment plan Ward 32 Nursing documentation audit sheet and results – November '16	Planned completion date: November 2016 Actual completion date: December 2016

Additional Actions	Assurance group	Completion/ Update timescales

CQC 4: Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records (links with review recommendation 12)	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales	Additional Actions	Assurance group	Completion/ Update timescales
New process developed to ensure that all conversations with families are recorded in patients' paper notes. 'Cardiac communications' page developed on the electronic patient record system, Medway, to record contact with any patient, accessible to all staff involved in a patient's care. Medway 'alerts' added to patients with a cardiac condition designed to signpost clinicians to additional cardiac communications systems for further information.	Example of a patient's notes with the sticker entry showing CNS communication with patient / parent Example of Medway communication record for use by all teams Email trail sent by Head of Nursing reminding all teams of requirement to record all conversations and where Clinical standard operating procedure detailing how to access Medway clinical record Example of Heart suite entry to be used in addition to Medway if required	Planned completion date: December 2016 Actual completion date: April 2017			

CQC 5: Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3 & CQC 1)

Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of procedure specific consent forms utilised by Alder Hey Hospital. Produce BRHC versions pertinent to procedures carried out; including percentage risks, benefits and methods used to carry out the procedure. Sign off of content/structure at the cardiac clinical governance meeting, 24th March 2017	33 separate information sheets relating to different operations/procedures; includes 1 generic form for those operations that fall outside of the 32 procedure specific sheets. Agenda of the Cardiac Clinical Governance Meeting, 24th March 2017	Planned completion date: April 2017 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
AUDIT AND REVIEW family and young persons feedback on revised consent process/supporting information one year from implementation.	Children's Hospital Quality Assurance Committee	April 2018

CQC 6: Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of the multi-professional input to the discharge planning process. Questionnaire to all allied health professionals involved in cardiac patient care. Multidisciplinary ward round held weekly as of February 2017 Ward multidisciplinary "Board round" weekly Continued documentation in the medical notes regarding any AHP involvement and ongoing plans A white board on ward with an "AHP / HCST" column, with coloured pens / magnets for each AHP / HCST group. A list of named contacts and telephone numbers for ward AHPs to be kept up-to-date on the ward and Doctors office, to enable quick and easy reference.	AHP questionnaire Briefing paper demonstrating outcomes of questionnaire Minutes available from Ward 32 sister on request – not included for confidentiality reasons	Planned completion date: January 2017 Actual completion date: February 2017

Additional Actions	Assurance group	Completion/ Update timescales
Further review to be conducted to ensure actions continue to benefit MDT and patients.	Children's Hospital Quality Assurance Committee	June 2017