People Scrutiny Commission Meeting in Common with South Gloucestershire Health Scrutiny Committee to receive INDEPENDENT REPORTS RELATING TO THE BRISTOL ROYAL HOSPITAL

Agenda

Date: Monday, 27 February 2017

Time: 10.00 am

Venue: Council Chamber, City Hall, College Green, Bristol

Distribution:

Bristol People Scrutiny Commission Councillors: Brenda Massey, Lesley Alexander, Eleanor Combley, Anna Keen, Jos Clark, Gill Kirk, Cleo Lake, Celia Phipps, Liz Radford, Mark Brain, April Begley, Toby Savage, Kaye Barrett, Janet Biggin, Robert Griffin, Paul Hardwick, Shirley Holloway, Sue Hope, Marian Lewis, Ruth Pickersgill, Sarah Pomfret, Ian Scott, Smith, Gloria Stephen, Erica Williams, John Swainston and Roger White

Health Partners (University Hospitals Bristol): Robert Woolley, Chief Executive, Carolyn Mills, Chief Nurse, Sean O'Kelly, Medical Director, Ian Barrington, Divisional Director, Women's and Children's

Copies to: Lucy Fleming (Scrutiny Co-ordinator), Karen Blong (Policy Advisor), Mike Hennessey (Service Director, Care and Support - Adults), Paul Jacobs (Service Director Education & Skills), Netta Meadows (Service Director, Strategic Commissioning & Commercial Relations), John Readman (Strategic Director - People) and Joshua Van Haaren (Democratic Services Officer)

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Agenda

1. Welcome, Introductions & Safety Information — 10.00 am

The Bristol City Council People Scrutiny Commission and South Gloucestershire Health Scrutiny Committee have agreed to hold a meeting in common to consider the **Independent Reports relating the Bristol Hospital for Children 2016 – Six month review**. Each committee remains independently constituted.

2. Apologies for Absence & Substitutions

3. Declarations of Interest

To note any declarations of interest from the Councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a disclosable pecuniary interest.

Please note that the Bristol City Council Register of Interests is available at https://www.bristol.gov.uk/councillors/members-interests-gifts-and-hospitality-register

Any declarations of interest made at the meeting which is not on the register of interests should be notified to the Monitoring Officer for inclusion.

4. Actions From the Previous Meeting — 10.10 am

To note/review the actions from the previous Meeting in Common of 23rd November 2016 — **(Page 5)**

5. Minutes of Previous Meetings

Received for information only for members to make reference to. — **(Pages 6 - 28)**

6. Chair's Business

To note any announcements from the Chair

7. Public Forum — 10.15 am

Up to 30 minutes is allowed for this item.

Any member of the public or Councillor may participate in Public Forum. The detailed arrangements for so doing are set out in the Public Information Sheet at the back of this agenda. Public Forum items should be emailed to democratic.services@bristol.gov.uk and please note that the following deadlines will apply in relation to this meeting:-

Questions - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in this office at the latest by **5 pm on Tuesday 21st February 2017.**

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest by **12.00 noon on Friday 24th February 2017.**

8. Independent Reports relating the Bristol Hospital for Children 2016 - Six month review

10.45 am

(Pages 29 - 69)

Web link to the agenda papers from the meeting in common on the 12th August 2016– click here to view.

a) Independent Review of Children's Cardiac Surgical Services at Bristol Royal Hospital for Children

To receive a six month update on the progress of the programme plan to deliver the recommendations for University Hospitals Bristol NHS Foundation Trust and South West Congenital Heart Network as set out in:

- The Report of the Independent Review of Children's Cardiac Services in Bristol, Eleanor Grey QC and Professor Sir Ian Kennedy, June 2016;
- Clinical Case Note Review: A review of pre-operative, peri-operative and postoperative care in cardiac surgical services at Bristol Royal Hospital for Children, Care Quality Commission, 23 June 2016.

COMFORT BREAK – 12:30 (Ten Minutes)

b) Independent Investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital

- To receive an update on progress delivering the recommendations of an independent investigation, commissioned by the University Hospitals Bristol NHS Foundation Trust from a specialist investigations consultancy called Verita, into events following the death of a baby at the Bristol Royal Hospital for Children in April 2015.
- The Trust has previously provided reports on this issue to the two Commissions in August and November 2016.

Public Information Sheet

Inspection of Papers - Local Government (Access to Information) Act 1985

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Committee rooms are fitted with induction loops to assist people with hearing impairment. If you require any assistance with this please speak to the Democratic Services Officer.

Public Forum

Members of the public may make a written statement ask a question or present a petition to most meetings. Your statement or question will be sent to the Committee and be available in the meeting room one hour before the meeting. Please submit it to democratic.services@bristol.gov.uk or Democratic Services Section, City Hall, College Green, Bristol BS1 5UY. The following requirements apply:

- The statement is received no later than **12.00 noon on the working day before the meeting** and is about a matter which is the responsibility of the committee concerned.
- The question is received no later than **three clear working days before the meeting**.

Any statement submitted should be no longer than one side of A4 paper. If the statement is longer than this, then for reasons of cost, only the first sheet will be copied and made available at the meeting. For copyright reasons, we are unable to reproduce or publish newspaper or magazine articles that may be attached to statements.

By participating in public forum business, we will assume that you have consented to your name and the details of your submission being recorded and circulated to the committee. This information will also be made available at the meeting to which it relates and placed in the official minute book as a public record (available from Democratic Services).

We will try to remove personal information such as contact details. However, because of time constraints we cannot guarantee this, and you may therefore wish to consider if your statement

contains information that you would prefer not to be in the public domain. Public Forum statements will not be posted on the council's website. Other committee papers may be placed on the council's website and information in them may be searchable on the internet.

Process during the meeting:

- Public Forum is normally one of the first items on the agenda, although statements and petitions that relate to specific items on the agenda may be taken just before the item concerned.
- There will be no debate on statements or petitions.
- The Chair will call each submission in turn. When you are invited to speak, please make sure that your presentation focuses on the key issues that you would like Members to consider. This will have the greatest impact.
- Your time allocation may have to be strictly limited if there are a lot of submissions. **This may be as short as one minute.**
- If there are a large number of submissions on one matter a representative may be requested to speak on the groups behalf.
- If you do not attend or speak at the meeting at which your public forum submission is being taken your statement will be noted by Members.

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Members of the public attending meetings or taking part in Public forum are advised that all Full Council and Cabinet meetings and some other committee meetings are now filmed for live or subsequent broadcast via the council's webcasting pages. The whole of the meeting is filmed (except where there are confidential or exempt items) and the footage will be available for two years. If you ask a question or make a representation, then you are likely to be filmed and will be deemed to have given your consent to this. If you do not wish to be filmed you need to make yourself known to the webcasting staff. However, the Openness of Local Government Bodies Regulations 2014 now means that persons attending meetings may take photographs, film and audio record the proceedings and report on the meeting (Oral commentary is not permitted during the meeting as it would be disruptive). Members of the public should therefore be aware that they may be filmed by others attending and that is not within the council's control.

Actions form the meeting in common – 23rd November 2016

Minutes No.	Title of Report/ Description	Action and Deadline	Responsible officer	Action taken and date completed
57	Independent Reports related to the Bristol Royal Hospital for Children 2016 – Three month review	A7. The family suggested that Recommendation 1 had not been completed. The Trust agreed to address the concern when provided responses to the 80 questions submitted.	UHB	An update will be provided at the meeting on the 27th February 2017
57	Same as above	A10. The Trust were asked to check what the circumstances were in this case regarding family accommodation.	UHB	An update will be provided at the meeting on the 27th February 2017
57	Same as above	A12. The Trust we asked to check the date and outcomes of the South West audit at Verita	UHB	An update will be provided at the meeting on the 27th February 2017
57	Same as above	A15. The Trust were asked to provide the specific figures related to the number of senior leaders who had been trained in accordance with recommendation 6.	UHB	An update will be provided at the meeting on the 27th February 2017
As part of the Resolution	Same as above	A visit to the hospital to see some of the changes first-hand would be arranged for Councillors prior to the next update meeting on the 27th February 2017	UHB / Officers	Visits arranged for • 14th February 2017 • 22nd February 2017
As part of the Resolution	Same as above	An update on the 80 questions formulated with the Condon family would be provided as part of the six month update in February 2017	UHB	An update will be provided at the meeting on the 27th February 2017

Bristol City Council
Minutes of the People Scrutiny Commission

12 August 2016 at 10.00 am

Bristol City Council Councillors and Officers

Members Present:-
Councillors: Brenda Massey (Chair), Lesley Alexander, Eleanor Combley and Anna Keen, Gill Kirk, Cleo Lake, Liz Radford and Clare Campion-Smith

Officers in Attendance:-
John Readman (Strategic Director - People), Hilary Brooks (Service Director, Care and Support - Children & Families) and Nancy Rollason (Service Manager Legal), Karen Blong (Scrutiny), Louise deCordova (Democratic Services)

Others in attendance:-
Dr Jo Copping

South Gloucestershire Councillors and Officers

Members Present:-
Councillors: Toby Savage, (Chair), Kaye Barrett, April Begley, Robert Griffin, Paul Hardwick, Shirley Holloway, Sue Hope, Trevor Jones (substitute for Janet Biggin), Ian Scott

Officers in Attendance:-
Claire Rees (Public Health)

Others in attendance:-
UHB: Robert Woolley, Sean O'Kelly, Carolyn Mills, Ian Barrington (substitute for Bryony Strachan)
CCG: Jill Sheppard, Guy Stenson, Tony Jones
NHS England: Linda Prosser, Vaughan Lewis

1. Apologies for Absence

Apologies for absence were received from, Councillor Jos Clark, Councillor Mark Brain, Councillor Celia Phipps, Councillor Ruth Pickersgill, Councillor Sarah Pomfret, Councillor Erica Williams, Councillor Gloria

Steven, Bryony Strachan – UHB Clinical Chair, Division Women's and Childrens, Mark Pietroni – Director of Public Health, South Gloucestershire.

2. Declarations of Interest

There were no declarations of interest.

3. Welcome, Introduction and Safety Information

In accordance with previously agreed arrangements, Councillor Brenda Massey, (Bristol), took the role of Chair and Councillor Toby Savage (South Gloucestershire), took the role of Vice-Chair.

The Chair led welcome and introductions and outlined the Health Scrutiny requirement and Meeting in Common powers in full as outlined in the agenda papers.

4. Public Forum

The Committee considered the public forum statements received as follows with Daphne Havercroft and Allyn Condon in attendance:

Statement 1	Yolanda and Steve Turner	The Bristol Review into Cardiac Services at Bristol Royal Hospital for Children 2010-2014
Statement 2	Daphne Havercroft	Children's Cardiac Services – Risk Management
Statement 3	Allyn Condon	UH Bristol Trust Progress of the Verita recommendations
Statement 4	Katharine Tylko	The Bristol Review – improvements in the safety of children's congenital heart surgery nationwide

5. Independent Reports Relating to the Bristol Royal Hospital for Children, 2016

The Committee considered the report presented by Robert Woolley, Chief Executive University Hospitals Bristol NHS Foundation Trust, accompanied by Sean O'Kelly, Medical Director, Carolyn Mills, Chief Nurse, Ian Barrington.

Which set out the Trust's response, to the Independent Review of Children's Cardiac Services in Bristol and the Trust's response to the two independent reports published on 30 June 2016, namely the report of the Independent Review of Children's Cardiac Services in Bristol and a Review of pre-operative, peri-operative and postoperative care in cardiac surgical services at Bristol Royal Hospital for Children. And presented the University Hospitals Bristol NHS Foundation Trust's Cardiac Review Action Plan.

Robert Woolley (RW) summarised the UHB response to failings identified in the report and made the following points.

a. Clarified that the CQC have stayed involved and have carried out random sample cases with audits targeting most complex cases. Separate independent clinical experts have been used to analyse case notes. Eleanor Grey had sight of the findings before she concluded her review. CQC did a comprehensive inspection in September 2014 with 70 inspectors. Review found services for CYP at UHB in 2014 were good overall, specifically good for safety.
b. In April 2016, NICOR published audit of all specialised children's cardiac centres and found outcomes and standards of care were comparable with standards in other UK centres.
c. In 2016 new a national congenital heart disease review announced results of assessments of all units against the new standards. Announced intention to cease commissioning from three units in England. UHB was not one of these and would receive support to comply with all commissioning standards (which came in from April 16).

RW read out the independent review conclusions and CQC conclusions and concluded with the following points:

d. Recognition that UHB fully accept findings, got things wrong in a number of ways. Care feel below acceptable standards, did not respond to parents concerns, apologised unreservedly and repeat this today.
e. Pleased that upon review standards now found acceptable, but must get it right for every parent every time. Have already taken number of actions and will describe significant improvements in response to questions later.
f. Referred to Chapter 14 which set out actions already taken and Appendix A3 which sets out the action plan against recommendations. Thirty-two recommendations apply in the main to the Trust and also to NHSE and DoH.
g. Issue of consent is one area that is being looked at – how can parents know exactly what they are consenting to; the way that incidents are dealt with. Grieving parents should not be expected to navigate the system of complaints handling– CDR, CQC, ombudsman, etc.
h. The result has been a confusing picture for all, UHB was inefficient in communications.
i. Staffing is major theme and paediatric cardiac intensive care provision across country needs to be addressed.
j. Failings in the report are not ones that persist now. Great deal of external assurance in place. Acknowledged the role parents played improvements made nationally and confirmed willingness to bring progress reports back to Committee. Agreed to facilitate visits by Councillors to the units.

Action: Officers to facilitate visits for Councillors to the units

Members' questions

Q1. What are the current staffing arrangements and are there sufficient staff and are bank or agency staff being used?

a. RW confirmed that as soon as CQC came in in 2012 they responded immediately to ensure ratio of staff to beds was correct. Subsequently invested significantly in staffing, dedicated HDU with 5 beds, 1 nurse to 2 patients on remainder of ward is 1 staff to 3 patients. £3m invested.
b. Ian Barrington (IB) confirmed that staff had been under significant pressure, had believed that using bank and agency staff to relieve this was acceptable at the time, but have now realised was not acceptable. Full establishment of staff, fully recruited to post. Additional challenge faced around staff retention. Significant effort invested and have developed faculty of nurse education and clinical skills base on the ward. Occasionally use agency staff for annual leave or sickness cover, but have full complement of permanent staff.

Q2. When parents raised the issue of staffing through complaints, was resources an issue at the time? Did NHSE have to release funding to address staff issues?

c. RW confirmed that there wasn't a resource issue in terms of staffing numbers on the ward – genuinely believed staffing model operating was safe, but knew it wasn't sustainable. With hindsight realise this wasn't the case. There was recognition that volumes were growing in terms of demand and complexity was increasing. Chapter 11 of report states that there wasn't a resource constraint in 2012. After CQC inspection, commissioners responded immediately with the resource to create HDU.

Q3. Is there now a robust process in place to manage complaints?

d. Reflected long and hard on how to manage complaints. The review outlines that they regrettably used the process to serve their own needs and on a number occasions lost sight that a grieving family was at the end of a complaint. Has been confusion between processes (CDR, etc) and it was not clear how to involve parents and keep them informed throughout the process.
e. Need to present a single face to family. Need a case manager to be the single POC for the families. Reviewed complaints policy and amended guidelines for staff about which procedure should follow.
f. IB – more done to address parents' concerns straight away. Every bed space has a chart for parents to say if unhappy with any aspect of child's care. Concerns are included in documentation on daily basis and addressed by a Matron who speaks to any family who is not happy each day.

Q4. How do we as a whole health service respond to potential issues in terms of service delivery?

g. NHSE has carried out a thorough review of congenital heart services nationally. It includes an agreed set of standards, developed with families, for every aspect of care for the children. Concerns raised by parents have informed the detail in the commissioning and monitoring standards.

Q5. With reference to paediatric intensive care unit beds and responsibility for coverage of the south west for planned admissions and emergencies. This is expensive. What do you feel you need to do or can do to minimise risk?

h. Invested in another intensive care bed and staff to go with it through agreement with commissioners. NHSE now needs to do a national review of capacity set against likely future demand. There are times of the year (winter) when availability of IC beds is low, a poor service meaning families need to travel 50-100 miles for intensive care. The Review asks NHSE to do a national review of IC bed availability.
i. Vaughan Lewis (VL) confirmed that a review was planned to start this month and carried out rapidly with initial outcomes delivered by the end of 2016. Review of numbers of beds, look at the split between HD and IC beds, so NHSE can make judgement.
j. Cover transport of critically ill children and also look at service for children with cardiac and respiratory disease.

Q6. Previously at committee we asked about why the HDU was not put in place in time and UHB said that had asked for one, but NHSE said no. However, looking at the Review report, (p43, section 1.95) it makes it clear that the Trust had not provided commissioners with right information. Feels UHB had not been honest with the committee before. What wold have happened if CQC not done an inspection?

k. RW apologised that the impression was given that they were passing the buck to commissioners previously. Confirmed that UHB was accountable for anything it did. They genuinely didn't believe there was a safety concern before. The Division and the Trust had been planning ahead appropriately to secure resources to get the HDU.
l. Confirmed that they got it wrong in that they did not work at sufficient pace and the pressures on the ward had been greater than they appreciated at that time.

Q7. Consent process and policy review? How linked together? (p284 and p283)

m. Sean O'K (SO) There will be representatives from the general surgical division as well as children's division, plus parents. Linking with Association of Anaesthetists regarding consent

around anaesthesia as well. IB – have also been working with parents on consents within cardiac unit.

Q8. Have there been any changes in the Trust senior leadership team since 2012 and if so why?

n. Have been changes but no disciplinary reasons for changes. There is now a strong connection between Management Board and Clinical leaders with departmental lead clinicians and department managers going to Management Board.

Q9. Please confirm parent experience for out patient's appointments, proposals for psychological support, and links with Wales.

o. IB – a high volume area. Working to increase number of clinics and staff. Confirmed it was not easy to recruit consultant cardiologists, but appointments have been made recently.
p. Recruited new full time psychologist working purely with paediatric surgery service. The further recommendations in the Review report will be addressed.
q. In April established a formal network for congenital heart services that covers Wales and South West, which includes a network and a board with parental representation to reduce fragmentation.

Q10. Provide detail of staff training regarding engagement with parents / families and how developing further, for example recent Kings Fund re. collaborative partnerships

r. CM – communication is a key challenge. Staff training in place for two professional groups, nurses and doctors. Key part of registration phase is communication skills. Have put support in place in children's service around psychology for staff and families. Above this is process about how we engage strategically, not easy to see from high level data.
s. IB – families involved in consent pathway. Also, involved families in rewriting of info sent out to families' pre and post hospital.
t. Planning a conversations week in September whereby all senior staff touring the hospital to talk to patients/families.
u. The goal is for every patient and family to know who to go to if want an answer or want to contribute.

Q11. The Vice Chair asked for both oral public statements to be addressed by UHB. What is UHB's response?

v. RW confirmed he would respond to Daphne Havercroft's risk management points during this section of the meeting, and then respond to Allyn Condon's oral statement as part of his opening remarks on the Verita report.

(The Vice Chair agreed to that approach)

w. RW – confirmed that the risk in question was analysed in detail in chapter 11, section 12. With reference to analysis of risk in NHS. Every risk is classified for its inherent risk, this is why risk '1901' was rated as high. Once mitigations were considered for example the use of temporary staff, the residual risk was then assessed, which resulted in a medium risk rating.
x. The risk was around sustainability not safety. Eleanor Grey concludes that the effectiveness of the mitigations was not being tested sufficiently robustly at the level at which the risk was assessed. An opportunity was missed in 2011 when a risk assessment was missed. Confirmed there was increased focus on how they manage risk in the organisation. It was very complex. Stated a personal determined to improve on it. External people have been invited in, problems were found in 2011 and 2014. Continue to work on this area. Had a review in 2015 by Deloitte which was reported to Fdn Trust regulator and they found that there was openness and transparency in the organisation. Received recommendations on how to keep focus, which UHB is following through.

Q12. Question for NHSE and its response to recommendations in the Action Plan

y. VL has been in discussion with RW. NHSE Director of SC will receive action plan. Timescale for completion by the end of the calendar year.

Q13. Don't think timescales are good enough?

z. NHSE gone through rigorous assessment of 12 key standards across country. Implementation Group been set up from each of regional teams and meets weekly regarding action plans to meet standards.

Q14. Patient groups involved in developing standards?

aa. Implementation group has patients on it. Congenital heart disease network board will have parent representation. Integral involvement of parent and user involvement throughout the whole process.

Q15. Staffing contingency plans re. Brexit and changes to nurse bursaries?

bb. Ongoing challenge, UHB in good position regarding registered nurses, strong across England but have a few hotspots. Each division has plans for staffing.
cc. Bursary changes impact – difficult to predict. Been in discussions with UWE to determine figures for 2017. Limiting factor at the moment is placement capacity. Working collaboratively with UWE to make UHB an attractive place to train.

Q16. How is UHB complying with recommendation around having a database manager?

dd. IB – Do not yet have a full time data manager (part time 0.8 at moment). Looking at how they can work with other areas to pool the Data Management resource and create resilience.

Q17. The Vice Chair referred to para 1.78 and 1.79. How is Robert Whoolley and his senior team now being informed of concerns?

ee. There is a far greater connection between Board, the senior leadership (clinicians and managers coming together with executives) and the push of standards for risk assessment and management deeper into the organisation. There is a clear process for reporting concerns.
ff. Currently refreshing the 'Speaking Out' Policy for Whistleblowers. Last staff survey showed that they are fastest moving trust in terms of improving staff engagement.

(The Committee broke for recess at 11.40am and reconvened at 11.55am)

6. Verita Report - University Hospital Bristol Trust Response Appendix B

The Committee considered a report presented by Robert Woolley on the Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital.

The points below were noted in the question and answer session that followed:

Summarised the key points that triggered the Veritas investigation and management response to the conclusion's detailed in the Veritas summarised as follows:

a. Staff behaviour; a meeting where parents were given inaccurate information about the timing of tests; an episode in a CDR feedback meeting, (during a recess the consultants continued to discuss matters after parents left the room and when they realised they were still being recorded, one suggested it be deleted). The Trust investigated this and as stated p297.
b. An allegation in an email from a parent about a cover up by staff which linked to a deeper allegation that clinical staff had been responsible for Ben's death on IC unit. That is why Verita was commissioned to do the investigation into the management response to the allegations.
c. The Trust were keen that Ben's family was able to influence the Terms of reference for the investigation and feed their concerns into the investigation.
d. The Report is the management response to staff behaviour subsequent to Ben's death. Confirmed that that there had been a formal inquest a few weeks ago, it did not find that failings in the care given to Ben, had caused Ben's death. Confirmed that Ben's family do not accept this finding and there are differences in opinion.

e. Acknowledged that Ben's family feel consultant staff have lied, but this was not the conclusion of the Trust. Nonetheless the investigation shows that the Trust has let Ben's family down in a number of ways. The Trust missed a number of opportunities to engage proactively and candidly with Ben's family. Delays in complaints being investigated, contributed to a sense of mistrust and suspicion. The senior management team failed to get a grip of the complaint at first, and then subsequently the complexity of the investigation and response required.
f. Veritas report states that the Trust hadn't explained sufficiently what they had found. Thereby the Trust's responses have compounded the issue with its poor responses and communications.
g. The Trust had begun to deliver the 9 recommendations, p300, the action plan demonstrates the progress made. This was shared with Ben's parents, who disputed the contents, before it went to the Trust's Board. This was discussed openly in a Board meeting. In response to recommendation 9 the Board agreed to identification of a senior clinician within the Trust from a different division to meet with Ben's parents and to understand the outstanding concerns and endeavour to agree a plan to answer those concerns. So it is a work in progress.
h. Ben's father has raised concern that the Trust is trying to lump in other matters to Reccommendation 9 but this is not the intent.
i. With reference to Reccomendation 3 – undertook a formal investigation 'through maintaining high professional standards' process and shared broad conclusions with Ben's parents. The Trust's interpretation is that there is a need to share more information on this to demonstrate that the investigation was robust but was unable to share the whole report due to a duty of care to the staff concerned. Legal advice is pending on this.

Members Questions:

Q1. There is acknowledgement of the apology for failure and that recommendations are being worked on but no mention of disciplinary actions. Noted that some dates outstanding , for example recommendation 9 has no date against it. This family has gone through a terrible tragedy, are they getting any help with their legal costs?

j. The formal investigation previously described is a preliminary to any disciplinary action if this is required, and the Trust concluded that this was not required. Recommendation 9 completion timescale remains open until both parties agree that as much as possible has been done, hence this attempt to reengage via a senior clinician form other area.
k. Question on legal advice is fair challenge – Trust didn't anticipate that there would be a legal obstruction in terms of releasing the report mentioned at recommendation 3, but this is position the Trust is in. Confirmed that he is determined to find a way to prove the investigation was robust.
l. Success of reengagement depends on the Trusts ability to answer questions to the family's satisfaction. There are avenues for independent investigation by the family which won't incur legal costs, but this is a consideration that could be needed at later date if warranted.

Q2. Will they make a commitment for financial provision of legal support to family within next two months?

m. Confirmed that they were happy to do that.

Q3. With reference to Recommendation 30 keeping families informed and provision of opportunities to be involved in design changes.

n. There is a review of cardiac improvements and revision of complaints provision families are involved .

Q4. Has there been a change in practice?

o. Current process - issues are addressed in a letter to parents. The Trust Have strengthened the process for complex complaints to include table of issues and actions. Under pinning this, representatives from all divisions meet so that parents can be involved in the specifics of progressing an action. Parents have named contact for who to approach regarding further involvement.

p. Wider PPI activity – confirmed that there are a number of complainants who want to be more involved via a Patient Public Network.

Q5. What are the representatives from UHB and NHSE each going to do personally to ensure that what has been heard and read today won't happen again?

q. RW – absolutely accept his accountability for the failings in these reports. Entirely incumbent on him to deliver recommendations in all the reports that they are taken forward at speed and done well and as far as possible are delivered with parents (if they wish) and it is done publicly with reports to board and future HOSC meetings. Personal commitment given to do everything in power to ensure done well and at pace.

r. LP confirmed that in NHSE and in commissioning community the absolute commitment to ensure recommendations and actions plans are implemented.

Q6. A personal response?

s. VL referred to the standards document previously discussed and confirmed as clinical director that he will be working with directly with Trusts and to ensure with Trust via regular meetings that there are clear action plans in place to meet standards and read the paragraphs relating to the two specific standards i) for Level 1 units (like UHB) and the ii) palliative care and bereavement. These are both standards that are difficult to measure but the NHSE already have a number of processes in place to draw on. A dashboard is being developed and should

include these areas. NHSE will pursue these areas with Trusts and confirmed that he would feed back to colleagues in other areas to ensure they meet standards too.

Q7. Recommendations 2 and 8 have completion dates against them of September this year. Are you confident these will be met?

t. RW – yes.

Q8. There is a need to move forward not back. What date should we come back?

u. Confirmed that the Trust would comply with a timescale that the committee felt appropriate. Suggested 3 months to can update us on action plans and the same frequency going forward to update in entirety.

Q9. Concerned that community learning could be forgotten. How do we ensure learning is embodied going forward?

v. RW agreed. There is a constant struggle to demonstrate learning. This report calls for a partnership across the NHS with patients and families which is still not embedded fully in the service. UHB is committed to developing this partnership and that level of holding to account by the very people they serve. Need to address concerns at time occur, driving responsiveness and learning.

Q10. Reference to 5c Discharge planning? Progressing repatriation policy to regional hospitals?

w. RW confirmed strategy they have and the new congenital standards put in place. As regional, tertiary centre have responsibility across network of hospitals to assist local hospitals to have ability to care for patients where appropriate closer to their homes and where appropriate travel to Bristol for specialist care.

Q11. Support for bereaved families - training and dissemination of guidance to staff?

x. IB – a palliative care team is in place and have developed bereavement support in place. Now trying to bring both together in comprehensive way.

The Committee briefly discussed the appropriate timescales for an update on both reports.

The Committee agreed that the Trust return to committee in 3 months to provide a progress report on the Veritas report (Item 5) and return to committee in 6 months to provide an update for the cardiac (Item 6).

Action: Officers to facilitate dates for further meetings.

Date of Next Meeting (to be confirmed)

The meeting closed at 12.40pm

CHAIR _____

Meeting in common of the South Gloucestershire Health Scrutiny Committee and the Bristol People Scrutiny Commission

Wednesday, 23rd November, 2016 (from 4.30pm)

South Gloucestershire:

Present
Councillors: Kaye Barrett, April Begley, Janet Biggin, Robert Griffin, Paul Hardwick, Shirley Holloway, Sue Hope, Marian Lewis, Sarah Pomfret, Toby Savage (Chair) Ian Scott and Maggie Tyrrell

Apologies for Absence
Apologies for absence were received from: Councillors Gloria Stephen (replaced by Maggie Tyrrell) and Erica Williams

Officers in Attendance
Gill Sinclair (Deputy to the Head of Legal & Democratic Services), Claire Rees (Health & Well Being Partnership Support Officer) and Karen King (Democratic Services)

Bristol:

Present
Councillors: Lesley Alexander (Vice-Chair for this meeting), Eleanor Combley, Anna Keen and Celia Phipps.

Apologies for Absence
Apologies for absence were received from: Councillors Mark Brain, Jos Clark, Gill Kirk, Cleo Lake, Brenda Massey, Liz Radford and Ruth Pickersgill.

Officers in Attendance
Karen Blong (Policy Advisor – Scrutiny) and Hilary Brooks (Interim Service Director Care and Support Children & Families)

Others in Attendance:
University Hospitals Bristol NHS Foundation Trust: Dr Sean O'Kelly (Medical Director) and Ms Bryony Strachan (Clinical Chair, Obstetrics and Gynaecology)

51 WELCOME AND INTRODUCTIONS (Agenda Item 1)

In accordance with previously agreed arrangements, Cllr Toby Savage (South Glos) took the Chair and Cllr Lesley Alexander acted as Vice-Chair*

The Chair welcomed everyone to the meeting and outlined the roles and responsibilities of health scrutiny and the arrangements for holding a meeting in common.

*(*NOTE: Bristol People Scrutiny Commission was inquorate at the start of the meeting, however at 4.40pm, the Commission became quorate and from that point Cllr Lesley Alexander acted as Vice-Chair of the meeting.)*

52 EVACUATION PROCEDURE (Agenda Item 3)

The Chair drew attention to the evacuation procedure.

53 DECLARATIONS OF INTEREST UNDER THE LOCALISM ACT 2011 (Agenda Item 4)

There were no declarations of interest.

54 SUBMISSIONS FROM THE PUBLIC (Agenda Item 5)

The meeting received two submissions from the public, as follows:

- Allyn Condon
- Daphne Havercroft (not present)

Details would be added to the Table of Public Submissions for review.

55 ITEMS FROM MEMBERS (Agenda Item 6)

Cllr Ian Scott asked what was the current position concerning a question set out in Min. No.6 of the last meeting in common held on 12th August 2016 which stated:

"Q.2 Will they make a commitment for a financial provision of legal support to family within next two months?
m. Confirmed they were happy to do that."

Dr O'Kelly answered that the Trust had taken legal advice on this matter, which related to the release of a report centred on an employee. The advice was that the Trust had a duty of confidentiality to the employee and could not release all of the report to the family, however the Trust had released as much as it could. There was no precedence for the Trust to fund legal advice to a member of the public through the use of public monies.

Dr O'Kelly was asked whether this had been discussed at Board level and whether the Board had said no to legal support for the family. Dr O'Kelly said that this was the case.

56 MINUTES OF THE MEETING HELD ON 12TH AUGUST 2016 (Agenda Item 7)

The minutes of the last meeting in common were received for information, for Members to refer to.

57 INDEPENDENT REPORTS RELATING TO THE BRISTOL ROYAL HOSPITAL FOR CHILDREN 2016 - THREE MONTH REVIEW (Agenda Item 8)

The Chair reminded Members of the purpose of the meeting which was to hold a 3 month review since the 12th August 2016 meeting in common. The meeting would receive an update on the UHB Trust's progress on implementing the recommendations set out within the Verita Report, commissioned following the death of a baby at the Bristol Royal Hospital for Children in April 2015.

Dr Sean O'Kelly, Medical Director and Ms Bryony Strachan, Clinical Chair, Obstetrics and Gynaecology (UHB) attended the meeting to report back and to answer questions from members.

A report from the Trust stated that seven of the nine recommendations in the Verita report had now been completed. One action had been completed to the extent possible (R3) and one further action (R9) remained in progress while meetings with the family continued. A number of the Trust Standard Operating Procedures, produced through the work to complete the Verita report's recommendations, had been circulated with the report presented to the meeting.

Dr O'Kelly reported on further action taken by the Trust, namely that following meetings with the family, a list of 80 questions had been formulated, to which the Trust would now begin to provide responses. The target date for completion of this process was the end of January 2017.

Members then questioned the Trust and received replies as follows:

Q.1 What happens when telephoning through results from the Pathology Laboratory to the ward?

A.1 If a result is phoned through to the ward it will be electronically recorded that this has happened, providing an audit trail. Individual wards also had their own procedures. It was important to go through the records on the ISystem to avoid any 'hidden' reports as had been referred to.

Q.2 When was the senior clinician referred to in R9 appointed, was there a gap before the clinician started work with the family, what was the Trust's view on the family's view that R3 is not completed; was it reasonable to

stretch the response time to the 80 questions to the end of January and what resources were the Trust putting in to resolve matters quickly?

A.2 A clinician was appointed shortly after the last meeting and there was a short time before the clinician began work with the family; R9 allows for residual questions on actions to be addressed and provides a 'safety net' for any outstanding issues to be addressed; there was a lot of work involved in answering the 80 questions and a second clinician had been appointed to undertake the necessary work; given the work involved it was not unreasonable to set a response time of January.

Q.3 Imparting news to the family does not seem to have been given enough weight; was it not disappointing that there had been no contact with the family since 7th October?

A.3 There have been meetings over several months resulting in the formulation of the 80 questions; the outcomes are being considered by the additionally appointed clinician and the Trust had been in contact with the family more recently than October, for example Dr O'Kelly had exchanged emails with them.

Q.4 If the Trust had only just formulated the questions why did they not indicate that this meeting was premature, in that they were not providing much updated information or answers to members?

A.4 The Trust had provided a 3 month update report as requested at the last meeting in common, had held 4 constructive meetings with the family and agreed the 80 questions with them, which the Trust saw as their progress.

Q.5 R1 is marked as complete in the progress report, however the family dispute that; how do the Trust respond to this?

A.5 The Trust is grateful for the family for spending time to cross-reference where existing questions are outstanding and in understanding the rationale for clinical decisions; a further clinician was appointed to help the family and the Trust reach a common understanding and the Trust was committed to continuing this journey; Dr O'Kelly represented the Trust in this process and Robert Woolley, Chief Executive, was also fully involved and reported to the Trust's Board.

Q.6 Noting the discrepancy over the date of the last communication with the family, the Trust was asked to explain how the 80 questions were arrived at and indicate when it would next be meeting the family?

A.6 The Trust stated that it had discussed the way forward with the family face to face, there have also been interim communications such as emails; they have worked around six themes so they can understand this difficult, complex story; they have gone slowly according to advice in order to address the needs of the family; a senior experienced person is in place to

work with the family and the Trust to reach a shared and common understanding of events.

Q.7 Will the disagreement on whether R1 is complete be picked up in the 80 questions?

A.7 Yes and if not, the Trust will ensure that the family's concerns are picked up. **(ACTION: UHB)**

Q.8 Would the Trust explain the roles in the reviewed Child Death Review (CDR) process?

A.8 There are two new posts in the bereavement team, with three core people all having a nursing and/or hospice background; it is recognised that every family has its own needs if there is a sudden death or death as a result of a long term condition; the team works with medical and palliative care teams; the Trust holds workshops and reviews around this work; when a child dies there are a number of investigative processes, including the Parliamentary and Health Service Ombudsman (PHSO), child safeguarding board, NHS England and the Coroner.

Q.9 Is it correct that some inquests take place in Southampton?

A.9 There is involvement from the Avon Coroner, however when it is a Coroner post mortem (as opposed to a hospital post mortem), this may have to be performed outside the Avon area in which case Southampton and Great Ormond Street Hospitals are options.

Q.10 Would accommodation at the hospital have been made available to the family if it had been known how ill their child was, and was it assumed that it was not a serious case of need?

A.10 There is a big challenge in providing accommodation to parents at the hospital; charitable efforts have improved provision; the Trust would need to check what the circumstances were in this case regarding family accommodation. **(ACTION: UHB)**

Q.11 What does the Trust mean when it says that the work on R2 is complete?

A.11 There was a task and finish group to refresh the pathways across the whole hospital and new family support (i.e. a wider provision than solely for bereavement) is underway.

Q.12 Recognising that there is a balance between a duty to staff and to the family in releasing certain information requested as part of R3, do the Trust feel that they have got the balance right or could they have considered trying to anonymise parts of the report; is naming staff the legal issue; is it not the case that there is no closure for the family as things stand and will this be picked up in the 80 questions?

A.12 Data subjects are entitled to confidentiality under the Data Protection Act (DPA); the Trust has tried to include as much as possible about the findings without contravening the DPA; the Trust is exploring ways of addressing the family's concerns and if this aspect is not in the 80 questions the Trust will pick this up. **(ACTION: UHB)**

Q.13 What was the outcome of the audit that was due in August and when was it completed?

A.13 There was an internal South West audit as Verita had identified issues with documents concerning their order and lack of dates; the audit report was presented to the Trust last week; the Trust would need to check the date the Audit was undertaken and would respond after the meeting on dates and what the outcomes were. **(ACTION: UHB)**

Q.14 How often does the Trust review its policies?

A.14 New policies are reviewed after 1 year and established policies after 3 years.

Q.15 In accordance with R6, how many senior leaders had been trained and were there any 'mop up' training sessions planned for those not able to attend?

A.15 The training rate is around 90% and monthly monitoring of training takes place; specific figures were not to hand and would be reported back after the meeting. **(ACTION: UHB)**

The Chair noted that many of the issues of concern were being picked up in the 80 questions and expected to see feedback on that at the next meeting on 27 February 2017.

Cllr Eleanor Combley said that she felt there had been significant progress if someone had been working with the family and welcomed that a degree of trust had been rebuilt, sufficient to formulate the 80 questions.

Cllr Ian Scott said that the meeting had an important duty and responsibility to hold NHS bodies to account, particularly in the context of the Mid Staffordshire case. He considered it a disgrace when reading the agenda reports, particularly that there were finances available to protect staff and the Trust's reputation but not for the family. He did not have confidence in the Trust and felt there were issues that needed to be highlighted nationally. As such he planned to move a motion adding to the recommendation that the matter be brought to the attention of the Secretary of State for Health

Cllr Anna Keen said that although she respected the reasons for requesting a referral to the Secretary of State, she felt that a decision should be delayed until the impact of this action could be considered and suggested that this be an item for a future agenda.

The Chair clarified that the decision making process would involve South Glos and Bristol members taking separate decisions, reflecting that the committees were meeting in common rather than as a joint body.

South Gloucestershire resolution:

Upon a proposal by Councillor Ian Scott, seconded by Councillor Sue Hope, it was UNANIMOUSLY*

RESOLVED:

(1) To note the progress achieved with the implementations of the recommendations contained within the Verita report, with a further meeting planned for Monday 27th February 2017, to include an update on progress with the Verita recommendations, an update on the 80 questions formulated with the Condon family and the planned 6th month review of the Independent review of Children's Cardiac Services in Bristol; and

(2) To write to the Secretary of State for Health to advise of the recent scrutiny of the Verita report and the UHB Trust's response/action plan, in order to bring this matter to the government's attention and ensure that there is local and national awareness of the matters raised and lessons are learned.

*(*NOTE: Cllrs Sarah Pomfret and Maggie Tyrrell took no part in the decision as they had not been present during the whole item)*

The Vice-Chair clarified the decision taken by South Glos members and sought the views of Bristol members.

Cllr Celia Phipps asked the Trust whether the Care Quality Commission (CQC) was informed of all child deaths. The Trust advised that not all deaths were notifiable to the CQC, although statistical information on mortality rates was provided to the CQC. There was however, a requirement to review all child deaths internally. A CQC inspection of the children's hospital was currently underway.

Ms Strachan reported that the response to the Verita report was an interim document and much work was underway. She apologised that she had not been able to attend the August meeting and noted that an offer had been extended to members to visit the hospital to see first-hand some of the changes that had been put in place. Ms Strachan extended the offer of a visit before the February meeting. **(ACTION: SGC/BCC/UHB)**

Bristol resolution:

The Vice-Chair proposed that the Bristol members support the recommendation in the Report, as amended by South Gloucestershire resolution and agreed by the South Glos Health Scrutiny Committee, to include a update on progress with the Verita recommendations, an update on the 80 questions formulated with the Condon family and the planned 6th month review of the Independent review of Children's Cardiac Services in Bristol.

Upon a proposal by Cllr Lesley Alexander, seconded by Cllr Anna Keen, it was UNANIMOUSLY

RESOLVED:

To note the progress achieved with the implementations of the recommendations contained within the Verita report, with a further meeting planned for Monday 27th February 2017, to include an update on progress with the Verita recommendations, an update on the 80 questions formulated with the Condon family and the planned 6th month review of the Independent review of Children's Cardiac Services in Bristol.

The meeting closed at 5.45pm

Chair…….

Date……..

South Gloucestershire Council

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Ministerial Correspondence and
Public Enquiries Unit
Department of Health
Richmond House
79 Whitehall
London, SW1A 2NS

By email to: mb-sos@dh.gsi.gov.uk

Date: 7 December 2016
Your ref:
Our ref:
Enquiries to: Gill Sinclair, Deputy Head of Legal and Democratic Services
01454 863039
gill.sinclair@southglos.gov.uk

Karen King, Democratic Services
01454 865428
karen.king@southglos.gov.uk

Dear Secretary of State for Health

Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital by Verita

The purpose of this letter is to bring to your attention the above named report regarding University Hospitals Bristol NHS Foundation Trust (UHBT), which has recently been scrutinised by the South Gloucestershire Health Scrutiny Committee. In discharging its functions the Committee unanimously resolved that the report and UHBT response be brought to your attention so that you can ensure there is national awareness of the issues raised and learning takes place to minimise such a situation arising again. The Scrutiny Committee is mindful of its responsibility to undertake rigorous scrutiny of the services. To date it has scrutinised two independent reports, UHBT's action plan and it has required the attendance of a number of senior UHBT officers at its meetings to answer questions and to provide information. As can be seen from the Committee reports, the Scrutiny Committee recognised the importance of working collectively with the Scrutiny Committee of Bristol City Council. This has resulted in the Committees meeting in common maximising and strengthening the effectiveness of their individual scrutiny functions.

In addition the Committee is mindful of the Mid Staffordshire Inquiry and your comments in the Foreword of 'Patients First and Foremost – The Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry'. You state that there are four key groups that are essential to creating a culture of safety, compassion and learning that is based on cooperation and openness, and local scrutiny bodies are part of the external structures surrounding each individual organisation to ensure that all hospitals deliver good care, they raise concerns and ensure action is taken. Extract below:

"There are four key groups that are essential to creating a culture of safety, compassion and learning that is based on cooperation and openness.

First, and most importantly, patients and service users, and their families, friends and advocates – these are the people who know immediately if something is not right and who must feel welcome and safe in every part of our NHS and care and support system.

Second, the frontline staff who can foster change through their individual responsibilities, behaviours and values, and by working effectively together in strong teams – we know that those organisations that treat their staff well provide better care for patients.

Third, the leadership teams and, in particular, the boards of each organisation – they have the principal responsibility for ensuring that care in their organisations is safe and that those who use their services are treated as individuals, with dignity and compassion.

Fourth, the external structures surrounding each individual organisation, including commissioners, regulators, professional bodies, local scrutiny bodies and Government – they are there to ensure that all hospitals deliver good care, to raise concerns and to ensure action is taken. The system must get its structures, accountabilities and ways of working right to support this and to tackle any areas of poor performance rapidly and decisively."

Background

On 12 August 2016 the South Gloucestershire Health Scrutiny Committee held a meeting in common with Bristol City Council People Scrutiny Commission to consider published independent reports relating to the Bristol Royal Hospital for Children.

In relation to Children's Cardiac Services in Bristol, the following reports were received:

- The Report of the Independent Review of Children's Cardiac Services in Bristol, Eleanor Grey QC and Professor Sir Ian Kennedy, June 2016;
- Clinical Case Note Review: A review of pre-operative, peri-operative and postoperative care in cardiac surgical services at Bristol Royal Hospital for Children, Care Quality Commission, 23 June 2016; and
- The UHBT response and action plan.

In addition the Committee received the report by Verita entitled 'Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital'; and the UHBT response and action plan.

The agenda papers and approved minutes are enclosed for reference.

The Committees agreed to hold a further meeting in three months to receive an update from the Trust on its progress with the recommendations set out in the Verita report; and another meeting in six months to follow up actions in relation to children's cardiac services.

The Committees met on 23 November 2016 to receive the three month update on the Trust's response to the recommendations in the Verita report. The agenda papers and draft minutes are enclosed for reference.

At the meeting on the 23 November, the Committees learned that since the meeting in August UHBT had held meetings with the family and agreed a list of 80 questions requiring a response. The Committees asked that a further progress report, including the Trust's response to the 80 questions be submitted to the six month update meeting (which is scheduled for 27 February 2017). In addition, the South Gloucestershire Scrutiny Committee unanimously resolved that a letter be sent to the Secretary of State for Health to inform you about the existence of the reports referred to and are aware of the issues raised therein; and that you give consideration on a national basis of the need for further awareness raising and dissemination of lessons learned.

South Gloucestershire Council Health Scrutiny Committee will continue to scrutinise the action plan of the Trust and work to secure service improvements, it does however recognise that a number of the issues raised in the reports will not be restricted to UHBT alone and where this is the case it considers it is important that it raises these issues at the earliest opportunity.

I hope you find this information helpful, and that you are able to take appropriate action to ensure that lessons are learned and the actions of this Trust are not repeated elsewhere.

Yours sincerely

Councillor Toby Savage Chair Health Scrutiny Committee	Councillor Sue Hope Lead Member Health Scrutiny Committee	Councillor Ian Scott Lead Member Health Scrutiny Committee

University Hospitals Bristol
NHS Foundation Trust

Report to meeting in common of the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission, 27 February 2017

INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES IN BRISTOL

and

CARE QUALITY COMMISSION CASE NOTE REVIEW OF CARDIAC SURGICAL SERVICES AT BRISTOL ROYAL HOSPITAL FOR CHILDREN

INTRODUCTION

This paper is provided to support a meeting in common of the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission on 27 February 2017.

The report provides an update to Council Members on the progress of the programme plan to deliver the recommendations for University Hospitals Bristol NHS Foundation Trust and South West Congenital Heart Network as set out in;

- *The Report of the Independent Review of Children's Cardiac Services in Bristol*, Eleanor Grey QC and Professor Sir Ian Kennedy, June 2016;

- *Clinical Case Note Review: A review of pre-operative, peri-operative and post-operative care in cardiac surgical services at Bristol Royal Hospital for Children*, Care Quality Commission, 23 June 2016.

For the background to the reviews see Appendix 1.

PROGRAMME MANAGEMENT

Independent Cardiac Review Steering Group

The steering group has met monthly since September 2016. It has had representation from NHS England and Welsh Commissioning since its inception and family representatives since December 2016. It has three working groups reporting to it:

- Women's and Children's Delivery Group
- Incident and Complaints Delivery Group
- Consent Delivery Group

These groups have clear terms of reference and are responsible for delivery of agreed actions that will ensure that the recommendations that relate to their areas of practice/service delivery are completed within the agreed timescales. There are detailed action plans for each group (See Appendix 2). Good progress is being made with delivering the actions. There a number of actions that are rated amber on the of the action plan. The key reason for this is the rigor of the assurance process prior to recommending actions for closure. The plan shows that all actions to deliver the

recommendations of the Independent Cardiac Review will be completed by 30 June 2017.

Reporting is a month in arrears to allow for validation and sign off of action plans by the relevant steering groups each month, before submission to the Trust Board.

ASSURANCE FRAMEWORK

Parent representatives have been appointed to act as the parent voice on the steering group (see Roles and Responsibility document, Appendix 3). A Cardiac Families Reference Group has been set up to act as the voice of the family and provide an objective "sounding board" for the paediatric cardiac service (Terms of Reference, Appendix 4).

- Four parent representatives attended the Steering Group meeting on 9 January and 7 February 2017.
- The Virtual Parents Reference Group has been used to review evidence as part of the assurance process prior to recommending actions for closure.
- There are fifteen projects in the action plans that have had, or will have, family involvement in the associated service developments and sign off of these actions as complete.
- A young person's involvement consultation has commenced to explore how these service users would like to get involved and feedback on where and how the Trust could further develop/improve service provision. The initial feedback indicated there are a range of ways young people would like to be involved in the Independent Review and ongoing service improvement work.

CONCLUSIONS

The Trust is committed to truly learn from the Independent Review and not treat the recommendations as a 'check list' of actions.

Underpinning the delivery of the recommendations is a commitment to learning and change, and an understanding that when we listen to the views and experiences of families and young people we can provide better quality services in a way that meets their needs.

NEXT STEPS

- Completion of actions to deliver all recommendations by June 2017.
- To provide for each completed recommendation a robust audit trail of supporting documentation and evidence.
- To move any service improvement actions identified through the review but not required to be completed to deliver the recommendations into an appropriate pre-existing working group.
- To ensure residual risk(s) are recorded in accordance with the risk policy.
- To continue to involve families through the forums set up to support the delivery and sign off of the actions/recommendations in the Independent

Cardiac Review in the co-design of services within the Bristol Royal Children's Hospital.

Carolyn Mills Chief Nurse
15 February 2017

APPENDIX 1

BACKGROUND TO THE REVIEWS

Child deaths in 2012

Concerns were raised in 2012 by two families about the deaths of their children in March and April of that year, following cardiac surgery at the Bristol Royal Hospital for Children.

CQC unannounced inspections

The Trust had responded to formal complaints from these families and sought to address their concerns but they were not satisfied with our explanations and contacted the Care Quality Commission (CQC). This prompted the CQC to inspect the children's cardiac ward and paediatric intensive care unit at the hospital in September 2012. This inspection found insufficient numbers of experienced staff to provide high dependency care on ward 32. The CQC served us a warning notice requiring improvement.

An unannounced follow-up inspection by the CQC in November 2012 reported improvements in nurse staffing, with adequate levels of suitably trained staff on ward 32 and high dependency provision in place on the paediatric intensive care unit.

A subsequent inspection in April 2013 found that the Trust had taken action to ensure that children on ward 32 experienced care and treatment that met their needs. The Trust opened a dedicated high dependency unit on ward 32 on a staged basis between April and September 2013, which remains part of our provision for sick children.

Independent review

However, some of the families for whom we had provided care continued to voice concern. In February 2014, the Medical Director of NHS England commissioned an independent review of the cardiac service at the Bristol Royal Hospital for Children, in response to the continuing concerns of families, including those whose children had died. 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.

Care Quality Commission review

At the same time, in consultation with NHS England, the Chief Inspector of Hospitals for the CQC agreed separately to review the clinical outcomes of the service with support from the National Institute for Cardiovascular Outcomes Research and to conduct a clinical case note review, on a random sample of notes, to assess the care provided by the service. The purpose of the review was to provide an assessment of current practice at the hospital. The review focused on surgical interventions undertaken in the three-year period between January 2012 and December 2014.

The Independent Review panel led by Eleanor Grey QC was able to study the findings of the CQC's work, prior to finalising its own report.

The reports of the Independent Review and the CQC expert review were published on 30 June 2016.

Care Quality Commission comprehensive inspection

In September 2014, the CQC carried out a comprehensive inspection of University Hospitals Bristol NHS Foundation Trust, which included the services provided by the Bristol Royal Hospital for Children. Services for children and young people were rated as good overall and, specifically, 'good' for safety, 'outstanding' for effectiveness, 'good' for caring, 'good' for responsiveness and 'good' for the 'well-led' domain.

National Institute for Cardiovascular Outcomes Research report

In April 2016, the National Institute for Cardiovascular Outcomes Research reported that the 30-day survival for all heart surgery procedures at Bristol was comparable with all 14 children's specialist cardiac centres during the three-year period 2012 to 2015.

National Coronary Heart Disease Review

In 2015, NHS England published new commissioning standards for specialist congenital heart disease services, following extensive consultation with patients and their families, clinicians and other experts. Since then, hospital trusts providing these services have been asked to assess themselves against the standards, which came into effect from April 2016, and to report back on their plans to meet them within the set time-frames.

As a result of these assessments, and following further verification with providers, on 8 July 2016, NHS England announced how it intends – subject to necessary engagement and service change processes – to take action to ensure all providers comply with the set standards. This included NHS England's announcement of its intention to support and monitor progress at University Hospitals Bristol (and a number of other recognised specialist surgical centres at major teaching Trusts) to assist us in our plans to fully meet the new commissioning standards which, as stated above, came in to effect in April of this year.

FINDINGS OF THE INDEPENDENT REVIEW AND CQC CASE-NOTE REVIEW

The full reports of both the Independent Review and the CQC case-note review were published on the Trust website on 30 June 2016 and provided to members.

Detailed conclusions and related recommendations are set out in each chapter of the Independent Review Report and its executive summary, and in the body of the CQC Clinical Case Note Review Report.

The extracts below are drawn respectively from the Independent Review Report (the Executive Summary and Chapter 17, 'Concluding Remarks and Recommendations') and the 'Conclusions' section of the CQC Report. They are reproduced faithfully here in their entirety and represent the published conclusions of each review.

Independent Review conclusions:

The Review reached the firm conclusion that there was no evidence to suggest that there were failures in care and treatment of the nature that were identified in the Bristol Public Inquiry of 1998-2001. The outcomes of care at the Children's Hospital were broadly comparable with those of other centres caring for children with congenital heart disease. There was evidence that children and families were well-looked after and were satisfied with the care their children received. There was, however, also evidence that, on a number of occasions, the care was less good and that parents were let down. The principal focus of the Review was on Ward 32 where children were cared for. It was clear that, particularly prior to the CQC's inspection in 2012, the nursing staff were regularly under pressure, both in terms of the numbers available and the range of skills needed. This led on occasions to less than good care for children and poor communication with parents and families.

The Review also reached the conclusion that, on occasions, the senior managers of the Hospital failed adequately to understand and respond effectively to the concerns of parents and adopted an unnecessarily defensive position in the face of the CQC's observations. This led to a deeply regrettable breakdown in communication which culminated in the commissioning of this Review.
…

We have noted what we consider to have been weaknesses in the response to evidence of risks on Ward 32, prior to the CQC inspection of September 2012, as well as strains on the capacity of outpatient clinics and the PICU [Paediatric Intensive Care Unit].

Detailed review of individual families' concerns suggested that there were some flaws in the management of investigations, such as RCAs [root cause analyses] and CDRs [child death reviews], but viewed overall, we accept that these processes were reasonably thorough, and candid. We did not see evidence of attempts to mislead or to avoid confronting areas of weakness. The investigations formed the basis of much of the work set out in the action plan which followed the CQC inspection. In the Review's judgment, there had been substantial learning, within cardiac services, from the criticisms which had been voiced and the findings of the Trust's own reviews and investigations.

The process of investigating a number of complex complaints or concerns did not succeed in maintaining, or rebuilding, trust between a number of families and the UHB and its staff…

CQC expert case review conclusions:

Overall the expert panel found the standard of care provided, as evidenced by the cases reviewed, to be within the expected level of quality and comparable with other centres in the UK.

The clinical panel noted that the findings changed during the period under review with more extensive documentation towards the later part of this period and particularly after the opening of a dedicated high dependency unit towards the end of 2012.

There was evidence of good practice, especially in relation to documentation with some excellent examples in the high dependency unit and paediatric intensive care unit and in relation to child death reviews.

There was evidence of thorough investigation of incidents, with documented explanations and apologies to families, including appropriate reference to duty of candour. Action plans agreed as a result of incidents were seen to be monitored and actions completed.

The expert panel noted that the methodology of this review meant that the majority of cases reviewed were complex conditions. There were no concerns about the management of any individual case reviewed. Individual outcomes for the patients reviewed were within the expert panel's expectations.

University Hospitals Bristol NHS Foundation Trust

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – November 2016

1. Women's and Children's Delivery Group Action Plan, Senior Responsible Office: Ian Barrington, Divisional Director

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
2	That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.	Deputy Divisional Director	Apr '17	**Blue- on target**	None		Review of staffing	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green- complete**	Staffing review report
							Results and recommendations reported at Women's and Children's Delivery Group in Sept. '16.	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green- complete**	Women's and Children's Delivery Group Agenda and minutes 20.09.16
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Paediatric Cardiac Services	Apr' 17	**Blue- on target**	Expression of interest form and Women's and Children's Operating Plan
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	Specialist Clinical Psychologist	Apr '17	**Blue- on target**			Information given to families at the point of diagnosis reviewed by the clinical team and the cardiac families – remaining information for Catheter Procedures and Discharge leaflet. Website and leaflets updated to reflect improvements	Clinical Team & Cardiac Families	Jan' 16	**Green- complete**	Revised patient information leaflets
							Links to access relevant information to be added to the bottom of clinic letters for patients.	Specialist Clinical Psychologist	Dec '16	**Blue- on target**	Clinic letter with links
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Blue- on target**	Revised Catheter and Discharge leaflet

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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.						Enhance existing information with a visual diagram displaying pathways of care (FI).	Specialist Clinical Psychologist	Apr' 17	**Blue- on target**	Pathway of Care accessible visual
							Website proposal to be written for new Children's website including cardiac information similar to Evelina to improve accessibility of our information. *This will be additional and not essential for delivery of the recommendation* (FI).	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Started**	
							Smart phone App proposal to be written for Cardiac Services to enable patient/families to access information electronically (FI). *This will be additional and not essential for delivery of the recommendation*	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Not started**	
4	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	CHD Network Clinical Director	Apr '17	**Amber – behind plan**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that operational challenges	Jun 17 due to delay in engagement with UHW and the operational challenges in their fetal cardiology service	Meeting arranged for 18th November with English and Welsh commissioners as well as Bristol and Cardiff trusts to establish: 1. Commissioner oversight of network 2. Commissioner support for IR actions (4,5 &11) 3. Establishment of working group(s) to address the specific changes in practices required	CHD Network Clinical Director and Network Manager	Nov '16	**Green - complete**	Agreed pathway of care in line with new CHD standards and in line with patient feedback
							Ahead of the meeting: define specifics of recommendation (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); CHD standards that relate to this recommendation; examples of practice from other centres	CHD Network Clinical Director and Network Manager	Nov '16	**Green- complete**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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				in delivery of the fetal cardiology service in UHW prevent focus on the achievement of this recommendation business plan		University Hospital Wales to define how additional fetal sessions will be delivered and who from fetal cardiology will lead the recommendation implementation and collaborate with Bristol to set up working group in January	Clinical Director for Acute Child Health, university hospital wales	Dec '16	**Blue- on target**	
							Fetal working group to define changes / new pathways, taking account of patient feedback	Working group	Jan '17	**Blue- on target**	
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Feb 17 due to delay in engagement with UHW and the operational challenges in their fetal service	**Amber – behind plan**	
							Co-design the offer with patient representatives for women whose fetus has been diagnosed with cardiac anomaly and deliver agreed model.	CHD Network Manager	Apr 17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							New pathways in place	CHD Network Clinical Director and Network Manager	~~Apr '17~~ Revised to Jun 17	**Amber – behind plan**	Summary paper showing previous and new ways of working, detailing an assessment of the benefits
5	The South West and Wales Network should regard it as a priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	CHD Network Clinical Director	Apr '17	**Amber – behind plan**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that lack of paediatric cardiology lead in UHW delays the ability to undertake actions	Final completion delayed to May 17 due to initial delay getting engagement from UHW	Network Manager and Network Clinical Director to contact Welsh Commissioners and University of Hospital of Wales to meet to discuss and agree process including method of monitoring its implementation	CHD Network Manager	Nov 16	**Green-complete**	
							Set up joint working group set up with Network Team facilitating. UHB, UHW and commissioners to deliver the relevant actions and improvements required for service.	CHD Network Manager	Dec 16	**Blue- on target**	
							To define the opportunities for improvement in coordination and the actions to achieve this	CHD Network Manager	Dec 16	**Blue- on target**	
							To undertake a patient engagement exercise (e.g. focus group, survey, online reference group) to test the proposed options for improvement	CHD Network Manager	Jan 17	**Blue- on target**	
							Deliver actions to improve coordination	CHD Network Manager	May 17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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.	Deputy Divisional Director	Jan '17	**Green-complete**	None		Audit proposal submitted to the audit facilitator for inclusion on the Children's annual audit plan	Patient Safety Manager	Aug '16	**Green-complete**	Audit proposal
							Conduct 1st annual audit into follow up care for cardiac patients as per recommendation	Patient Safety Manager	Nov '16	**Green-complete**	Audit report
							Report findings of the audit	Patient Safety Manager	Jan '17	**Green-complete**	Audit presentation and W&C delivery group Agenda and minutes November meeting
							System developed for the regular reporting and review of follow up waiting lists at monthly Cardiac Business meeting.	Assistant General Manager for Paediatric Cardiac Services	Aug '16	**Green-complete**	Follow up backlog report, Cardiac Monthly Business meeting standard agenda
8	The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective.	Nurse Project Lead	Oct '16	**Approved as closed by Steering Group (09/01/17)**			Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed)	Outpatients Experience working group	Aug '16	**Green-complete**	1.Outpatients and Clinical Investigations Unit Service Delivery Terms of Reference
							Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatient's completed	Outpatients Experience working group	Sept '16	**Green-complete**	2. Outpatients and Clinical Investigations Unit Service Delivery Group

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '16	**Green- complete**	Agenda(3.10.16) 3. Outpatients and Clinical Investigations Unit Service Delivery minutes of meeting (3.10.16) 4. OPD Patient Experience Report (October 2016) 5. Paediatric Cardiology – Non-Admitted RTT Recovery (Appendix 1) 6. Cardiology Follow-Up backlog update (Appendix 7. Project on a Page: Outpatient Productivity at BRHC (Appendix 7)
9	In the light of concerns about the continuing pressure on cardiologists and the facilities and	Divisional Director	Jan'17	**Blue- on target**	Risk that other sites are unable to share data		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	CHD Network Manager	Jan '17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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.				required to complete a comprehensive benchmarking exercise Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.		Identification of actions required to address the gaps	CHD Network Manager	Jan '17	**Blue- on target**	
							Progress to implementing any changes in practice that are deemed necessary	CHD Network Manager and Divisional Director	Jan '17	**Blue- on target**	
11	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	CHD Network Clinical Director	Jan'17	**Blue- on target**	Linked to recommendation no.9. Actions detailed under recommendation no. 9 will also achieve recommendation no. 11. Risks to delivery, timescales, progress against delivery and evidence will be the same as per recommendation no. 9						

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)										
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.	Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**			Enhance existing guidance to describe team working and in particular the involvement of other operators and team members in patient care. Review by the Trust wide consent group and Cardiac Clinical Governance for approval and then implement.	Consultant Paediatric Surgeon and Specialist Clinical Psychologist	Dec '16	**Blue- on target**	
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.	Deputy Divisional Director	Nov '16	**Green- complete**			Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure	Cardiac Review Programme Manager	Aug '16	**Green- complete**	Current process review report
							Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented	Consultant Paediatric Surgeon and Cardiac Review Programme Manager	Nov '16	**Green- complete**	JCC performance review meeting agenda and cancelled operations report

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
20	That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	Deputy Divisional Director	Nov '16	**Green-complete**	None		End-of-life care and bereavement support pathway developed (FI)	Deputy Divisional Director	Sept '16	**Green-complete**	End-of-life and bereavement support pathway
							Implementation and roll out of new pathway	Deputy Divisional Director	Nov '16	**Green-complete**	Communication and presentations to roll out
21	Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support	Commissioners		**Green-complete (provider actions)**			Previous submission to commissioners for psychological support updated	Head of Psychology Services	Sept '16	**Green-complete**	Submission to Commissions
							Expression of Interest for increased resource to be submitted as part of business planning	Head of Psychology Services / Deputy Divisional Director	Mar'17	**Green-complete**	Expression of interest and W&C Business plan
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.	Deputy Divisional Director	Dec '16	**Blue- on target**	None		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	Deputy Divisional Director	Sept '16	**Green-complete**	
							Annual programme- Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff	Deputy Divisional Director	Dec '16	**Blue- on target**	
CQ C.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Clinical Lead for Cardiac Services	Nov '16	**Amber-behind target**		Jan '17 *Slippage due to capacity constraints*	ECHO form for reporting in theatres implemented	Consultant Paediatric Cardiologist	Aug '16	**Green-complete**	
							Audit to assess implementation (Nov'16) and request to Steering Group to close	Patient Safety Manager	Nov '16	**Amber-behind target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
CQC. 3	Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	Ward 32 Manager	Aug '16	**Green- complete** **22/11/16- approved for closure by W&C delivery group**			Documentation developed to record pain scores more easily	Ward 32 Manager	Jan'16	**Green- complete**	Nursing documentation
							Complete an audit on existing practise and report findings	Ward 32 Manager	Aug '16	**Green- complete**	Audit of nursing documentation
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)	Head of Nursing	Dec '16	**Blue- on target**			Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records and review option of Medway proforma's to support recording in notes	Head of Nursing	Dec '16	**Blue- on target**	
CQC. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3)	Clinical Lead for Cardiac Services	Apr '17	**Blue- on target**	Linked to recommendation no. 3. Actions detailed under recommendation no. 3 will also achieve CQC recommendation no. 5						
CQC.6	Ensuring that advice from all professionals involved with individual children is	Head of Allied Health Professionals and Clinical	Jan '17	**Blue- on target**		Agreed mechanism for including AHP	Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services Audit completed and results to be formulated 27th October 2016.	Head of Allied Health Professionals	Oct '16	**Green- complete**	Assessment documentation

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	included in discharge planning to ensure that all needs are addressed.	Lead for Cardiac Services				advice into discharge planning for children within Cardiac Services	Agree with Cardiac Services Team an effective mechanism for including Allied Health Professionals into discharge planning for Cardiac Services. Meeting setup for 4th November.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Nov'16	**Blue – on target**	Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services
							Implement agreed mechanism for including Allied Health Professionals into discharging planning for Cardiac Services	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan 17	**Blue – on target**	Implementation plan delivery report

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

2. Trust wide Incidents and Complaints Delivery Group Action Plan – Senior Responsible Officer; Helen Morgan, Deputy Chief Nurse

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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.	Chief Nurse	Jan '17	**Amber- behind target**		Jun'17 additional and amended actions to fulfil recommendation	**26.1** Develop an appendix to the Serious Incident (SI) policy defining "link" between Child Death Review (CDR), complaints and SI investigations / reporting, includes adults and children.	Women and Children's Head of Governance	July '16	**Green- Complete** ***Approved by delivery group 15.11.16***	Link between serious incidents and other investigatory procedures (e.g. Complaints and Child Death Review) July 2016
							26.2 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.	Women and Children's Head of Governance	Dec '16	**Blue- on target**	
							26.3 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.	Head of Quality (Patient Safety)	Jul '16	**Green- Complete**	Guidance for Supporting and Working with patients/families after unexpected death of an adult or a serious incident involving an adult, July 2016 (latest version)
							26.4 Develop 'guidance' / information for **families** in **children's services** how the x3 processes of Child Death Review (CDR) / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate ***(FI)***	Women and Children's Head of Governance	April '17	**Blue- on target**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							26.5 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.	Women and Children's Head of Governance	Dec '16	**Blue- on target**	
							26.6 Develop the above **staff** guidance for **adult** patients and families (minus CDR)	Head of Quality (Patient Safety)	Dec '16	**Blue- on target**	
							26.7 Develop the above **family** guidance for **adult** patients and families (minus CDR) **(FI).**	Head of Quality (Patient Safety)	Apr '17	**Blue- on target**	
							26.8 Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options **(FI).**	Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	
							26.9 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 **(FI)**	Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	
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.	Chief Nurse	Jun '17	**Blue- on target**			**27.1** Guidance developed for staff for the preparation and conduct of meetings with parents/families to discuss concerns and/or adverse event feedback	Medical Director	Jun '16	**Green- complete**	Guidance for the Preparation and Conduct of Meetings with Parents/Families to discuss concerns and/or adverse event feedback, June 2016
							As per actions 26.4 and 26.5, included in recommendation no. 26 to develop guidance for staff				

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							27.2 Develop a framework for training staff to support them to effectively and sensitively manage processes relating to CDR/SI's and complaints. Develop and pilot session. Existing complaints training materials to be reviewed and updated to include guidance on supporting families in circumstances where a complaint is being investigated alongside a CDR or SI. January 2017. Other bespoke training opportunities to be considered in light of development of staff guidance by Children's Services (see 26.5), due April 2017.	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	
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.	Chief Nurse	Dec '16	**Blue- on target**			**28.1** To review UHBristol's previous use of independent review / benchmarking from other trusts to inform above. - Complaints - RCA's	Patient Support and Complaints Manager and Patient Safety Manager	Nov '16 Nov '16	**Green- complete**	Reports of the Reviews undertaken
							28.2 Develop guidance for when to access 'independent advise / review' for - Complaints - SI RCAs	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Oct '16 Dec '16	**Blue- on target**	Complaints policy Serious Incident Policy (appendix 9, pg. 33)
							28.3 The Trust has entered into exploratory discussions with the Patients Association about developing a model for exceptional independent investigation/review. This work will commence with a focus group of previous dissatisfied complainants in	Head of Quality (Patient Experience and	Mar '17		

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							February 2017.	Clinical Effectiveness			
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.	Chief Nurse	Apr '17	**Blue- on target**			**29.0** Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution. 29.1 Visit the Evelina to understand their model for mediation and possible replication at UHBristol. A report will be presented following the visit to consider next steps and possible resource implications.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green- complete**	Complaints policy
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.	Chief Nurse	Dec '16	**Amber- behind target**		Apr '17 Revised to allow for family involvement	**30.1** 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 **(FI).**	Head of Quality (Patient Safety) and Clinical Effectiveness)	Apr '17	**Blue- on target**	
							30.2 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 **(FI)**	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green- complete**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							30.3 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 raised to be audited at the end of February 2017, including review of survey replies.	Head of Quality (Patient Experience and Clinical Effectiveness)	Feb '17	**Blue – on target**	
							30.4 Regular complainant focus groups to be held from April 2017 onwards 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.	Head of Quality (Patient Experience and Clinical Effectiveness)	April '17	**Blue – on target**	

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FI	Indicates family involvement in the action(s)

3. Trust wide Consent Delivery Group Action Plan – Senior Responsible Officer: Jane Luker, Deputy Medical Director

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
12	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.	Medical Director	Dec '16	**Blue on target**			**12.1** Guidance developed to 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	Medical Director	Aug '16	**Green-completed**	Medical Staff Guidance
							12.2 Review of new existing guidance to reflect the recommendation and include recommendation in updated consent policy , guidance notes and e-learning	Deputy Medical Director	Nov '16	**Green-Completed**	Consent policy Guidance on consent policy e-learning for consent
							12.3 Incorporate new guidance into existing Children's Consent pathway (existing letter that goes to families before their surgical appointment) (FI)	Consultant Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**	Letter to families
13	That the Trust review its 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	Deputy Medical Director	Jan '17	**Blue-on target**	E-learning lead is currently on learn term sick which has led to a delay in updating e-learning material		**13.1** Trust wide Consent delivery group set up	Deputy Medical Director	Sept '17	**Green-Completed**	Terms of reference for Trust Wide Consent Group Minutes and actions from meetings
							13.2 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	Consent Group	Nov'16	**Green Completed**	Revised consent policy ratified by CQC December 2016
							13.3 Develop training and communication plan	Deputy Medical Director	Dec '16	**Amber behind but no impact on completion date**	Training and communications plan

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							13.4 Advice from legal team and safeguarding on revised consent policy and e-learning	Deputy Medical Director	Nov '16	**Amber**	Legal and safeguarding assurance confirmation
							13.5 Update e-learning for any changes to consent policy and process	Deputy Medical Director	Jan '17	**Amber**	Updated E-learning package for consent
14	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	Deputy Medical Director	**Linked to recommendation no. 13, actions, timescales and status as detailed under this recommendation – Blue on target, date completion scheduled Jan '17**								
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	Deputy Medical Director	May'17	**Blue-on target**			**17.1** 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 (FI)	Consultant Paediatric Cardiac Anaesthetist	Dec '16	**Blue on target**	Minutes and actions from meeting
							17.2 Liaise with Royal College of Anaesthesia and other appropriate professional bodies with regarding national policy	Paediatric Anaesthesia consent group	Jan' 17	**Blue-on-target**	Correspondence with Royal College of Anaesthetists and Associations
							17.3 Implementation plan for trust wide consent process	Paediatric Anaesthesia consent group	May '17	**Not started**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	relating to consent										
CQC. 1	Recording the percentage risk of mortality or other major complications discussed with parents or carers on consent forms	Deputy Medical Director	Jan' 17	**Blue- on target**			**1.1** Review trust wide consent form in use to agree whether they should be amended to improve recording of risk	Consent Group	Dec '17	**Blue- on target**	Updated / amended trust consent forms
							1.2 Paediatric Cardiac Services to agree whether service would benefit from a bespoke cardiac consent form that includes percentage risk	Consultant Paediatric Cardiac Surgeon	Nov '16	**Amber**	Agreement of Paediatric Consent Group to utilise bespoke consent forms where appropriate
							1.3 Cardiac Services- agree and implement process for discussing percentage risk with families (FI)	Consultant Paediatric Cardiac Surgeon	Nov '16	**Green**	Information and consent forms available to parents

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

4. Other Actions Plan – governed by the Independent Review of Childrens Cardiac Services Steering Group

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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.	Trust Secretary	Sept '16	**Green-complete**			Review of current arrangements and processes (Sept '16)	Trust Secretary	Sept '16	**Green-complete**	Executive Lead Role description
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.	Commissioners and Trust	Jan '16	**Blue- on target**			Discussion with commissioners about the issues and agreement to mitigate a similar occurrence	Commissioners and Trust	Jan '16	**Blue- on target**	
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	Chief Nurse	Oct '16	**Green-complete**			Trust board paper presented in July acknowledging the role which parents have played in bring about significant changes in practice and in improving the provision of care	Chief Executive	July '16	**Green-complete**	Trust Board Paper and Trust Board Agenda, July '16
							Presentation to Health and Overview Scrutiny Committee	Chief Executive, Medical Director, Chief Nurse and Women's and	Aug '16	**Green-complete**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	and in improving the provision of care.							Children's Divisional Director			
							Presentation to the Bristol Safeguarding Children's Board	Chief Nurse	Oct '16	**Green- complete**	
32	That the Trust redesignate 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.	Medical Director	Dec '16	**Blue- on target**			Adoption of the term "Safety of Patients" in place of "Patient Safety" going forward and communication of preferred term Trust wide	Medical Director	Dec '16	**Blue- on target**	

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
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University Hospitals Bristol
NHS Foundation Trust

Parent Representative Role and Responsibility
Independent Review of Children's Cardiac Services Steering Group

1. Introduction

The Trust is responsible for the delivery of 32 recommendations from the Independent Review of Children's Cardiac Services and CQC report (http://www.uhbristol.nhs.uk/about-us/reports-and-findings-relating-to-the-children's-hospital/). A Steering Group has been set up, chaired by Carolyn Mills, Chief Nurse and Executive Lead for Children's Hospital, to ensure that the recommendations are delivered in a timely and comprehensive manner.

Parents have played an important role in bringing about significant changes and in improving the care we provide. We would like to work in partnership with parents to help deliver the recommendations of these reports. There are a number of ways we are engaging and involving parents and families in this work, and this includes inviting parent representatives on the Steering Group. Parent representative on the Steering Group will play an important part in supporting and informing the implementation of the recommendations from a parent and family perspective.

2. What is a parent representative?

A parent representative is a member of a group or committee who has personal experience of using health or care services. They offer a different point of view from people who provide or commission health care services.

Parent Representatives are appointed by the hospital to promote openness and transparency by involving and consulting the public in its work.

Parent representatives are not expected to represent the views of the wider community but rather bring a different, lay perspective to the work of the group, which professionals hear and take seriously. They are not constrained by professional protocols and can speak out, but also know how to listen and engage in constructive debate.

Parent Representatives are not paid for their work but are entitled to claim reimbursement of travel costs including mileage or public transport fees and parking.

3. What will I be asked to do?

The role of the parent representative will be to;

- Act as the voice of the parent on the Steering Group, ensuring the interests of the families of cardiac services in the Children's hospital are represented in the implementation and sign off of the recommendations.
- Provide advice guidance and challenge to the Steering Group to help ensure that the family involvement in the implementation has been appropriate, relevant and effective.
- Be part of the virtual parents reference group (please see Cardiac Families Group Terms of Reference for more detail) and to be the link and liaison between the Steering Group and the parents reference group – disseminating information and updating both groups as required.
- Support the assessment of whether a recommendation, should be signed off as effectively completed from a parent/family perspective.

- To engage in the monthly meetings of the Independent Review Steering Group meeting by reviewing the meeting papers and providing input/comments prior to the meeting taking place or by attending the meeting if possible *(Times and dates of meeting currently being reviewed).*

- Maintain confidentiality at all times and to comply with UH Bristol Health & Safety Policy, Information Governance policy, Safeguarding and Equalities legislation and other relevant policies. These will be provided at the commencement of your role.

- As Parent Representatives you <u>are not</u> responsible for the delivery of the recommendations or the delivery of any specific actions.

4. What skills and qualities will I need?

As a parent representative you will need the following skills:

- Willingness to develop an understanding of the work of the steering group and the role it plays in the Trust
- The ability to process and consider detailed information in the form of reports
- The ability to participate confidently in meetings
- The ability to focus on other individuals or on groups and organisations outside of one's own experiences.
- Empathy and the capacity to consider the needs and feelings of others
- Able to give an appropriate time commitment.
- The ability to maintain confidentiality.
- Good communications skills including respect for the views of others and the ability to listen and take part in constructive debate.

5. How will I be supported?

As a Parent Representative you will receive support from the Cardiac Review Programme Manager and the Family Involvement Working Group members. This will include:

- An initial induction to Trust policies and processes.
- Sending of papers for the Steering Group meeting plus the opportunity to discuss these prior to the meeting with the Cardiac Review programme manager
- Individual support to deliver the role, as required, including preparation for meetings and claiming your travel costs.
- A named individual to represent your views when you are unable to attend meetings and to give you feedback on the outcomes
- Ongoing support to identify development opportunities to allow you to develop in this role

You will also have the opportunity to be actively involved in the Congenital Heart Disease Network and other Children's hospital groups should you be interested.

6. Terms of Engagement

To act as a Parent Representative it would be important that you:

- Are able to commit to undertaking the responsibilities above
- Be willing to act in the best interests of all service users, independent of specific personal interests

We will ask you to complete a simple Expression of Interest form to let us know why you are interested in the role and what you would hope to gain from it. We will also ask you to complete a Disclosure and Barring form according to our standard procedures.

7. Duration

This is flexible and can be adapted to suit the individual circumstances. The implementation programme for the review is due to complete in June 2017 with a period of evaluation post implementation which we would expect to conclude by the end of the year.

We anticipate that there will then be further opportunities within the Congenital Heart Disease (CHD) Network to continue in a similar role for any parents who wish to do so. The CHD network links together all the healthcare providers, patients and families in the South Wales and South West region. The networks vision is to ensure high quality, equitable access to care across the region; providing excellent information to patients, families and staff;

collaborating to improve quality; and ensuring that there is a strong collective voice for CHD services.

We are aware that circumstances may change which may influence your ability to be part of this work. We hope that we would be able to support you with any changes or adjustments necessary but should you feel unable to continue with the role at any point, please advise the programme manager

If you would like to become a parent representative, please contact the LIAISE team on 0117 342 7444 or email bchinfo@UHBristol.nhs.uk and we will be happy to contact you to discuss this further.

University Hospitals Bristol NHS Foundation Trust

Terms of Reference – Cardiac Families Reference Group

Document Data		
Corporate Entity	Cardiac Reference Group	
Document Type	Terms of Reference	
Document Status	Final version 1.0	
Hospital Lead	Clinical Chair, Women and Children's Division	
Document Owner	Cardiac Review Programme Manager	
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Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
	FINAL v1.0, 29/11/16	01/12/2016
Estimated Reading Time	5 mins	

Document Abstract
This document provides the Terms of reference for the Cardiac Family Reference Group, giving guidance on the purpose and makeup of the group and identifying duties carried out by the group.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
3/11/16	V0.1	Cardiac Review Family Involvement Group	Content	Content additions/deletions and amendments
17/11/16	V0.3	Cardiac Families	Content	Content additions/deletions and amendments
29/11/16	V1.0	Cardiac Review Family Involvement Group	Content	Content additions/deletions and amendments

What is the Group for?

This group is for supporting developments and improvements in the cardiac service both in Bristol and the wider South West Network.

Who can join this group?

The group is open to patients who are currently accessing or have accessed the cardiac service and their families. This includes both patients seen by a Cardiologist, and those who have undergone cardiac surgery.

How do you become a member?

Please let us know if you would like to become a member by emailing bchinfo@UHBristol.nhs.uk with your name and a contact number. We will telephone you to confirm the additional details we need and then send you the link to join the group. By accepting the invitation you are agreeing to the **Group Guidelines** detailed below.

What does the group do?

- Acts as a voice of the family and provides an objective "sounding board" for the cardiac service to understand their views.
- Brings together families from a wide geographic area to participate in service development where attending meetings and focus groups may be a barrier to engagement.
- Provides a forum to discuss ideas about how to develop and improve the services offered.
- Works together to reach a consensus on the best way to progress specific projects or activities.
- Supports the development of documents such as patient information leaflets, policy and guidance documents and electronic information resources.
- Helps form and facilitate task groups for various activities as and when required
- Reviews and approves, from a family perspective, actions taken as a result of any reports or reviews of the cardiac service either by internal or by external organisations

Where will the outcomes of this group be shared?

Outcomes will be shared on the hospital and Congenital Heart Disease (CHD) network website, via the hospital facebook page, and through the cardiac support groups. They will be included in the CHD network newsletter which will be distributed across the region. The CHD network links together all the healthcare providers, patients and families in the South Wales and South West region. The networks vision is to ensure high quality, equitable access to care across the region; providing excellent information to patients, families and

staff; collaborating to improve quality; and ensuring that there is a strong collective voice for CHD services.

How will the group work?

This is a virtual group which uses facebook as a platform for communication. The group will only be visible to group members in order to protect your privacy. Invitations to join the group will be offered patients who are currently accessing or have access the cardiac service and their families, which will be verified by the clinical team. Your profile will be visible to other group members according to your own personal privacy settings. We will post when we would like you to get involved in pieces of work which may have a specific deadline for responses. There is no obligation or expectation for any of the group members to be involved in any pieces of work that is sent to them. We appreciate that members of the group have many other important commitments and may not be able to participate or get involved in the work at any given time. We respect every group member's right to withdraw their involvement at any time. Access to the group will be limited to group members and the hospital staff that are leading on involving families in this work, namely the Clinical Chair, Specialist Clinical Psychologist, LIAISE team manager and the Cardiac Review Programme Manager. Feedback from the group will be anonymised before sharing wider. Group members can get involved in a variety of different types of work; from reviewing documents to helping design and improve a specific process.

Group Guidelines

1. Any reporting of the discussions that take place in the group will be anonymised and will not contain any information that will identify members.
2. We expect that participants only post comments and commentary that is relevant to the group and the discussions taking place. Members should be respectful to the group community. Administrators will not accept vulgarity, personal attacks or insulting posts and all discussions must remain civil and courteous.
3. Members are expected to respect the privacy of other members of the group and treat any discussions within the group as confidential.
4. The group is not a means of communication with the cardiac team and should not be used to ask questions about diagnosis or treatment. Please speak to your clinical team should you have any questions. Any complaints or comments relating to the service for which you require a response should be directed through LIAISE or the Patient Support and Complaints Team. The group will not act as a support group however it may signpost people to relevant support groups if appropriate.
5. Only upload images or graphics that are owned by yourself and do not upload anything that encourages illegal activity.
6. The administrators reserve the right to remove members, posts, photos and comments from the group. This may be with or without explanation.
7. If any posts are identified which cause concern for an individual's safety the administrator will escalate this concern according to the Trust safeguarding policy.

8. Your participation in this group is at your own risk and you will take full responsibility for your comments and any information you choose to provide.
9. Be careful when providing personal information online. We would strongly advice that you do not upload the following information; full address, DOB, telephone no. national insurance no, school/workplace/birth place/previous addresses.
10. Please be aware that the views of members do not necessarily represent or reflect the opinions of University Hospital Bristol and the wider Congenital Heart Disease Network.
11. Please abide by Facebooks Statement of Rights and Responsibilities (www.facebook.com)

How can I unsubscribe from the group?

At any point you can remove yourself from the online group. Should you wish to re-join at a later date you can contact us on bchinfo@UHBristol.nhs.uk

Who will be the administrator for the group?

The Cardiac Review Programme Manager will be responsible for administrating and overseeing this group. This is a hospital employee whose responsibility is to lead and coordinate the implementation of the Cardiac Review and CQC recommendations.

I want to be involved, but not part of this group?

We have a range of options for engagement and participation. Please contact us on bchinfo@UHBristol.nhs.uk or telephone 0117-3427444 and we will be happy to discuss these further.

Report to meeting in common of the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission, 27 February 2017

INDEPENDENT INVESTIGATION INTO THE MANAGEMENT RESPONSE TO ALLEGATIONS ABOUT STAFF BEHAVIOURS RELATED TO THE DEATH OF A BABY AT BRISTOL CHILDREN'S HOSPITAL

1. INTRODUCTION

This paper updates the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission on progress in delivering the recommendations of an independent investigation, commissioned by the University Hospitals Bristol NHS Foundation Trust from a specialist investigations consultancy called Verita, into events following the death of a baby at the Bristol Royal Hospital for Children in April 2015.

The Trust has previously provided reports on this issue to the two Commissions in August and November 2016.

2. BACKGROUND

Ben, who was born at 29 weeks' gestation on 17 February 2015, sadly died on the paediatric intensive care unit at the Bristol Royal Hospital for Children on 17 April 2015, after one week on the unit.

Subsequent to Ben's death, his parents raised concerns about:

- a delay in informing them that Ben had had an infection (pseudomonas)
- inaccurate information from clinicians about the timing of blood tests
- suggested deletion of an audio recording of a discussion between clinicians in a recess of a Child Death Review feedback meeting
- inadequate Trust investigations into these concerns.

In December 2015, the Trust commissioned Verita to undertake an independent investigation into the management response to allegations about staff behaviours related to Ben's death.

Verita concluded that Ben's parents had, very soon after their son's death, formed the view that his care had been inadequate, that his death might have been avoided, and that there had been a conspiracy to cover this up (which the Trust disputes). Verita found that the Trust had missed a number of significant opportunities to engage proactively with Ben's family after their baby's death, to be more open and candid with the family, to understand the seriousness of their allegations and to give them clear answers to a number of their questions.

The Trust accepted Verita's findings in full and wrote to the family, giving unreserved apologies for the failings identified by the Verita investigation.

Subsequent progress in implementing Verita's recommendations has been reported publicly at meetings of the Trust Board. In line with recommendation 9, the Trust identified two senior clinicians, independent of the PICU, to work with Ben's family to ensure that their remaining questions were fully understood. Over a number of weeks these two clinicians met with Mr Condon on four occasions, for a cumulative period of about ten hours, to discuss and define these remaining questions. From this engagement, a detailed list of 80 questions was produced which, in the family's opinion, remained to be addressed.

Following this the Trust then identified another senior clinician, Professor Michael Stevens, Emeritus Professor at the University of Bristol and former Consultant Paediatric Oncologist, who accepted the task of working with the set of questions and, by reviewing existing records and consulting with staff as appropriate, producing a set of responses, documented in a report to be submitted to the family by the end of January 2017.

This task was completed within the timeframe and a 45 page document providing responses to the set of questions was produced and forwarded to the Condon family. The document concluded with a suggestion for next steps with the ongoing engagement, and described a proposal for a meeting, or series of meetings, between Professor Stevens, Senior Trust management including the Chief Executive and Medical Director, and an independent mediator with experience of mediation in a health care setting. The family subsequently indicated their wish to decline this offer.

3. INQUEST

An inquest into the death of Ben Condon took place at the Coroner's Court on 21st June 2016.

This determined that Benjamin Condon was born premature at 29 weeks on 17th February 2015. He was discharged from hospital (North Bristol Trust) following his birth on 7th April 2015. On 10th April he was unwell and was taken to his local hospital (Weston General) by his parents. Following an assessment he was transferred that day to the Bristol Royal Hospital for Children, Upper Maudlin Street, Bristol. He was diagnosed with human metapneumovirus respiratory infection. He received supportive treatment. He developed acute respiratory distress syndrome, this caused his collapse on 17th April and his death.

The conclusion of the coroner as to the death was that Benjamin Condon died due to viral bronchiolitis caused by the human metapneumovirus which was the trigger for his acute respiratory distress syndrome; it was the development of this condition that caused air to leak from his lungs causing a catastrophic deterioration of his condition on 17th April and his death.

4. ANSWERS TO THE 6 ACTIONS FROM NOV JHOSC

Responses to actions from the November JHOSC are at appendix 1.

5. RECOMMENDATIONS

Councillors are asked to:

- Note the Trust's response to the Verita recommendation to address outstanding issues with Ben's family and the steps taken to do so in an entirely open and collaborative way

Appendix 1. Actions form the meeting in common – 23rd November 2016

Minutes No.	Title of Report/ Description	Action and Deadline	Responsible officer	Action taken and date completed
57	Independent Reports related to the Bristol Royal Hospital for Children 2016 – Three month review	A7. The family suggested that Recommendation 1 had not been completed. The Trust agreed to address the concern when provided responses to the 80 questions submitted.	UHB	Addressed again in Prof Stevens report under section A.3.1
57	Same as above	A10. The Trust were asked to check what the circumstances were in this case regarding family accommodation.	UHB	Children come to Bristol from throughout the South West Region, Wales and beyond for specialist treatment. We have three internal parent rooms close to intensive care and accommodation supported by our charity providers at Ronald MacDonald and the Grand Appeal. The demand for parent accommodation does, on occasion, exceed our capacity A degree of priority is given to parents who live long distances from Bristol and would therefore not be able to commute daily to visit their child. We believe that no parent accommodation was available when the family made their request. Accommodation became available later in the admission, by which time the parents opted to remain in the accommodation they had arranged themselves.

57	Same as above	A12. The Trust we asked to check the date and outcomes of the South West audit at Verita	UHB	The action specified in Recommendation 4 was implemented immediately following receipt of the Verita report. A follow up audit completed in August 2016 showed that all new BRHC guidance documents approved since the implementation were compliant with the policy and had ratification and review dates specified.
57	Same as above	A15. The Trust were asked to provide the specific figures related to the number of senior leaders who had been trained in accordance with recommendation 6.	UHB	A total number of 58 senior Trust leaders have received formal training in investigation methodology at two training events held in August and December 2016.
As part of the Resolution	Same as above	A visit to the hospital to see some of the changes first-hand would be arranged for Councilors prior to the next update meeting on the 27th February 2017	UHB / Officers	Visits have been arranged.
As part of the Resolution	Same as above	An update on the 80 questions formulated with the Condon family would be provided as part of the six month update in February 2017	UHB	A response to the 80 questions was provided to the family in January 2017.