University Hospitals Bristol
NHS Foundation Trust

COUNCIL OF GOVERNORS

Meeting to be held on 28 April 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

SUPPORTING INFORMATION

Q3 16/17 Complaints Report

Q3 16/17 Patient Experience Report

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

University Hospitals Bristol NHS Foundation Trust

Report to the Council of Governors meeting to be held on 28 April 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

		Agenda Item	8.1b
Meeting Title	Council of Governors	**Meeting Date**	28 April 2017
Report Title	Quarterly Complaints and Patient Experience Report (Quarter 3)		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

Action/Decision Required (please tick any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose

To share insight and learning from patient-reported experience generated from complaints, patient surveys and patient and public involvement activities during Quarter 3.

Key points to note

Complaints

Improvements in Q3:

The number of complaints received in Q3 represents a significant decrease on previous quarters. This reduction applies across all Divisions except Women's & Children's Services and to all major complaints categories.

- The Trust also achieved its goal of less than 0.21% of patient attendances resulting in a complaint.
- In Q3, 94.2% of responses were posted within the agreed timescale, compared to 88.1% in Q2, 76.2% in Q1 and 74.6% in Q4 (2015/16). In December, the Trust achieved its target of 95% of responses within timescale.

- In Q3, fewer complainants expressed dissatisfaction with our response to their concerns (<10%)
- Complaints about the GUCH (Grown up congenital heart disease) service, which had increased in Quarter 2, decreased significantly in Q3. Complaints about trauma and orthopaedics – highlighted in Q2 – also fell in Q3.

However:

- Complaints about gynaecology services increased in Q3. The reason for this increase has been identified and addressed.
- Complaints regarding appointments and admissions in the Division of Diagnostics and Therapies increased in Q3, although the number of complaints remains small and there are no common themes arising.

Corporate plans include:

- Establishing a new complaint review panel, planned for May 2017
- Working with the Patients Association to develop a potential model for exceptional external investigation or review of high-risk complaints. This work will commence with an invited focus group of previous dissatisfied complainants in May 2017.

Patient Experience and Involvement

This report incorporates current Patient and Public Involvement activity and patient survey data received during Quarter 3 2016/17. The key messages from this report are:

- The "enter and view" carried out at South Bristol Community Hospital by Healthwatch in October 2016 generated positive feedback about inpatient care at the hospital. Most of the recommendations focussed on non-clinical aspects of care. In particular, it was highlighted that many inpatients at the hospital have relatively long stays for rehabilitation, so it is important to ensure that they have access to magazines, activities, and the hospital café. A response from South Bristol Community Hospital has been provided to Healthwatch and was discussed at the Trust's Patient Experience Group in February 2017.
- Feedback obtained from patients via the Trust's corporate survey programme remained positive about the quality of care at UH Bristol. For example, 98% of inpatients would recommend the care to their friends and family and praise for staff was by far the most frequent type of written feedback received.

A number of survey scores / issues are highlighted in the report, in particular:

- Wards primarily providing care to elderly patients consistently receive *relatively* low survey scores in our key surveys (although it should be noted that the feedback is still very positive). However, this does not correlate with other quality data reviewed by the Division of Medicine. In order to explore the survey results further, and to provide further assurance that the quality of care is of the highest standards in these areas, in Quarter 1 the Patient Experience and Involvement Team will engage with "care of the

elderly" service-users and staff in a variety of ways (e.g. via the Involvement Network, *Face2Face* interview programme, and Patient Experience at Heart staff workshops).

- Postnatal wards received a relatively low Friends and Family Test score in Quarter 3. This may be linked to staffing levels on the wards in this period, which saw a high incidence of staff sickness (although these staffing levels were still within recommended limits).
- Ward A605 ("delayed discharge ward") is a notable outlier in the Trust's inpatient experience tracker in Quarter 3 and a number of recent service improvements are identified in the report
- Below target response rates in the Bristol Royal Hospital for Children Friends and Family Test survey (26% in Quarter 3, against a target of 30%): the Head of Nursing has discussed this with the ward teams and a positive improvement is evident in Quarter 4 to date (32%).

Recommendations

Governors are asked to:

- **Note** the report.

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

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

Date papers were previously submitted to other committees

Nominations and Appointments Committee	Quality Focus Group	Governor Strategy Group	Constitution Focus Group	Public Trust Board 30/03/17

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 3, 2016/2017

(1 October 2016 to 31 December 2016)

Authors: Louise Townsend, Acting Patient Support and Complaints Manager
Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)

Overview

Successes	Priorities
• The number of complaints received in Q3 represents a significant decrease on previous quarters. This reduction applies across all Divisions except Women's & Children's Services and to all major complaints categories. • The Trust also achieved its goal of less than 0.21% of patient attendances resulting in a complaint. • In Q3, 94.2% of responses were posted within the agreed timescale, compared to 88.1% in Q2, 76.2% in Q1 and 74.6% in Q4 (2015/16). In December, the Trust achieved its target of 95% of responses within timescale. • The majority of complaints continue to be resolved by the Trust informally. • Fewer complainants have expressed dissatisfaction with our response to their concerns (<10% to date) • Complaints about the GUCH (Grown up congenital heart disease) service, which had increased in Quarter 2, decreased significantly in Q3. Complaints about trauma and orthopaedics – highlighted in Q2 – also fell in Q3.	• To continue to implement learning arising from the complaints and incidents delivery group following the independent review of children's cardiac services, including strengthening the patient/family voice within the complaint process. • To retain an ongoing focus on delivery of training to senior divisional staff about conducting complaints investigations and writing effective responses.
Opportunities	**Risks & Threats**
• To establish a new complaint review panel in Q1 2017/18. • To continue to work with the Patients Association to develop a potential model for external patient advocacy for high-risk complaints. • To apply learning from: the recent NHS Improvement review of the complaints service; the recent Care Quality Commission inspection and the forthcoming internal audit of learning from complaints. All to be incorporated into complaints work plan for 2017/18.	• Complaints about gynaecology services increased in Q3. The reason for this increase has been identified and addressed. • Complaints regarding appointments and admissions in the Division of Diagnostics and Therapies increased in Q3, although the number of complaints remains small and there are no common themes arising. • In Q3, 24 written complaints were not acknowledged within three working days in accordance with the NHS Constitution (instead they were acknowledged in four working days). The reasons for this have been identified and addressed for the future.

1. Complaints performance – Trust overview

The Board monitors three indicators of how well the Trust is doing in respect of complaints performance:

- Total complaints received as a proportion of activity;
- Proportion of complaints responded to within timescale; and
- Numbers of complainants who are dissatisfied with our response.

1.1 Total complaints received

The Trust's preferred way of expressing the volume of complaints it receives is as a proportion of patient activity, i.e. total inpatient admissions and outpatient attendances in a given month.

We received 397 complaints in Q3, which equates to 0.19% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]. This figure does not include concerns which may have been raised by patients and dealt with immediately by front line staff. The number of complaints received in Q3 represents a significant decrease of 23% compared to Q2 and an 11% decrease on the corresponding period one year previously.

Figure 1 shows the pattern of complaints received in the last 15 months. Figure 2 shows the complaints received as a percentage of patient activity and Figure 3 shows the numbers of complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process.

1.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with, or arrange a meeting to discuss, our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q3, 94.2% of responses were posted within the agreed timescale, compared to 88.1% in Q2, 76.2% in Q1 and 74.6% in Q4 (2015/16). This represents 8 breaches out of 97 formal complaints which were due to receive a response during Q3[2]. Figure 4 shows the Trust's performance in responding to complaints since July 2015.

[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.
[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

Figure 1: Number of complaints received

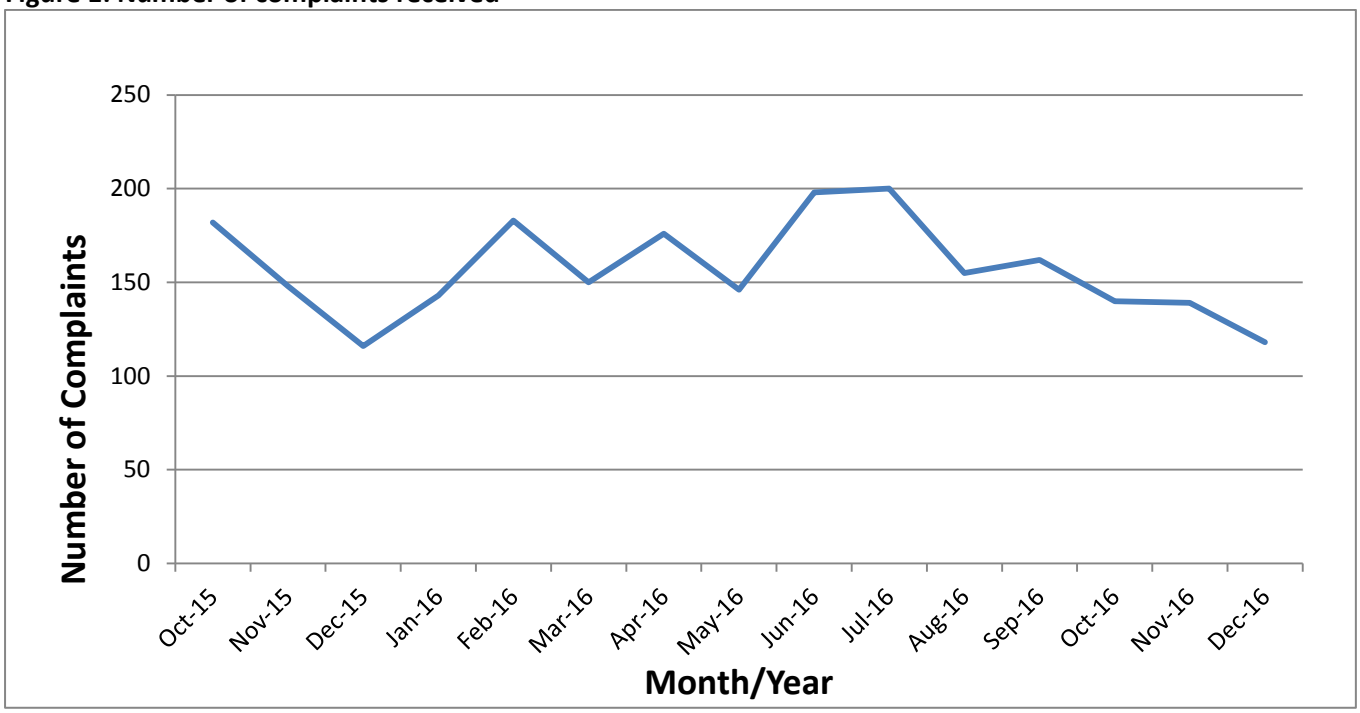


Figure 2: Complaints received, as a percentage of patient activity

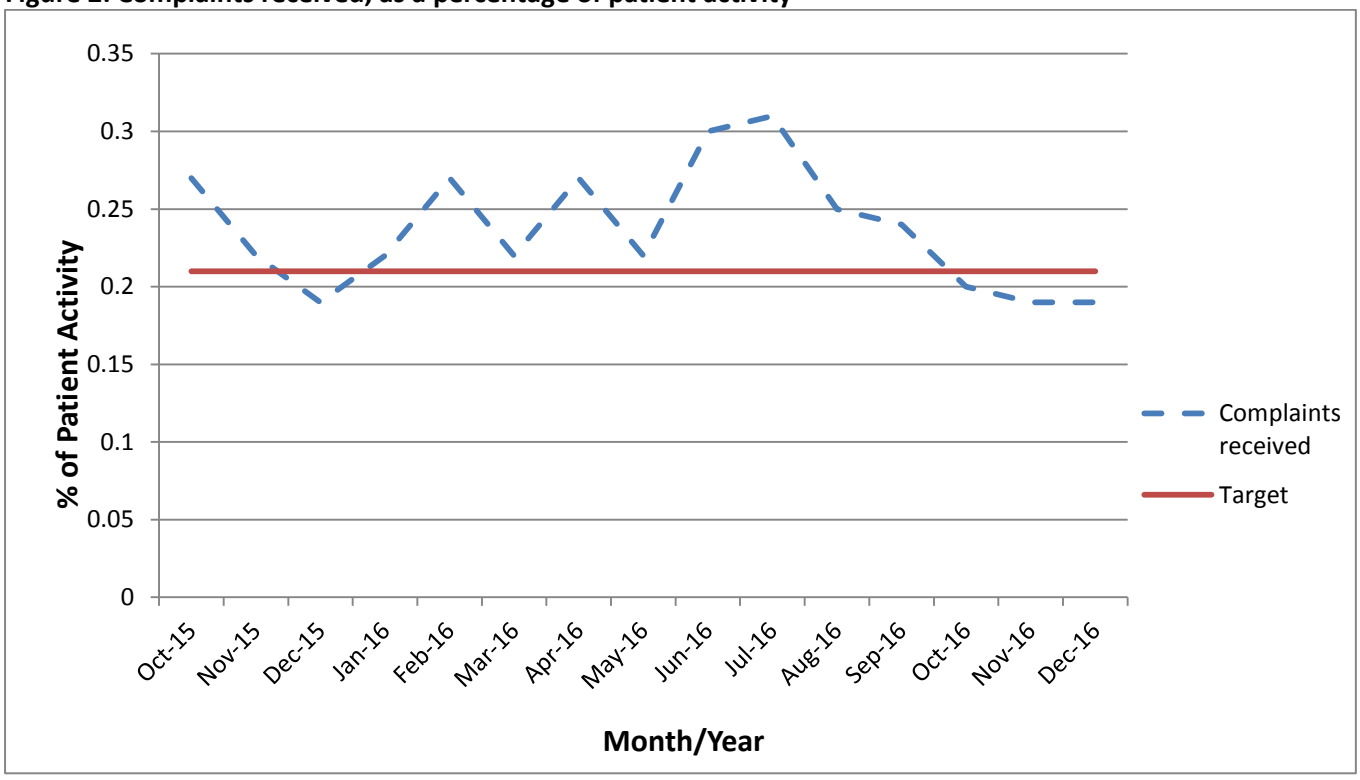


Figure 3: Numbers of formal v informal complaints

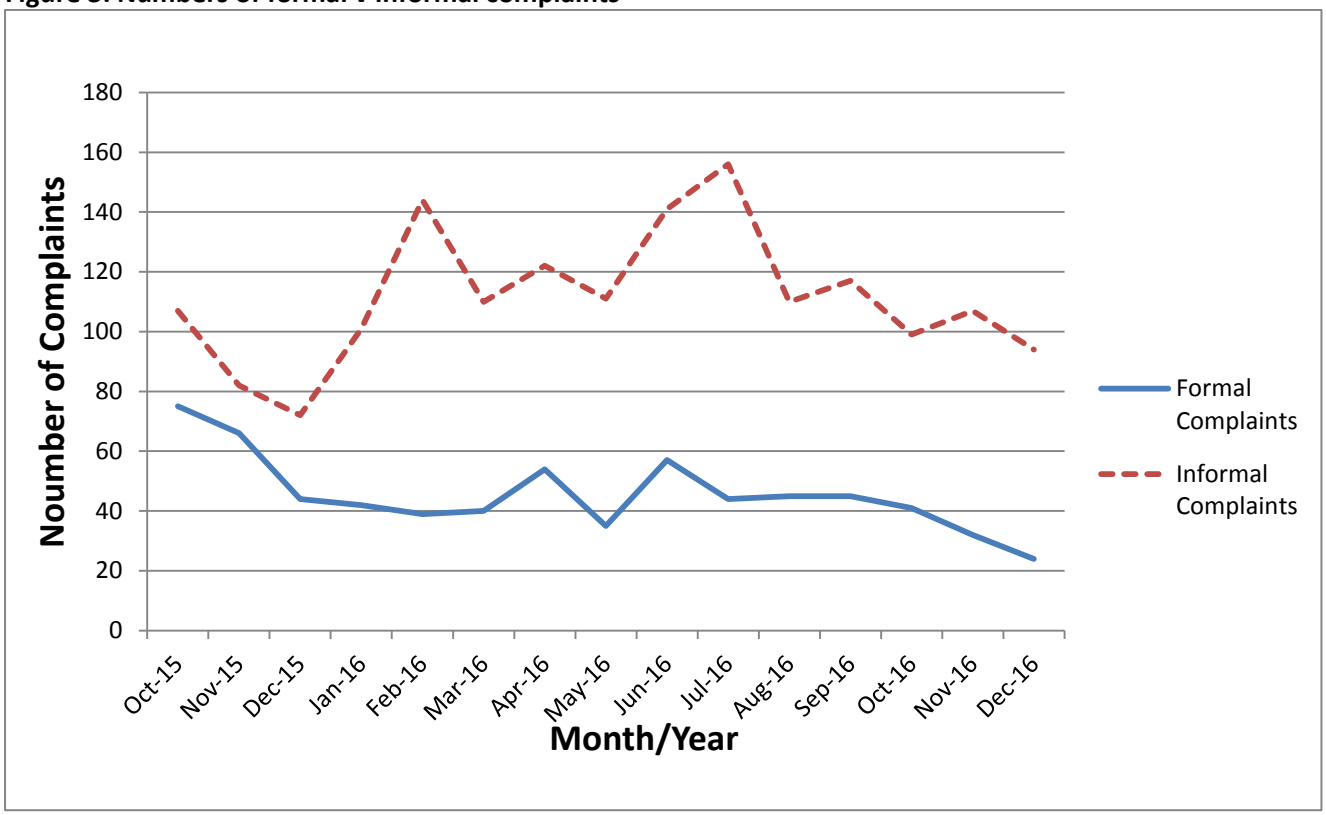


Figure 4: Percentage of complaints responded to within agreed timescale

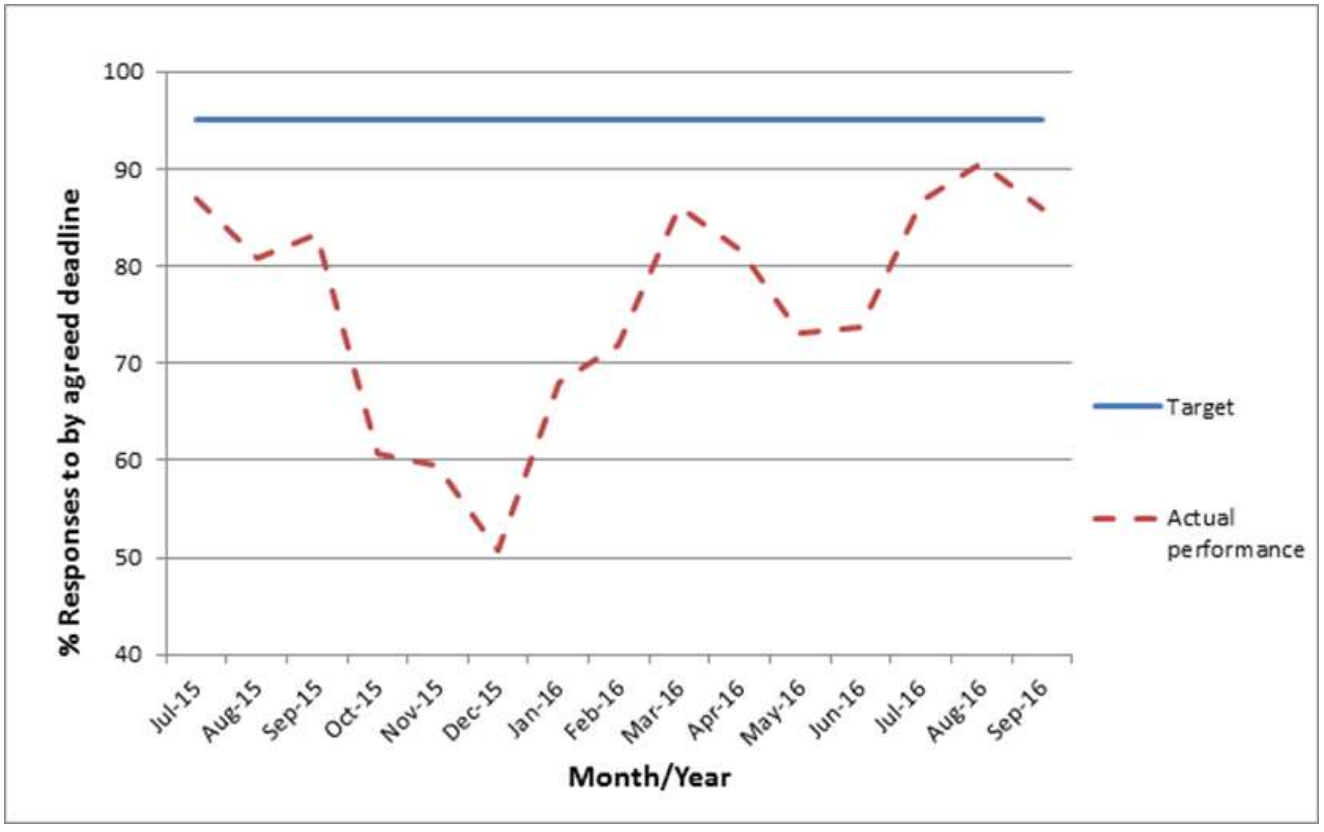


Table 1: Complaints performance

Items in italics are reportable to the Trust Board. Other data items are for internal monitoring/reporting to the Patient Experience Group where appropriate.

		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Total complaints received (inc. TS and F&E from April 2013)	TOTAL	182	148	116	143	183	150	176	146	198	200	155	162	140	139	118
	Formal	75	66	44	42	39	40	54	35	57	44	45	45	41	32	24
	Informal	107	82	72	101	144	110	122	111	141	156	110	117	99	107	94
Number and % of complaints per patient attendance in the month	%	0.27%	0.22%	0.19%	0.22%	0.27%	0.22%	0.27%	0.22%	0.30%	0.31%	0.25%	0.24%	20.37%	19.02%	19.02%
	Complaints	182	148	116	143	183	150	176	146	198	200	155	162	140	139	118
	Attendances	68,131	67,434	61,126	63,582	68,391	67,932	64,750	66,973	66,816	63,580	63,073	67,371	68,730	73,088	62,047
% responded to within the agreed timescale (i.e. response posted to complainant)	%	60.70%	59.50%	50.80%	68.10%	71.80%	86.10%	80.00%	73.10%	73.80%	86.80%	90.60%	86.00%	92.31%	93.44%	97.44%
	Within timescale	34	25	32	32	28	31	40	38	31	33	48	37	36	57	38
	Total	56	42	63	47	39	36	49	52	42	38	53	43	39	61	39
% responded to by Division within required timescale for executive review	%	80.40%	81.00%	90.50%	91.50%	84.60%	100%	86.00%	92.30%	92.90%	89.50%	94.30%	81.40%	92.31%	85.25%	76.92%
	Within timescale	45	34	57	43	33	36	43	48	39	34	50	35	36	52	30
	Total	56	42	63	47	39	36	50	52	42	38	53	43	39	61	39
Number of breached cases where the breached deadline is attributable to Division	Attributable to Division	7	7	20	12	10	5	3	8	7	4	4	4	2	3	1
	Total Breaches	22	17	31	15	11	5	9	14	11	5	5	6	3	4	1
Number of extensions to originally agreed timescale (formal investigation process only)		23	13	26	21	14	25	21	8	11	15	18	12	15	16	13
% of complainants dissatisfied with response and case re-opened	%	10.70%	4.80%	7.90%	6.40%	7.70%	8.30%	8.00%	9.60%	16.70%	10.50%	13.20%	18.6%	0%	9.83%	12.82%
	Reopened Dissatisfied	6	2	5	3	3	3	4	5	7	4	7	5	0	6	5
	Total Responses Due	56	42	63	47	39	36	50	52	42	38	53	43	39	61	39

1.3 Dissatisfied complaints

Reducing numbers of dissatisfied complainants was one of the Trust's corporate quality objectives for 2015/16 and remains a priority in 2016/17. We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are then dissatisfied with the quality of our investigation into and response to their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation to that we do not make the same mistake again. Our target is that nobody should be dissatisfied with the quality of our response to their complaint[3].

An additional level scrutiny of dissatisfied cases has been incorporated into the process for dealing with cases where the complainant is unhappy with our response. This involves the Head of Quality (Patient Experience and Clinical Effectiveness) reviewing all dissatisfied responses before they are sent to the Executives for sign-off. This additional review ensures that we are learning from these cases, i.e. is there anything we could or should have done differently in our original response. This learning is then shared with the Division responsible for the response.

The way in which dissatisfied cases are reported is expressed as a percentage of the responses the Trust has sent out in any given month. From Q3 2015/16 onwards, our target has been for less than 5% of complainants to be dissatisfied. This data is now reported two months' in arrears in order to capture the majority of cases where complainants tell us they were not happy with our response.

In Q3, of the 139 responses sent out in October, November and December 2016, and by the cut-off point of mid-January 2017 (the date on which the dissatisfied data for October 2016 was finalised); 11 people had contacted us to say they were dissatisfied. This represents 7.9% of the responses sent out during this period.

Previously, in Q2, a total of 134 responses were sent out. By the cut-off point of mid-October 2016 (the date on which the dissatisfied data for August 2016 was finalised), 19 people had contacted us to say they were dissatisfied with our response. This represented 14.8% of the responses sent out.

Figure 5 shows the percentage of complainants who were dissatisfied with aspects of our complaints response up until August 2016.

Each case where a complainant advises they are dissatisfied, the case is reviewed by the Patient Support and Complaints Officer. This review leads to one of the following courses of action, according to the complainant's preference:

- The lead Division is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues;

- The lead Division is asked to reinvestigate the outstanding concerns and arrange to meet with the complainant to address these issues

- On rare occasions, a letter may be sent to the complainant advising that the Trust feels that it has already addressed all of the concerns raised and reminding the complainant that if they remain unhappy, they have the option of asking the Ombudsman to independently review their complaint. This option might be appropriate if, for example, if a complainant

[3] Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response.

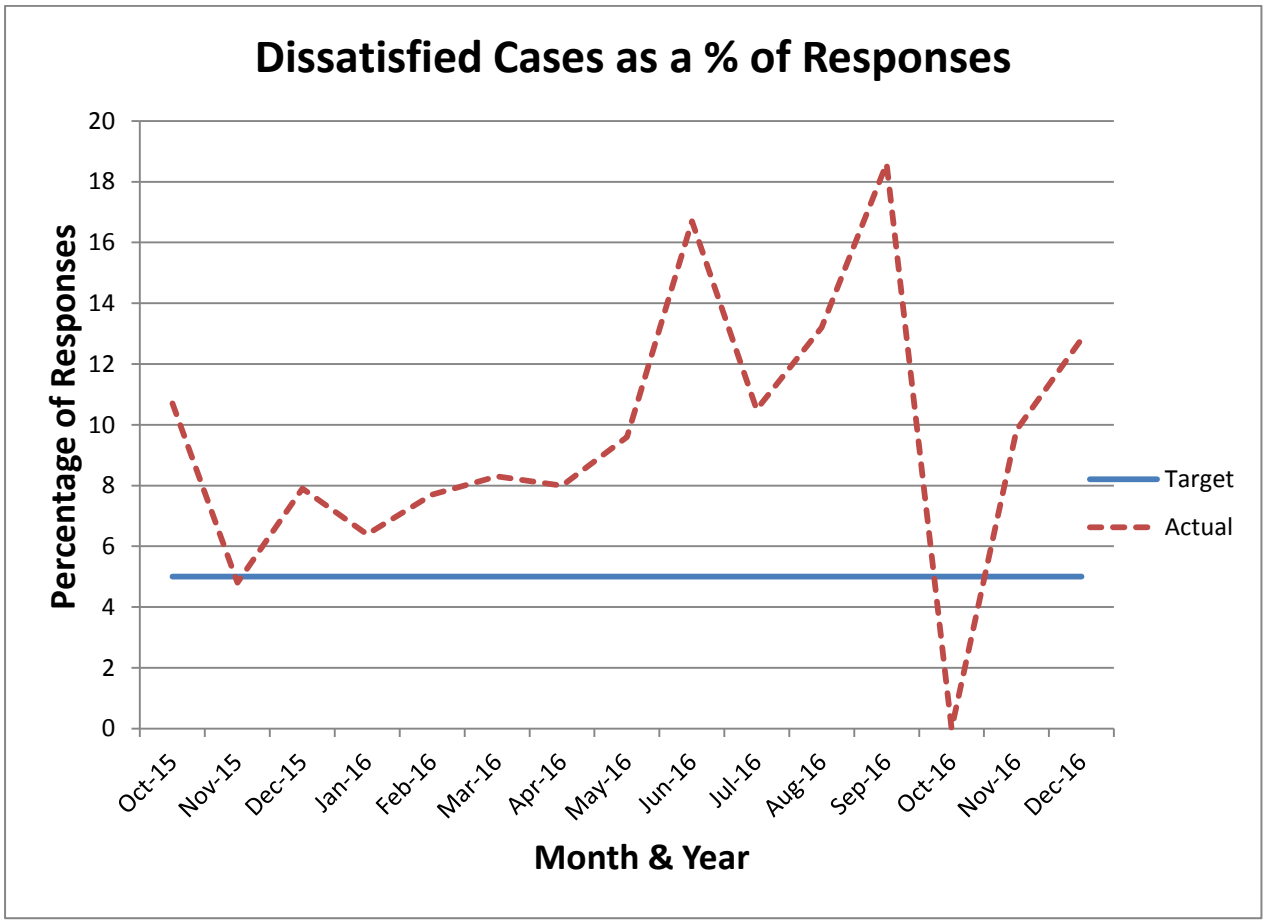
was disputing certain events that had been captured on CCTV and were therefore incontrovertible.

In the event that we do not have enough information to initiate the process outlined above, the allocated caseworker from the Patient Support and Complaints Team will contact the complainant to clarify which issues remain unresolved and, where possible, identify some specific questions that the complainant wishes to be answered. Following this, the process noted above would then be followed.

In all cases where a further written response is produced, the draft is reviewed by the Patient Support and Complaints Manager and by the Head of Quality (Patient Experience and Clinical Effectiveness) before sending it to an Executive Director for signing.

In the event that a complainant comes back to us again, having received two responses (whether in writing or by way of a meeting), the case will be escalated to the Chief Nurse for review.

Figure 5: Percentage of complainants dissatisfied with complaint response



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Table 2 provides a breakdown of complaints received in Q3 2016/17 compared to Q2 2016/17. The noteworthy changes compared to Q2 are the reductions of complaints in all categories/themes especially appointments and admissions (170 to 118) and a continued reduction of complaints about staff attitude and communication (116 to 99). Complaints about access also decreased from 10 in Q2 to 1 in Q3. This category includes complaints about physical access to our hospitals, services not being available and dissatisfaction with visiting hours.

Table 2: Complaints by category/theme

Category/Theme	Number of complaints received in Q3 (2016/17)	Number of complaints received in Q2 (2016/17)
Access	1 (0.2%) ↓	10 (1.9% of total complaints)
Appointments & Admissions	118 (29.7%) ↓	170 (32.9%)
Attitude & Communication	99 (24.9%) ↓	116 (22.4%)
Clinical Care	104 (26.2%) ↓	132 (25.5%)
Discharge/Transfer/Transport	20 (5.3%) ↓	28 (5.4%)
Documentation	3 (0.7%) =	3 (0.6%)
Facilities & Environment	20 (5.3%) ↓	26 (5%)
Information & Support	32 (8.6%) =	32(6.2%)
Total	**397**	**517**

Each complaint is also assigned to a more specific sub-category, for which there are over 100. Table 3 lists the ten most consistently reported sub-categories. In total, these sub-categories account for approximately two thirds of the complaints received in Q3 (397/517).

Table 3: Complaints by sub-category

Sub-category	Number of complaints received in Q2 (2016/17)	Q2 (2016/17)	Q1 2016/17	Q4 2015/16
Cancelled/delayed appointments and operations	66 ↓(37.7% decrease compared to Q2)	106	142	111
Communication with patient/relative	25 ↑ (8% increase complained to Q2)	23	34	62
Clinical Care (Medical/Surgical)	54 ↓ (10% decrease compared to Q2)	60	70	41
Failure to answer telephones/failure to respond	24 ↓ (11.1% decrease compared to Q2)	27	34	29
Clinical Care (Nursing/Midwifery)	13 ↓ (31.6% decrease compared to Q2)	19	22	25
Attitude of Medical Staff	14 ↓ (41.7% decrease compared to Q2)	24	23	18

Attitude of Admin/Clerical Staff	11 =	11	16	13
Attitude of Nursing Staff	5 ↓ (70.5% decrease compared to Q2)	17	12	8
Appointments Administration Issues *(new sub-category)*	15 ↓ (60.5% decrease compared to Q2)	38	20	-
Transport (Late/Non Arrival/Inappropriate)	2 ↓ (81.8% decrease compared to Q2)	11	6	2

Complaints about 'cancelled or delayed appointments or operations/procedures' have decreased from 106 in Q2 to 66 in Q3[4].

Figures 6, 7, and 8 show the four most commonly recorded sub-categories of complaint as detailed above, tracked since July 2015. These graphs suggest a deteriorating pattern in respect of complaints about cancelled or delayed appointments and operations since December 2015 and a similar rise in complaints about clinical care (medical/surgical). However, complaints about communication with patients/relatives have fallen significantly from a previous high point in February 2016 (one of the Trust's corporate quality objectives for 2016/17 is to reduce complaints about failures in communication).

Figure 6: Cancelled or delayed appointments and operations

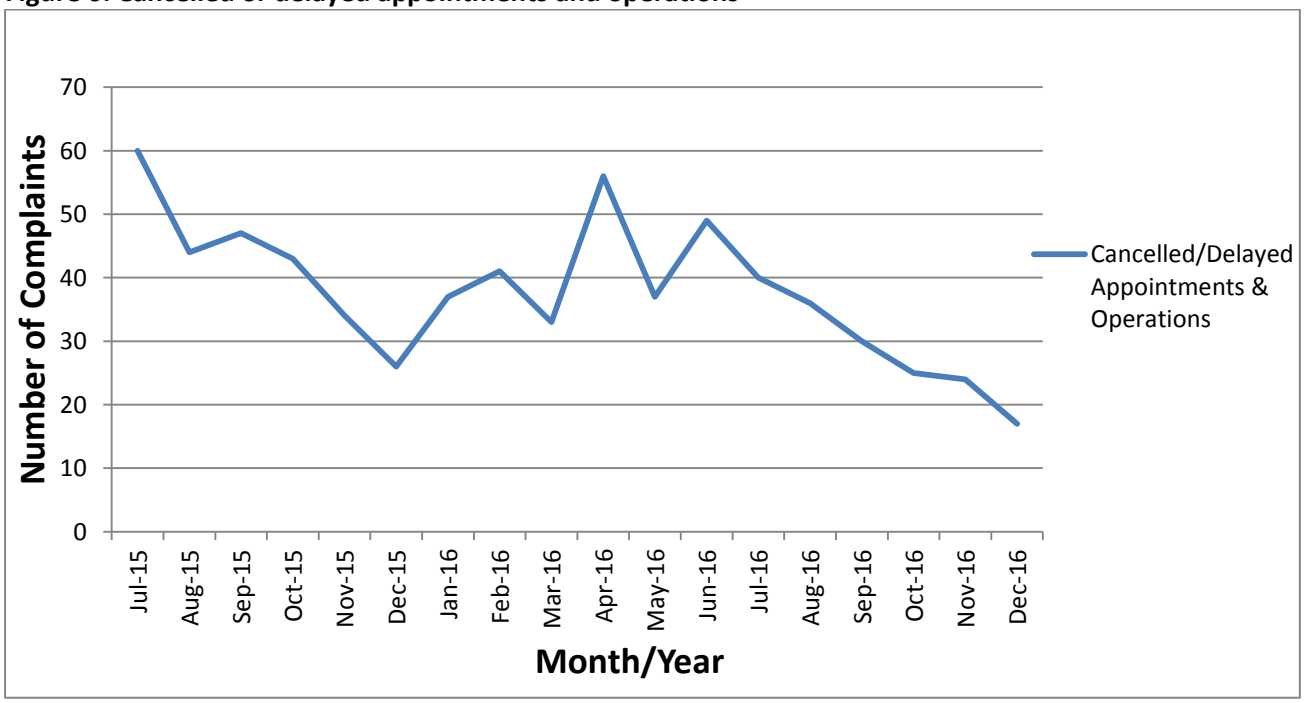


Figure 7: Clinical care – medical/surgical

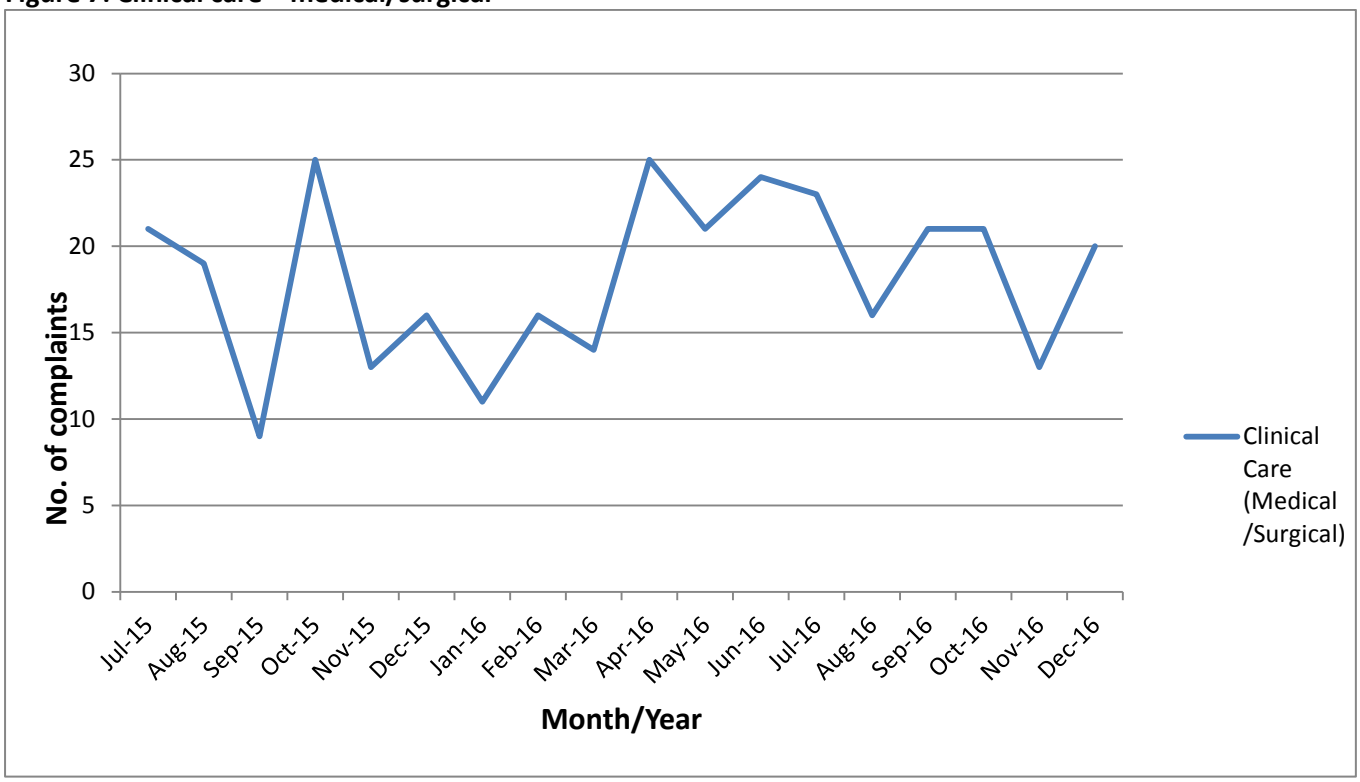
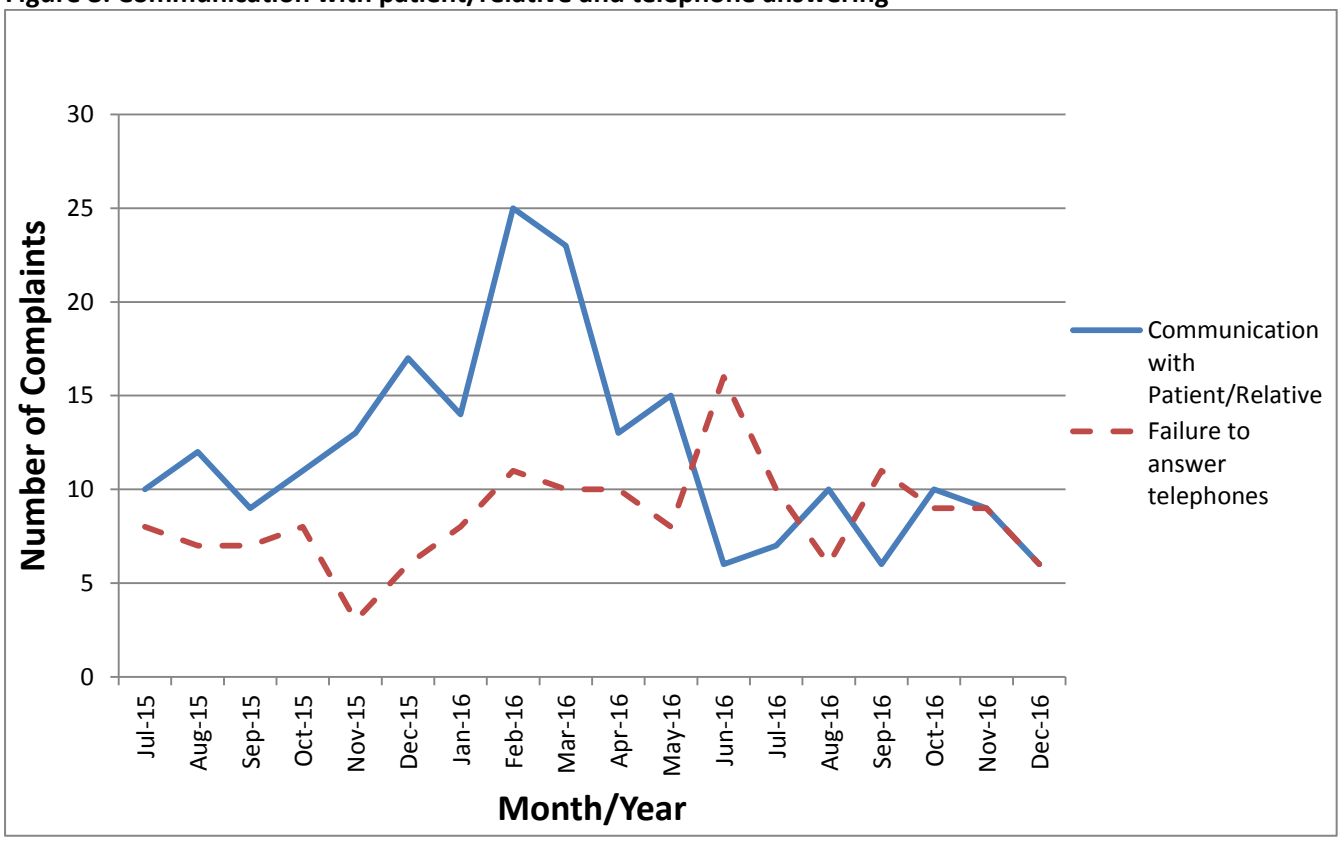


Figure 8: Communication with patient/relative and telephone answering

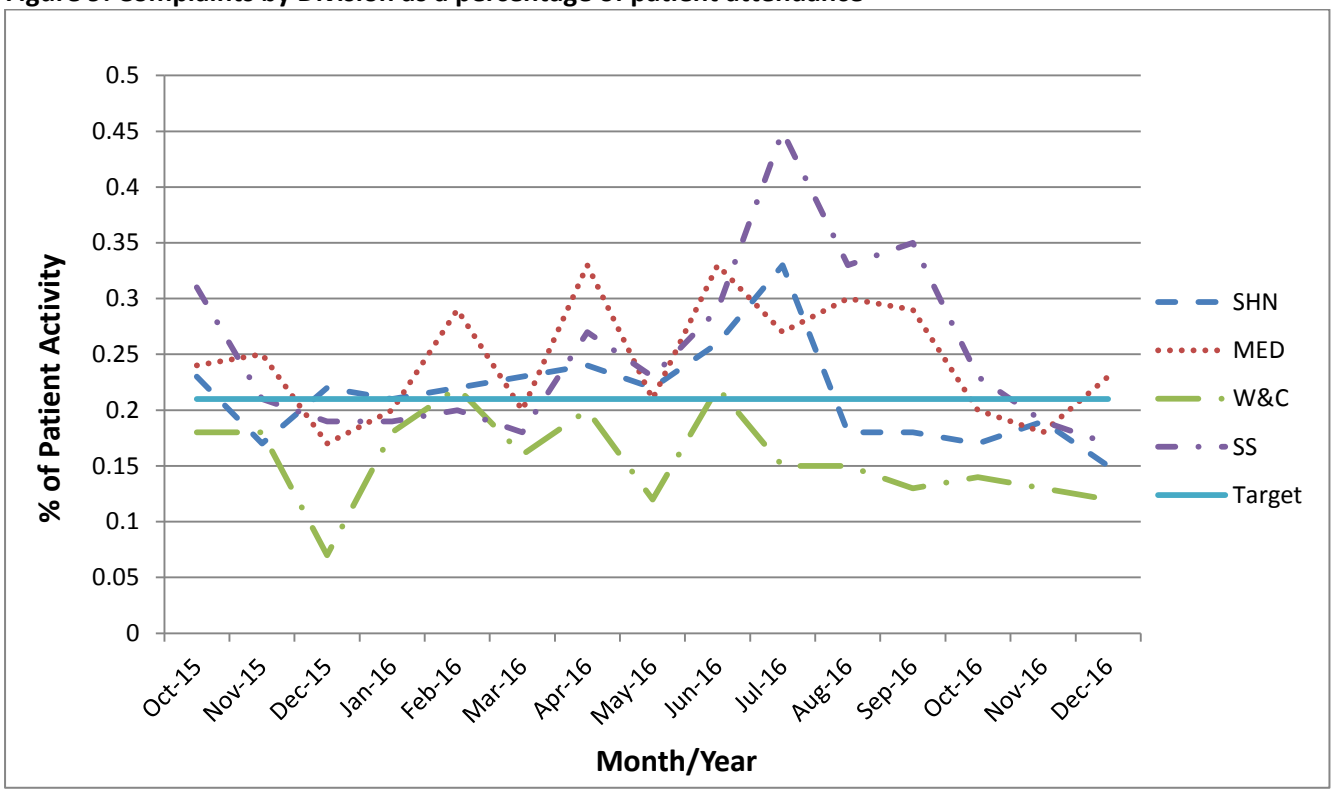


3. Divisional performance

3.1 Total complaints received

A divisional breakdown of the percentage of complaints per patient attendance is provided in Figure 9. This shows an overall increase in the volume of complaints received in the bed holding Divisions during Q4, with only Specialised Services showing a decrease in the number of complaints received.

Figure 9: Complaints by Division as a percentage of patient attendance



It should be noted that data for the Division of Diagnostics and Therapies is excluded from Figure 9 because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Overall, reported Trust-level data includes Diagnostics and Therapies complaints, but it is not appropriate to draw comparisons with other Divisions. Since July 2015, the number of complaints received by the division has been as follows:

Table 4: Complaints received by Division of Diagnostics and Therapies

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
No. of complaints received	12	5	7	5	13	6	5	7	12	4	9	6	7	3	7

3.2 Divisional analysis of complaints received

Table 5 provides an analysis of Q3 complaints performance by Division[5]. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 5	**Surgery, Head & Neck**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**
Total number of complaints received	145 (182) ↓	89 (123) ↓	49 (95) ↓	64 (62) ↑	17 (19) ↓
Total complaints received as a proportion of patient activity	0.19% (0.23%) ↓	0.21% (0.29%) ↓	0.2% (0.38%) ↓	0.13% (0.14%) ↓	N/A
Number of complaints about appointments and admissions	60 (87) ↓	20 (26) ↓	11 (27) ↓	15 (18) ↓	11 (6) ↑
Number of complaints about staff attitude and communication	41 (32) ↑	25 (34) ↓	7 (22) ↓	15 (15) =	3 (3) =
Number of complaints about clinical care	28 (37) ↓	30 (29) ↑	21 (32) ↓	23 (19) ↑	2 (6) ↓
Area where the most complaints have been received in Q3	Trauma & Orthopaedics – 37 (47) Bristol Eye Hospital – 33(40) Bristol Dental Hospital – 31(34) ENT – 13(10) Upper GI – 10(13)	Emergency Department (BRI) – 20(22) Dermatology – 9(18) Ward A300 (AMU) – 5(7) Rheumatology Department – 3(1)	BHI (all) – 41(66) BHI Outpatients – 11(11) GUCH Services – 7(21) Ward C708 – 5(11)	Gynaecology Outpatients (StMH) – 9(2) Children's ED & Ward 39 (BRHC) – 9(7) Paediatric Orthopaedics – 5 (5)	Physiotherapy – 5(4) Radiology – 3(8) Audiology – 3(4)
Notable deteriorations compared to Q2	None	None	None	Gynaecology Outpatients (StMH) – 9(2)	None
Notable improvements compared to Q2	Bristol Eye Hospital – 33(40)	Dermatology – 9(18)	BHI (all) – 41(66) GUCH Services – 7(21) Ward C708 – 5(11)	None	Radiology – 3(8)

[5] It should be noted that the overall percentage of complaints against patient activity as shown in Table 5 differs slightly from the overall Trust percentage of 0.24% as the latter includes complaints from non-bed-holding Divisions.

3.2.1 Division of Surgery, Head & Neck

In Q3, the Division of Surgery Head & Neck had an increase in complaints about attitude and communication (up from 32 in Q2 to 41 in Q3). There were significant decreases in complaints about discharge transfer and transport, and trauma and orthopedics. Complaints relating to the Bristol Eye Hospital have continued on a long term downwards (improving) trend.

Table 6: Complaints by category type

Category Type	Number and % of complaints received – Q3 2016/17	Number and % of complaints received – Q2 2016/17
Access	0 (0% of total complaints) ↓	2 (1.1% of total complaints)
Appointments & Admissions	60 (41.4%) ↓	87 (47.8%) ↓
Attitude & Communication	41 (28.3%) ↑	32 (17.6%) ↓
Clinical Care	28 (19.3%) ↓	37 (20.3%) ↓
Facilities & Environment	2 (1.4%) ↓	3 (1.6%) ↑
Information & Support	8 (5.5%) ↑	6 (3.3%) ↓
Discharge/Transfer/ Transport	6 (4.1%) ↓	12 (6.6%) ↑
Documentation	0 (0%) ↓	3 (1.6%) ↑
Total	**145**	**182**

Table 7: Top sub-categories

Category	Number of complaints received – Q3 2016/17	Number of complaints received – Q2 2016/17
Cancelled or delayed appointments and operations	35 ↓	49 ↓
Clinical Care (Medical/Surgical)	16 =	16 ↓
Communication with patient/relative	15 ↑	7 ↓
Attitude of Medical Staff	4 =	4 ↓
Attitude of Nursing/Midwifery	1 ↓	3 ↓
Attitude of Admin/Clerical Staff	2 ↓	4 ↓
Clinical Care (Nursing/Midwifery)	1 ↓	2 ↓
Failure to answer telephones	14 ↑	13 ↓

Figure 10: Surgery, Head & Neck – formal and informal complaints received

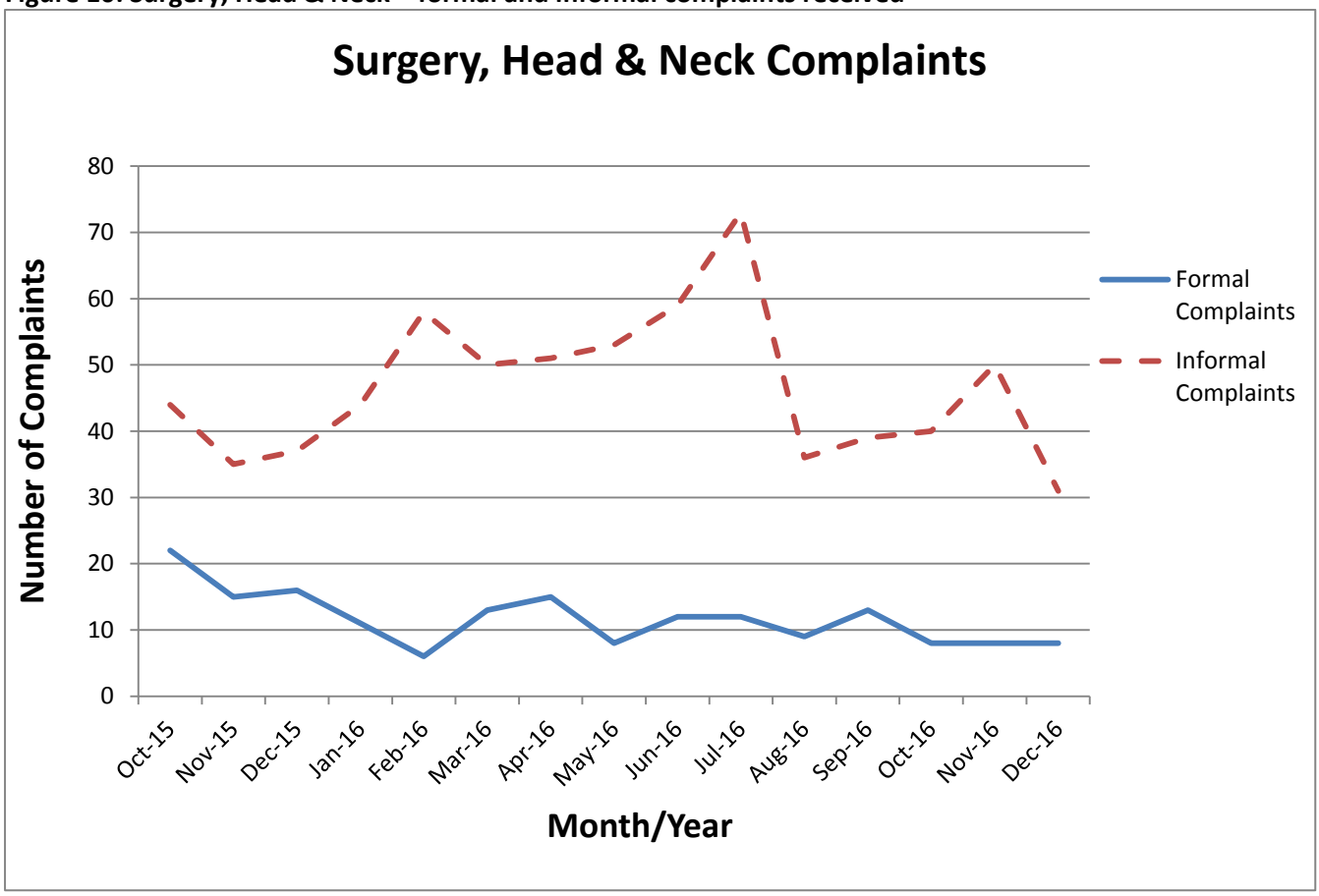
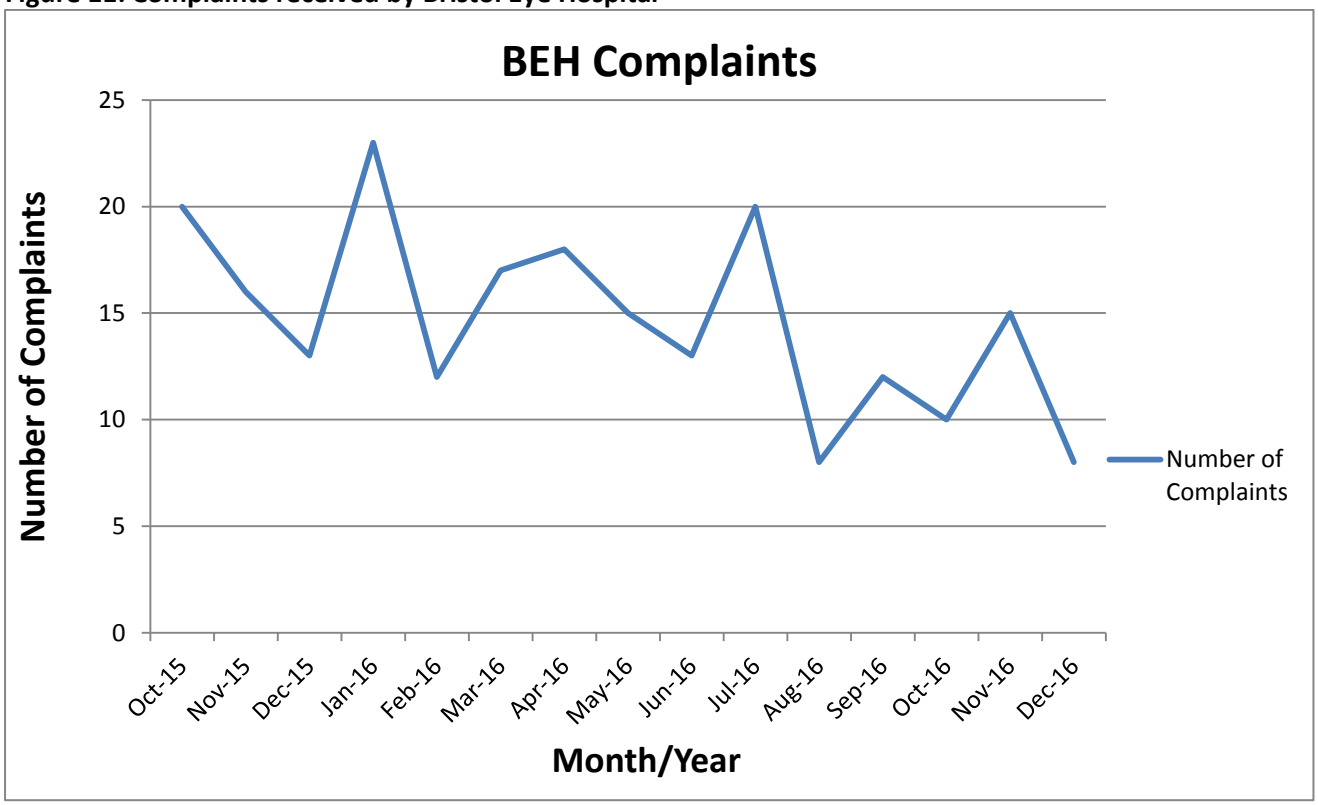


Figure 11: Complaints received by Bristol Eye Hospital



3.2.2 Division of Medicine

In Q3, there was a reduction in complaints in all major complaints categories except clinical care. Q3 data also shows a concerted shift toward informal resolution of concerns.

Table 8: Complaints by category type

Category Type	Number and % of complaints received – Q3 2016/17	Number and % of complaints received – Q2 2016/17
Access	0 (0%) ↓	2 (1.6% of total complaints) ↑
Appointments & Admissions	20 (22.5%) ↓	26 (21.1%) ↓
Attitude & Communication	25 (28.1%) ↓	34 (27.6%) ↓
Clinical Care	30 (33.7%) ↑	29 (23.6%) ↓
Facilities & Environment	6 (6.7%) ↓	9 (7.3%) ↑
Information & Support	3 (3.4%) ↓	9 (7.3%) ↑
Discharge/Transfer/ Transport	5 (5.6%) ↓	11 (8.9%) ↓
Documentation	0 (0%) ↓	3 (2.4%) ↑
Total	**89**	**123**

Table 9: Top sub-categories

Category	Number of complaints received – Q3 2016/17	Number of complaints received – Q2 2016/17
Cancelled or delayed appointments and operations	9 ↓	17 =
Clinical Care (Medical/Surgical)	15 ↑	14 ↓
Communication with patient/relative	4 ↓	5 ↓
Attitude of Medical Staff	3 ↓	9 ↑
Attitude of Nursing/Midwifery	1 ↓	7 ↑
Attitude of Admin/Clerical Staff	3 ↓	4 ↓
Clinical Care (Nursing/Midwifery)	6 ↓	5 =
Failure to answer telephones	5 ↓	6 ↑

Figure 12: Medicine – formal and informal complaints received

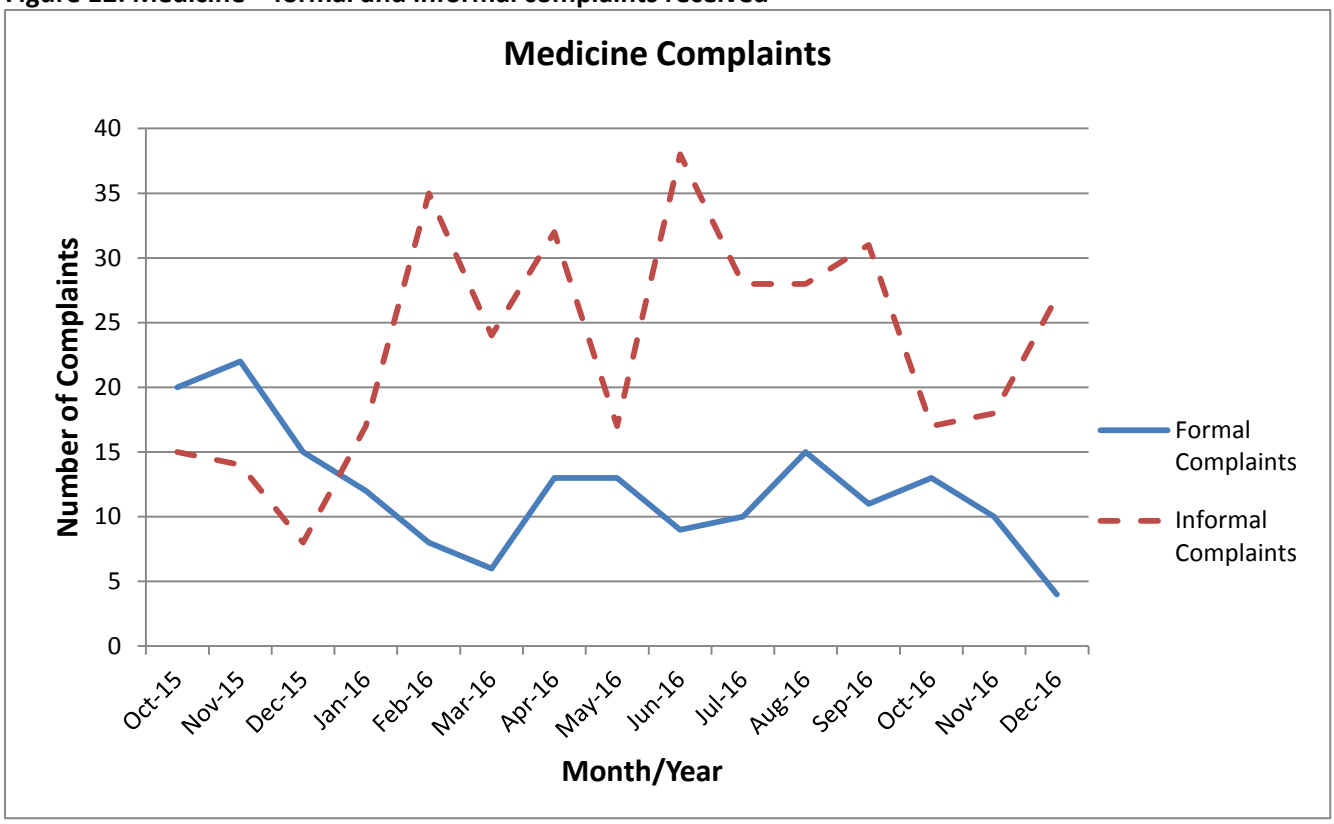
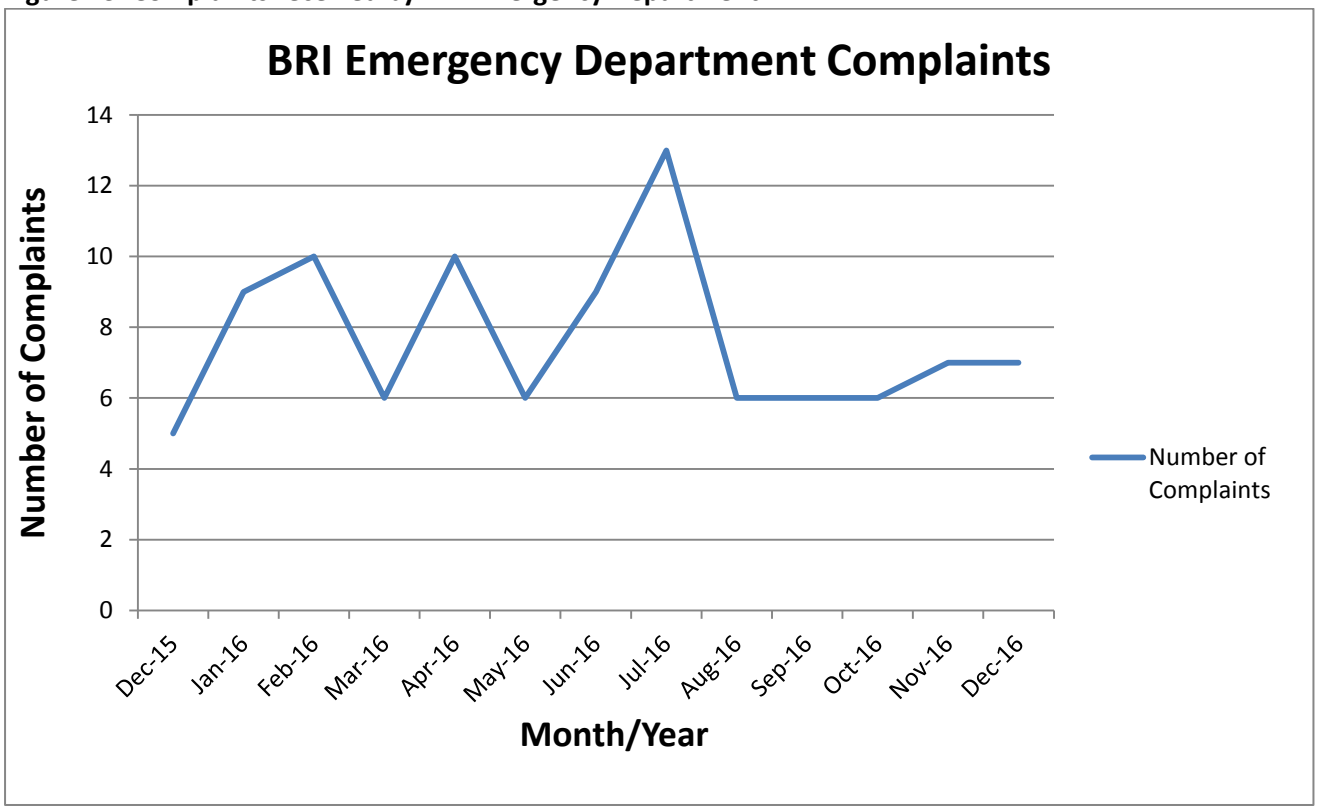


Figure 13: Complaints received by BRI Emergency Department



3.2.3 Division of Specialised Services

In Q3, the Division of Specialised Services experienced a significant decrease in complaints from 92 in Q2 to 49 in Q3. This included substantial reductions in complaints relating to cancelled or delayed appointments, and operations and clinical care.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q3 2016/17	Number and % of complaints received – Q2 2016/17
Access	0 (0% of total complaints) ↓	2 (2.18% of total complaints) ↑
Appointments & Admissions	11 (22.4%) ↓	32 (34.8%) ↑
Attitude & Communication	7 (14.3%) ↓	21 (22.8%) =
Clinical Care	21 (43.8%) ↓	31 (33.7%) ↑
Facilities & Environment	2 (4.0%) ↓	1 (1.09%) ↑
Information & Support	4 (8.2%) ↓	3 (3.2%) ↑
Discharge/Transfer/Transport	4 (8.2%) ↓	1 (1.09%) ↓
Documentation	0 (0%) ↓	1 (1.09%) =
Total	**49**	**92**

Table 11: Top sub-categories

Category	Number of complaints	Number of complaints received – Q2 2016/17
Cancelled or delayed appointments and operations	8 ↓	27 ↑
Clinical Care (Medical/Surgical)	10 ↓	17 ↑
Communication with patient/relative	3 ↓	5 ↓
Attitude of Medical Staff	2 ↓	5 ↑
Attitude of Nursing/Midwifery	0 ↓	2 ↑
Attitude of Admin/Clerical Staff	0 ↓	1 =
Clinical Care (Nursing/Midwifery)	3 ↓	4 ↑
Failure to answer telephones	0 ↓	5 =

Figure 14: Specialised Services – formal and informal complaints received

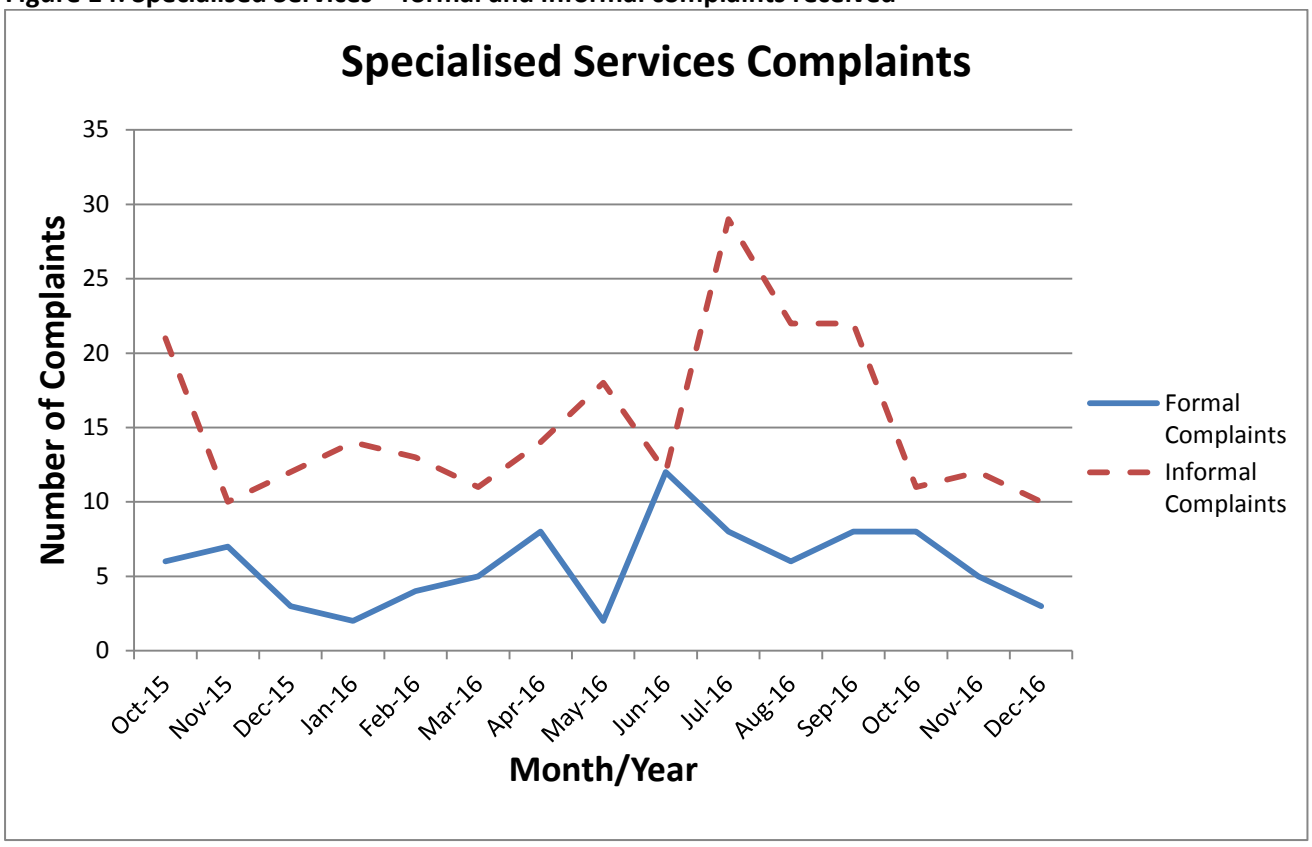
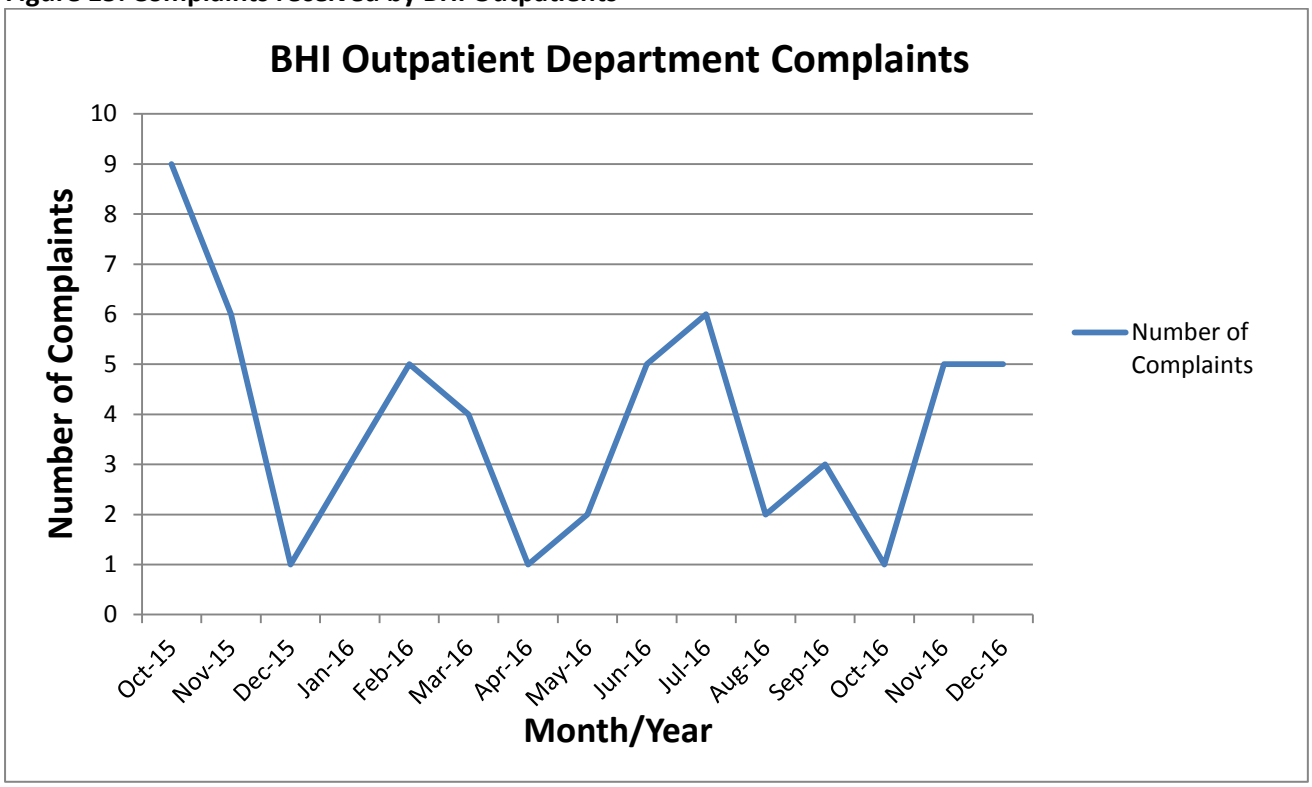


Figure 15: Complaints received by BHI Outpatients



3.2.4 Division of Women's and Children's Services

In Q3, the Division of Women's and Children's Services continued to receive fewer complaints about appointments and admissions. Complaints about clinical care however increased slightly in Q3 (from 19 to 23).

Table 12: Complaints by category type

Category Type	Number and % of complaints received – Q3 2016/17	Number and % of complaints received – Q2 2016/17
Access	0 (0% of total complaints) ↓	1 (1.6% of total complaints) ↑
Appointments & Admissions	15 (23.4%) ↓	18 (29%) ↓
Attitude & Communication	15 (23.4%) =	15 (24.2%) ↓
Clinical Care	23 (35.9%) ↑	19 (30.6%) ↓
Facilities & Environment	1 (1.6%) ↓	2 (3.2%) ↑
Information & Support	6 (9.4%) ↑	3 (4.8%) ↓
Discharge/Transfer/Transport	4 (6.2%) ↑	2 (3.2%) =
Documentation	0 (0%) ↓	2 (3.2%) ↑
Total	**64**	**62**

Table 13: Top sub-categories

Category	Number of complaints received	Number of complaints received
Cancelled or delayed appointments and operations	7 ↓	11 ↓
Clinical Care (Medical/Surgical)	13 ↓	7 ↓
Communication with patient/relative	2 ↓	4 ↑
Attitude of Medical Staff	5 ↓	6 ↑
Attitude of Nursing/Midwifery	3 ↓	4 ↑
Attitude of Admin/Clerical Staff	2 ↑	0 ↓
Clinical Care (Nursing/Midwifery)	3 ↓	7 ↑
Failure to answer telephones	1 =	1 ↓

Table 14: Divisional response to concerns highlighted by Q3 data

Concern	Explanation	Action
Complaints about Gynaecology (StMH) increased (from 2 to 9). Of these nine complaints received, three were in respect of appointment and admission issues. Two complaints were in respect of attitude and communication and three complaints were in respect of clinical care.	Four complaints related to a new consultant – concerns related to their attitude, communication and clinical care. One complaint was about lack of patient information on the management of miscarriage	Assistant divisional manager and medical lead have spoken with the new consultant and provided appropriate support for them in their new role. A leaflet is being developed for patients who are awaiting a second scan to determine viability of pregnancy.

Figure 16: Women & Children – formal and informal complaints received

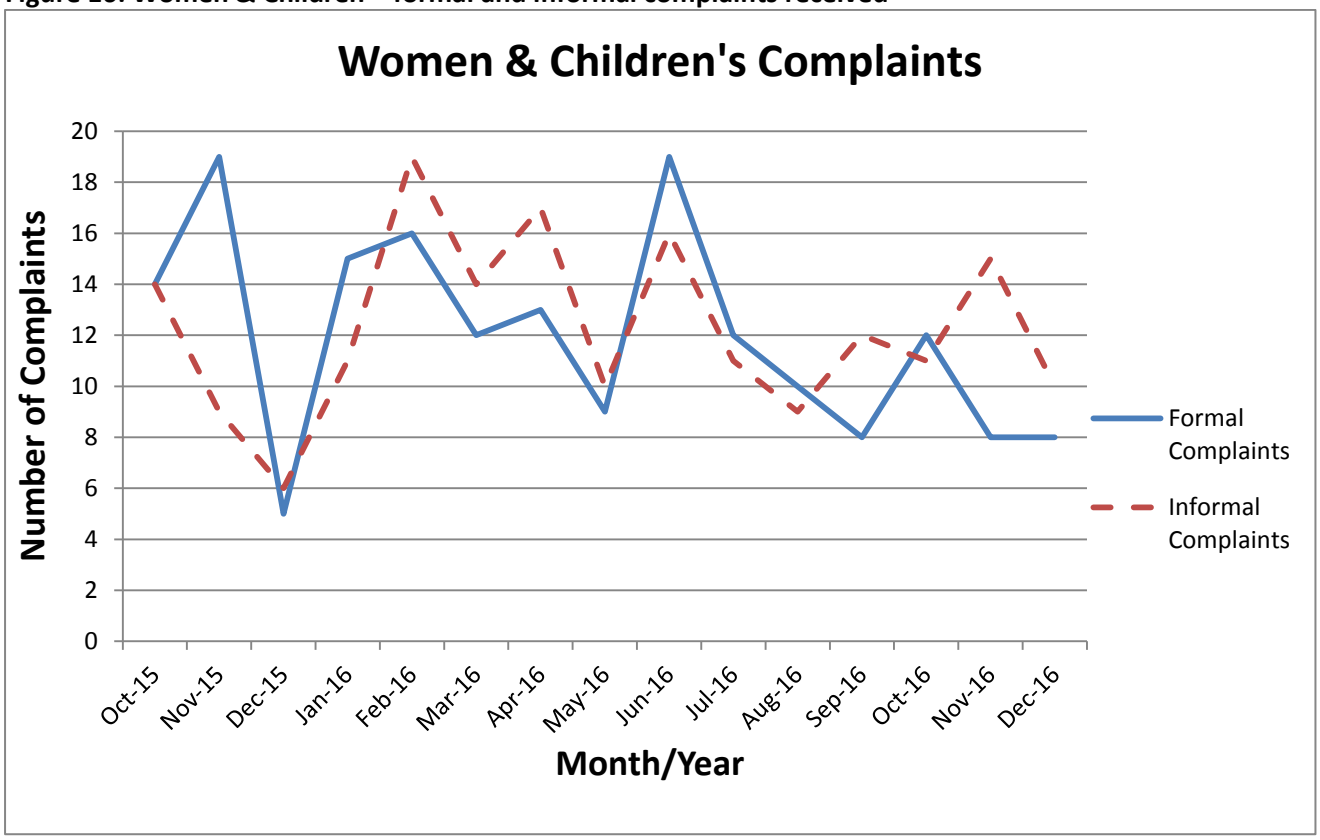
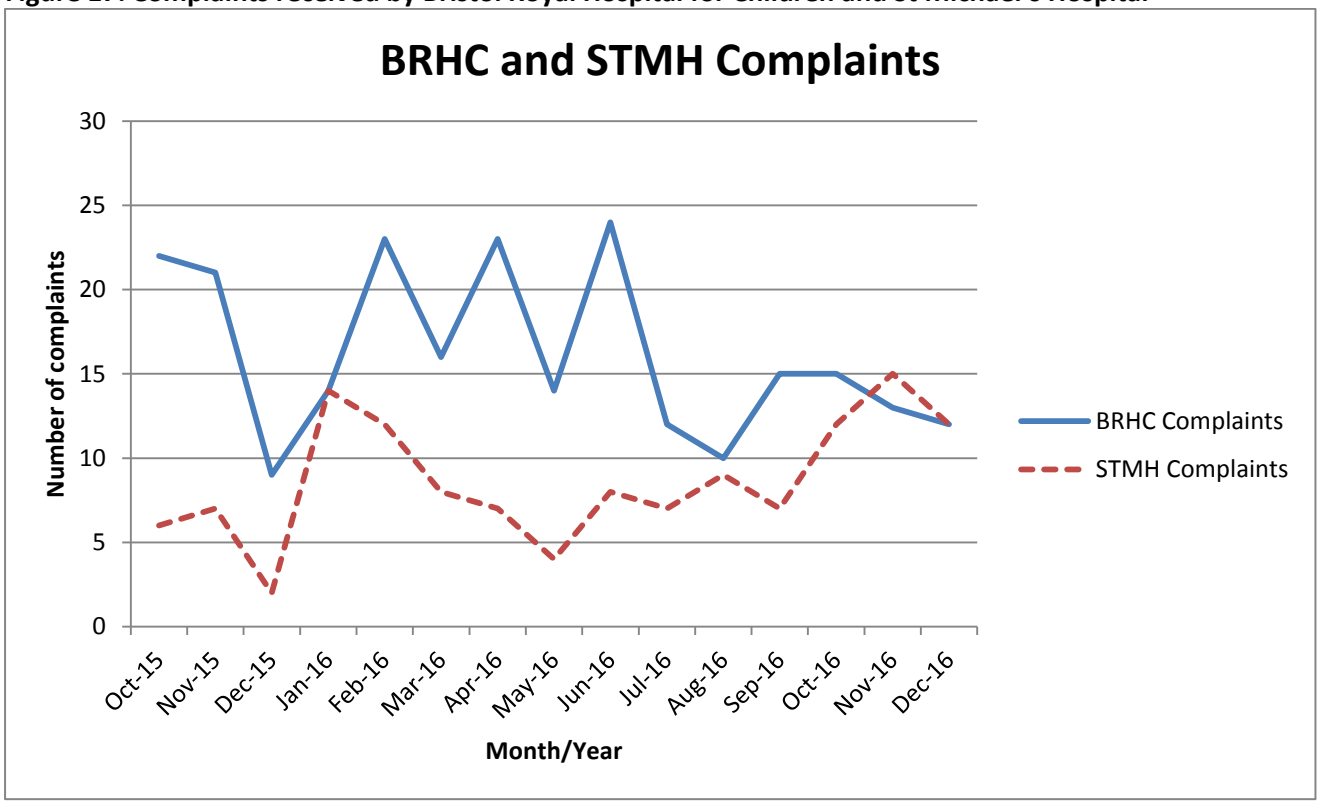


Figure 17: Complaints received by Bristol Royal Hospital for Children and St Michael's Hospital



3.2.5 Division of Diagnostics & Therapies

In Q3, complaints received by the Diagnostics and Therapies Division continued to fall from 19 to 17. However, there was a significant increase in the number of complaints received in Q3 regarding appointments and admissions (11 compared to 6 in Q2).

Table 15: Complaints by category type

Category Type	Number and % of complaints received – Q3 2016/17	Number and % of complaints received – Q2 2016/17
Access	0 (0% of total complaints) ↓	2 (10.5% of total complaints) ↑
Appointments & Admissions	11 (64.7%) ↑	6 (31.6%) ↓
Attitude & Communication	3 (17.6%) =	3 (15.8%) ↓
Clinical Care	2 (11.7%) ↓	6 (31.6%) ↓
Facilities & Environment	0 (0%) ↓	1 (5.3%) ↓
Information & Support	1 (5.9%) ↑	0 (0%) =
Discharge/Transfer/Transport	0 (0%) ↓	1 (5.3%) ↑
Documentation	0 (0%) =	0 (0%) =
Total	**17**	**19**

Table 16: Divisional response to concerns highlighted by Q3 data

Concern	Explanation	Action
Complaints regarding appointments and admissions increased (6 to 11). Of these seven complaints received, related to delayed appointments for Audiology, Neurophysiology and Adult Therapies. Three complaints were in relation to follow up appointments for Physiotherapy and one complaint related to the appointment reminder system for the Orthotic department.	An analysis of these complaints reveals no common themes, however examples of individual complaints are provided below: Examples of audiology complaints (both informal): Complaint received from MP regarding a patient who was unhappy with the delay in waiting for hearing aid repairs. Complaint from a patient who was requesting assistance in getting an earlier hearing test for their mother to fit in with a follow up consultation. Examples of physiotherapy complaints: Complaint from a patient who had to wait six months for a physiotherapy appointment	 The patient was offered an appointment the day before the MP's letter was received. The patient was provided with an appointment before the follow up consultation and they thanked the service for facilitating their request (via PSCT). The service apologised for the delay of six months and acknowledged that such a long

	(Women's Health).	wait was unacceptable. They confirmed that the target wait is 11 weeks and explained that this is a specialist area in physiotherapy that has a limited number of staff trained to carry out this work. The service explained to the complainant that it is striving to get back on track with this clinic by freeing up the physiotherapists from other duties to undertake this activity. Additional physical capacity is also being explored to support patients being seen in a timely fashion.
	Complaint from a patient's father who had difficulties obtaining physiotherapy appointments for their child.	The service was unable to offer the specific time and date requested by the family due to availability and explained to the complainant that patients are booked in order of priority. The complainant remained unhappy and, as an exceptional arrangement, the therapy service arranged for a senior physiotherapist from orthopaedics to treat the patient on the date requested. The Head of Therapies and Divisional Director also spoke personally with the complainant.

Figure 18: Diagnostics and Therapies – formal and informal complaints received

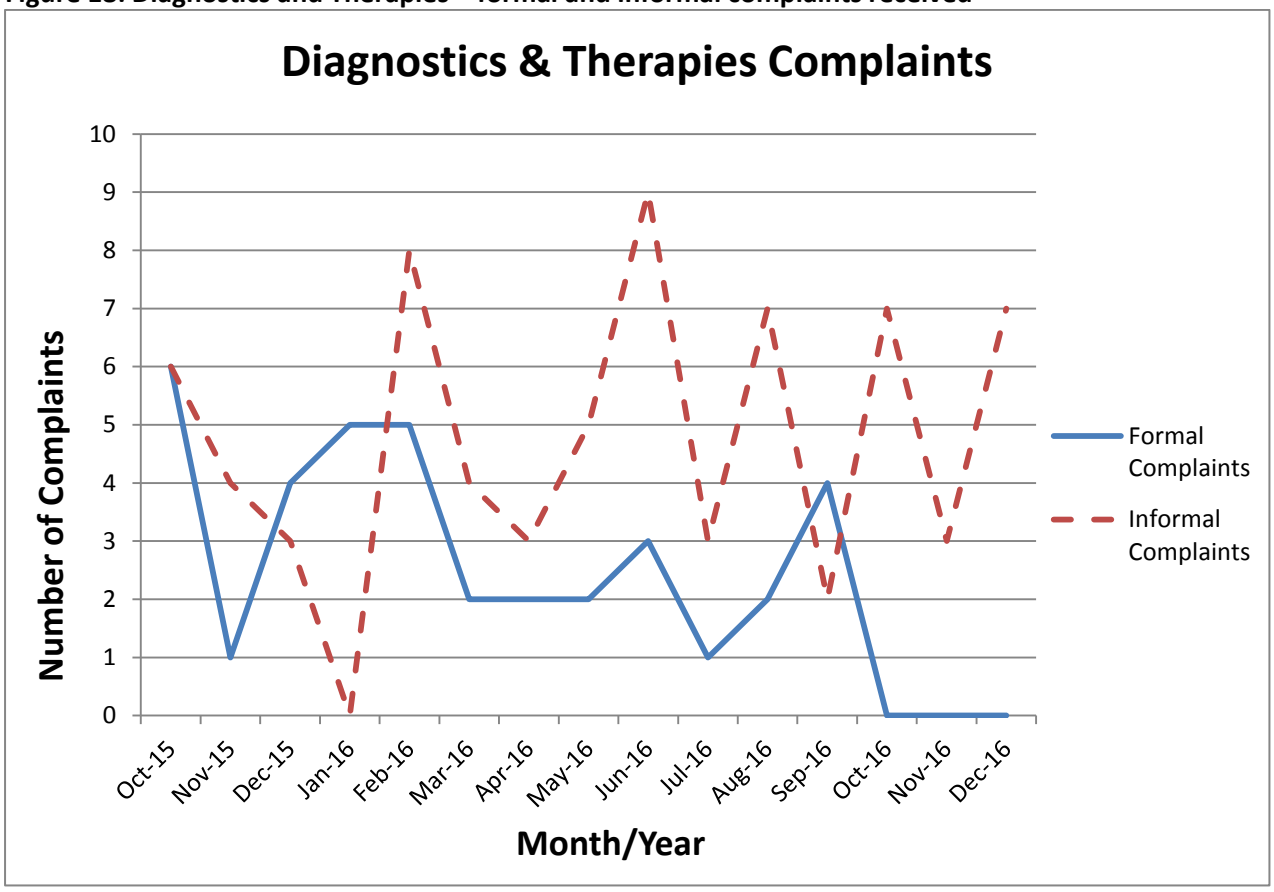
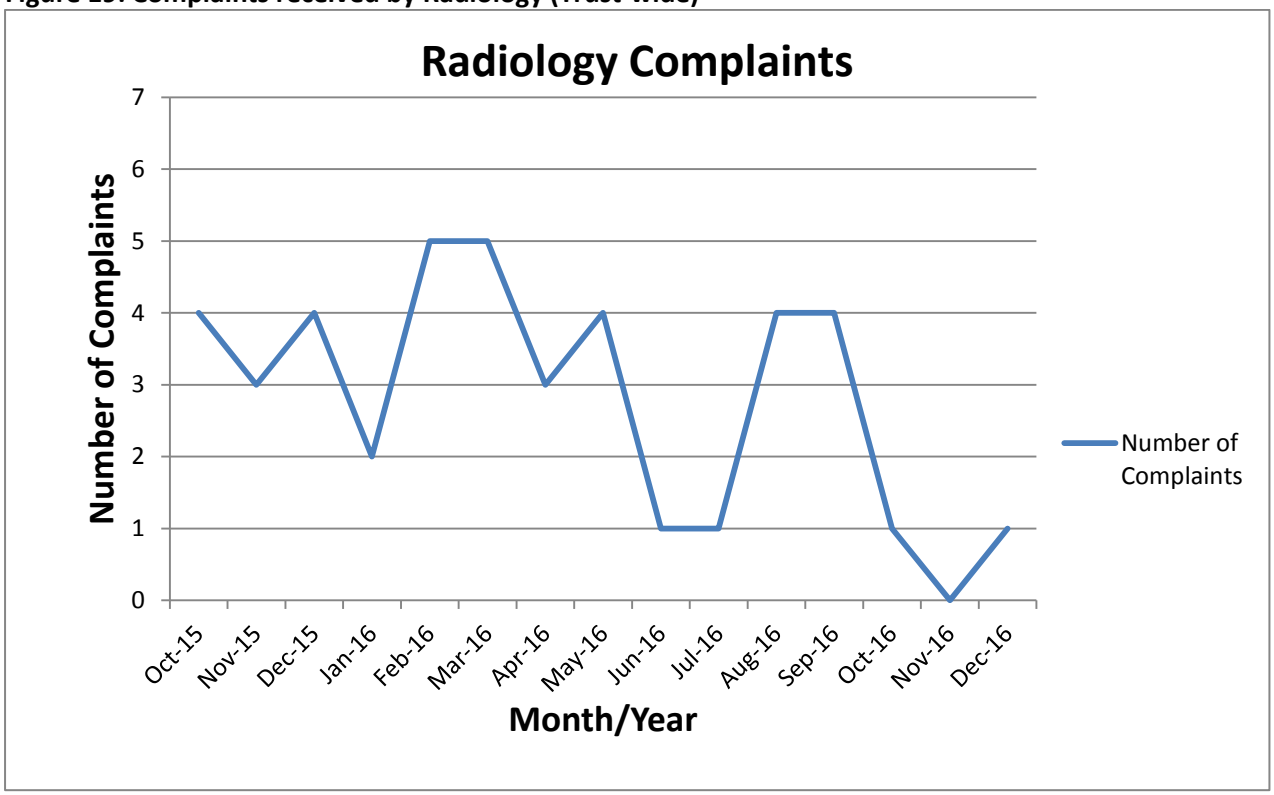


Figure 19: Complaints received by Radiology (Trust-wide)



3.3 Complaints by hospital site

Of those complaints with an identifiable site, the breakdown by hospital is as follows:

Table 17: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q3 2016/17	Number and % of complaints received in Q2 2016/17
Bristol Royal Infirmary (BRI)	178 (44.9%) ↓	234 (45.3%)
Bristol Eye Hospital (BEH)	33 (8.3%) ↓	41 (7.8%)
Bristol Dental Hospital (BDH)	29 (7.3%) ↓	34 (6.6%)
St Michael's Hospital (StMH)	39 (9.8%) ↓	40 (7.7%)
Bristol Heart Institute (BHI)	41 (10.3%) ↓	66 (12.8%)
Bristol Haematology & Oncology Centre (BHOC)	13 (3.3%) ↓	35 (6.8%)
Bristol Royal Hospital for Children (BRHC)	40 (10.1%) ↑	38 (7.4%)
South Bristol Community Hospital (SBCH)	11 (2.8%) ↓	12 (2.4%)
Trust Headquarters	2 (0.5%) ↑	0 (0%)
Southmead Hospital (UHB)	1 (0.2%)	1 (0.19%)
Central Health Clinic	2 (0.5%) ↓	7 (1.4%)
Car parks	2 (0.5%) ↑	1 0.19%)
Community Midwifery Services	0 (0%) ↓	2 (0.39%)
Community Sexual Health	0 (0%) ↓	1 (0.19%)
Other Trust Concerns	6 (1.5%) ↑	5 (0.84%)
Total	**397**	**517**

Table 18 below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints each hospital site receives is broadly in line with its proportion of attendances. For example, in Q3, the BRI accounted for 30.18% of all attendances and 44.9% of all complaints.

Table 18: Complaints rates by main hospital sites

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	178	61,389	0.29%	30.18%	44.9%
BEH	33	32,726	0.10%	16.09%	8.31%
BDH	29	22,894	0.13%	11.26%	7.30%
StMH	39	23,211	0.17%	11.41%	9.82%
BHI	41	5,043	0.81%	2.48%	10.3%
BHOC	13	18,023	0.07%	8.86%	3.27%
BRHC	40	33,136	0.12%	16.29%	10.08%
SBCH	11	6,971	0.16%	3.43%	2.77%
Other	15	472	3.18%	0.23%	3.78%
Total	**397**	**203,865**			

Figures 20 and 21 below show that the Bristol Royal Infirmary consistently receives more complaints than other UH Bristol sites, measured in terms of total complaints received. With the exception of the Bristol Heart Institute, the BRI also receives more complaints than other sites when measured as

a proportion of patient attendances. Reasons for this longstanding difference are currently being explored; one hypothesis being that this may be statistical artefact of a different inpatient to outpatient activity ratio. However, the number of complaints about the Bristol Royal Infirmary reduced significantly in Q3 (178 compared to 234 in Q2) reflecting the overall downward trend in complaints described in this report.

Figure 20: Complaints received by hospital site

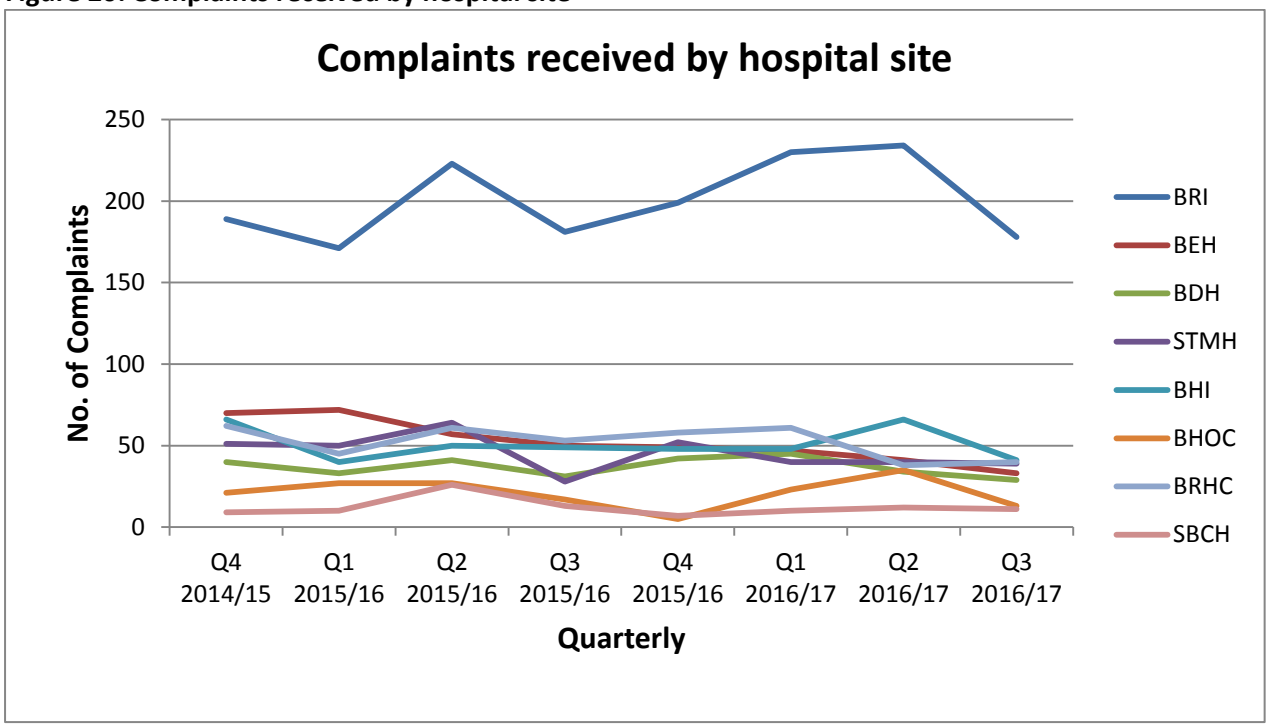
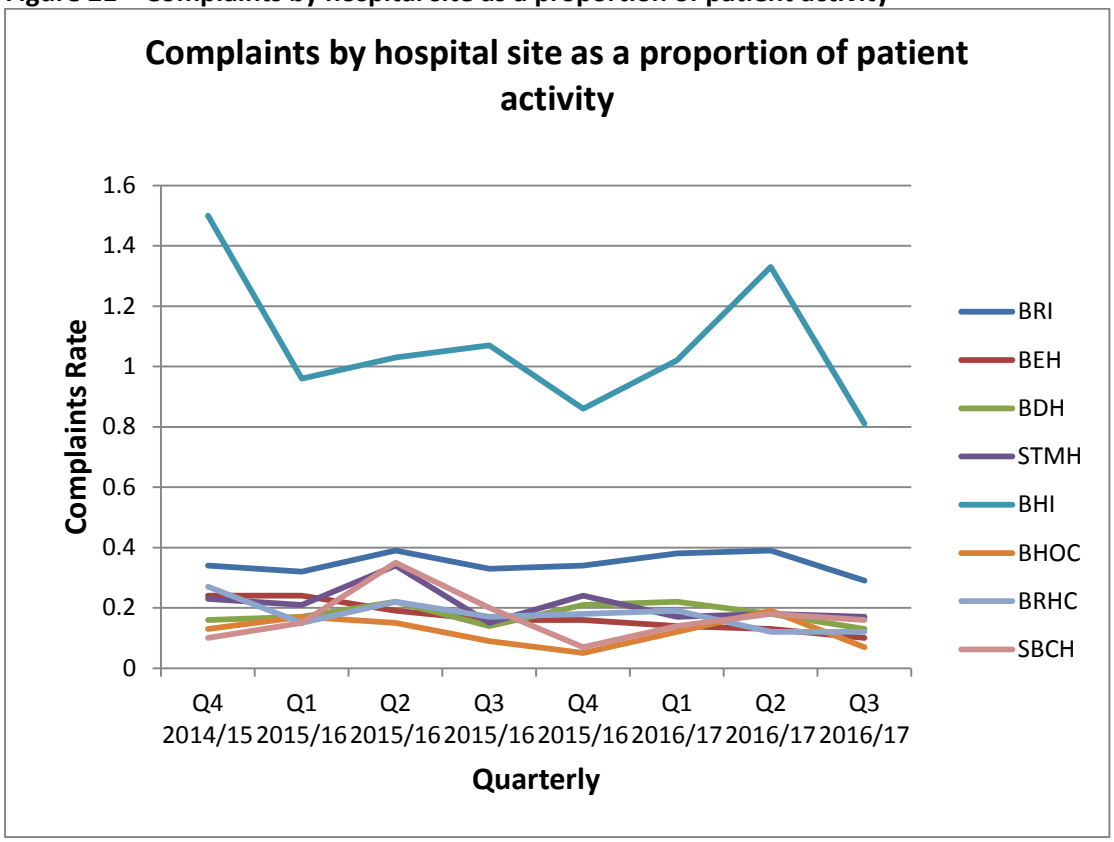


Figure 21 – Complaints by hospital site as a proportion of patient activity



3.4 Complaints responded to within agreed timescale

The Divisions of Surgery, Head and Neck, Specialised Services and Women and Children reported breaches in Q3, totalling eight breaches, which is a decrease on the 12 breaches recorded in Q2. Table 21 shows that the division of Specialised Services has recorded four breaches in Q3, compared to one breach in Q2, however there continues to be a quarterly pattern of reductions in breached deadlines across the clinical divisions.

Table 19: Breakdown of breached deadlines

Division	Q3 (2016/17)	Q2 (2016/17)	Q1 2016/17	Q4 2015/16
Surgery, Head & Neck	1 (0.69%)	0 (0%)	6 (14.6%)	10 (24.4%)
Medicine	0 (0%)	4 (11.1%)	12 (36.4%)	10 (28.6%)
Specialised Services	4 (8.9%)	1 (4.5%)	2 (15.4%)	3 (23.1%)
Women & Children	3 (4.7%)	5 (16.7%)	12 (30.8%)	8 (34.8%)
Diagnostics & Therapies	0 (0%)	0 (0%)	2 (18.2%)	0 (0%)
Trust Services	0 (0%)	2 (0.1%)	0 (0%)	0 (0%)
All	**8 breaches**	**12 breaches**	**34 breaches**	**31 breaches**

(So, as an example, there were four breaches of timescale in the division of Specialised Services in Q3, which constituted 8.2% of the complaints responses which had been due in that division in Q3).

Breaches of timescale were caused either by late receipt of draft responses from Divisions which did not allow adequate time for Executive review and sign-off; delays in processing by the Patient Support and Complaints Team; any delays during the sign-off process itself; and/or responses being returned for amendment. Sources of delay are shown in the table below.

Table 20: Source of delays

	Source of delays in Q3 2016/17				Totals
	Division	**PSCT**	**Executive sign-off**	**Other**	
Surgery, Head & Neck	1	0	0	0	**1**
Medicine	0	0	0	0	**0**
Specialised Services	4	0	0	0	**4**
Women & Children	1	2	0	0	**3**
Diagnostics & Therapies	0	0	0	0	**0**
Trust Services	0	0	0	0	**0**
All	**6**	**2**	**0**	**0**	**8 breaches**

Actions being taken to improve the quality of responses and reduce the number of breaches include:

- All response letters received from Divisions are checked by the caseworker managing the complaint and then reviewed by the Patient Support & Complaints Manager prior to Executive sign-off.
- A random selection of complaint responses are also reviewed by the Head of Quality (Patient Experience & Clinical Effectiveness) prior to Executive sign-off.
- Training aimed at improving the quality of written complaint responses is being rolled out to all Divisions, with two sessions having already been delivered at the time of writing this report.
- Standard Operating Procedures (SOPs) have been produced in respect of the process for checking and signing off response letters and for the escalation of more serious or complex complaints for Executive review.

- During Q4 of 2015/16, the process was changed to allow seven working days for the review and sign-off process.

3.5 Outcome of formal Complaints

In Q3 we responded to 97 formal complaints, table 21 below shows a breakdown, by divisions of how many cases were upheld, partially upheld or not upheld.

Table 21: Outcome of formal complaints

	Upheld	Partially Upheld	Not Upheld
Surgery, Head & Neck	5	21	9
Medicine	5	12	0
Specialised Services	1	9	3
Women & Children	2	20	5
Diagnostics & Therapies	0	1	1
Trust Services	0	1	2
Total	13	64	20

4. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with help and support, including:

- Non-clinical information and advice;
- A contact point for patients who wish to feedback a compliment or general information about the Trust's services;
- Support for patients with additional support needs and their families/carers; and
- Signposting to other services and organisations.

In Q3, the team dealt with 151 such enquiries, compared to 212 in Q2. These enquiries can be categorised as:

- 117 requests for advice and information (124 in Q2)
- 34 compliments (80 in Q2)[6]
- 1 request for support (8 in Q2)

The table below shows a breakdown of the 117 requests for advice, information and support dealt with by the team in Q3.

Table 22: Enquiries by category

Category	Number of enquiries
Information about patient	25
Hospital information request	15
Signposting	15
Clinical information request	14
Medical records requested	5

[6] This figure includes compliments added directly to the Datix system by Divisions.

Clinical care	5
Accommodation enquiry	5
Transport request	4
Employment and volunteering	4
Appointments administration issues	4
Support with access	3
Communication with patient/relative	2
Freedom of information request	2
Delayed appointment	2
Benefits and social care	1
Discharge arrangements	1
Expenses claim	1
Transfer arrangements	1
Personal property	1
Patient choice information	1
Confidentiality	1
Failure to answer phone	1
Privacy and Dignity	1
Services not available	1
Disability Support	1
Family support referral	1
Total	**117**

5. Acknowledgement of complaints by the Patient Support and Complaints Team

One of the Key Performance Indicators (KPIs) used by the Patient Support and Complaints Team is the length of time between receipt of a complaint and sending an acknowledgement.

The Trust's Complaints and Concerns Policy states that when the Patient Support and Complaints Team reviews a complaint following receipt:

- a risk assessment will be carried out;
- agreement will be reached with the complainant about how we will proceed with their complaint and a timescale for doing so;
- The appropriate paperwork will be produced and sent to the Divisional Complaints Coordinator for investigation; and
- An acknowledgement letter confirming how the complaint will be managed will be sent to the complainant.

The NHS Complaints Procedure (2009) states that complaints must be acknowledged within three working days. This is also a requirement of the NHS Constitution. The Trust's own policy states that complaints made in writing (including emails) will be acknowledged within three working days and that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q3, 233 complaints were received in writing (email, letter or complaint form) and 164 were received orally (18 in person via drop-in service and 146 by telephone). Of the 164 oral complaints, 163 (99.4%) met the Trust's standard of being acknowledged within two working days. Of the 233 complaints received in writing, 209 (89.7%) met the NHS standard of being acknowledged within

three working days (the remaining 24 cases were all acknowledged within four working days). Overall compliance in Quarter 3 was therefore 93.7% (372/397).

The reasons why 24 cases submitted in writing missed the NHS standard have been investigated. In the past, it has been routine practice to send an acknowledgement letter for all complaints received in writing – in effect, a holding letter. This practice stopped in 2016 at a point when the Patient Support and Complaints Team was responding to complaints in 'real time', i.e. complaints were being processed without delay. However, at a later point when the team was no longer able to respond immediately, the practice of sending acknowledgement letters was not reinstated. As of March 2017, we have reintroduced this as standard practice.

6. PHSO cases

During Q3, the Trust was advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in one complaint. During Q3, six existing cases were closed, four of which were not upheld and two of which were partially upheld. Actions and learning from the partially upheld cases are described below.

Table 23: complaints opened by the PHSO during Q3

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
2095	NH	MH	16/6/16 [26/10/16]	BRI	Lower GI	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO. Pending further contact from the PHSO.						

Table 24: complaints ongoing with the PHSO during Q3

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
3983	AG	LCY	29/9/15 [7/9/16]	BRI	Trauma and Orthopaedics	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO. The PHSO have advised the Trust that their draft decision is not to uphold this complaint. Pending the PHSO's final report.						
4841	AJ		9/11/15 [30/9/16]	BEH	Outpatients	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO on 17 November 2016. Currently awaiting PHSO response.						
17173	DF	DJ	29/10/14 [21/9/15]	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Currently awaiting further contact from the PHSO.						

18856	SC	VP	22/5/15 [15/2/16]	BRI	Ward B501	Medicine
Information relating to this case was most recently submitted to the PHSO in July 2016. Currently waiting to hear further from PHSO.						

Table 25: complaints closed by the PHSO during Q3

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received Trust [and date notified by PHSO]	Site	Department	Division
14561	HB	PB	5/12/13 [15/6/16]	STMH	ENT	Surgery, Head & Neck
The Trust has received the PHSO's final report - not upheld						
18315	SOC		19/3/15 [13/1/16]	BRI	Rheumatology	Medicine
The Trust has received the PHSO's final report - not upheld						
18318	SOC		27/3/15 [13/1/16]	BRI	Adult Therapy	Diagnostics & Therapies
Note: Case handled by PHSO in conjunction with 18315 The Trust has received the PHSO's final report - not upheld						
17763	AP-S	CW	16/1/15 [6/4/16]	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
The PHSO's report was received by the Trust on 3 June 2016 however the 'partially upheld' judgement was subsequently challenged by the Trust. Following discussion between UH Bristol consultants and the PHSO's clinical advisor, the 'partially upheld' judgement has been retracted and the case has not been upheld.						
18479	NK		9/4/15 [8/6/16]	BEH	Outpatients	Surgery, Head & Neck
The PHSO advised the Trust on 11 October 2016 that they have decided to partially uphold this complaint, pertaining to the adequacy of a pre-operative assessment prior to eye surgery and how the risks associated with the surgery were shared with the patient. The PHSO recommended that the Trust, within four weeks of the date of their final decision, write to the patient. In this letter the Trust should: • Acknowledge that the Trust failed to complete an adequate pre-operative assessment; • Acknowledge that the Trust failed to give the patient an adequate appraisal of the increased risks of surgery and increased likelihood of poor outcome in this case; • Acknowledge that the patient suffered distress because their treatment had not achieved the improvement they expected in their vision; • Pay the patient £400 in recognition of the distress the patient suffered in consequence of these failings. The PHSO also directed the Trust to develop an action plan to address the failings identified and said that where possible the Trust should explain any learning the Trust has taken from this complaint. A letter of apology and a cheque for £400 was sent to the patient on 16 November 2017.						

Note: since the end of Q3, a further letter and action plan has been sent to the patient detailing that the Trust's clinical lead has reviewed the details of this case with the manager of the pre-operative assessment service and concluded that the clinician who consented the patient on the day of surgery failed to note the patient's past medical history which was documented in his medical records. As a result he therefore did not discuss this with the patient or note the increased risk on the consent form.

The clinician concerned has since left the service however the clinical lead for the Bristol Eye Hospital has committed to ensuring that this situation does not occur again with any other surgeons and will be writing to all ophthalmic specialty leads reminding them of the need for careful review of patient records prior to consenting patients for cataract surgery where consent has not been completed by the pre-operative assessment department.

15534	AN		22/4/14 [12/4/16]	BDH	Adult Restorative Dentistry	Surgery, Head & Neck

The PHSO advised the Trust on 31 October 2016 that they have decided to partially uphold this complaint, pertaining to how the Trust responded to a patient's concerns about pain they were experiencing following wisdom tooth extraction surgery.

The PHSO considered all the available evidence related to the patient's complaint and did not find any failings in the wisdom tooth extraction surgery. However, they found that the follow up action, when the patient was experiencing pain, fell below the relevant standards, causing delays in a nerve damage diagnosis and further surgery caused the patient ongoing distress.

The PHSO recommended that within one month of the date of their report the Trust should:

- Write to the patient and acknowledge the failings identified in their report and apologise for the distress and additional pain caused;
- Pay the patient £1,000 for the injustice they have identified.

A letter was sent to the patient on 5 December 2016 and a cheque for £1,000 was sent on 15 December 2016.

The PHSO also directed the Trust to produce an action plan addressing the failings identified within three months of the date of the report.

Note: since the end of Q3, a covering letter and action plan have been sent to the patient explaining that the clinical leads for the Bristol Dental Hospital have agreed that patients should be reviewed if they raise concerns about altered sensation. At this review, after thorough examination to ensure that no immediate remedial treatment is required, patients will be advised to return should the sensation not resolve in order that the clinician can arrange for further review/treatment or onward referral depending on the patient's needs.

Learning was shared at the Bristol Dental Hospital oral and maxillofacial team meeting in January 2017 and the relevant patient information leaflet revised to include appropriate phone number to use to seek help; the leaflet was also altered following the initial complaint to include more information to direct patients who wish to investigate their treatment more thoroughly.

University Hospitals Bristol
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 3 2016/17

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1. Overview of patient-reported experience at UH Bristol: update since the last Quarterly Report

Successes	Priorities
• Consistently high service-user satisfaction scores were achieved in Quarter 3, with praise for staff being the most common feedback theme. 98% of inpatients would recommend the care to their friends and family • The Patient Experience at Heart workshops in maternity services have been shortlisted for a Health Services Journal national award. These workshops provide a forum for staff to discuss the delivery of a positive patient experience. • *#Conversations* (parent and patient engagement activities at the Bristol Royal Hospital for Children) has been shortlisted for a Patient Experience Network award	• For 2017/18, the Trust has been set a challenging response rate target for the outpatient Friends and Family Test by the Bristol Clinical Commissioning Group. An options appraisal has been carried out by the Trust's Patient Experience and Involvement Team, which supports the use of an SMS (text message) based approach in this setting. This has support in principle from the Trust's Outpatient Steering Group and a funding bid has been put forward (a decision in respect of this bid is anticipated in March 2017).
Opportunities	**Risks & Threats**
• In light of the Trust's new Quality Strategy, to enhance the collection and use of patient feedback via the procurement of a new "real-time feedback" IT system. A working group re-convened in early December 2016 to design the procurement specification. This project will move forward to a business case in April 2017, and then on to a formal tender exercise (if the current funding bid for this system is successful – a decision in respect of this bid is anticipated in March 2017).	The following wards received relatively low survey scores in Quarter 3 (a full exploration of these results is provided in Section 3 of the current report): • Wards primarily providing care to elderly patients: there is a consistent theme of relatively low survey scores for these areas (although it should be noted that the feedback is still very positive). This does not correlate with other quality data received by the Division, and we continue explore the reasons why these scores are occurring. • Postnatal wards received a relatively low Friends and Family Test score in Quarter 3. This may be linked to staffing levels on the wards in this period, as there was a high incidence of staff sickness (although these staffing levels were still within recommended limits). • In Quarter 3, there were a cluster of low survey scores in outpatient services around informing patients of delays in clinic. This theme is the focus of a corporate quality (improvement) objective. • Below target response rates in the Bristol Royal Hospital for Children Friends and Family Test survey (26% in Quarter 3, against a target of 30%): the Head of Nursing has discussed this with the ward teams and a positive improvement is evident in Quarter 4 to date (32%).

2. Update on recent and current Patient and Public Involvement (PPI) Activity

2.1 Overview

The UH Bristol Patient Experience and Involvement Team carries out a range of activities to ensure that patients and the public influence and shape the services that the Trust provides. There are three broad areas of work in this respect:

- The corporate Patient and Public Involvement (PPI) programme (principally the Involvement Network, *Face2Face* patient interviews, Patient Experience at Heart staff workshops, and the "15 steps challenge" – see Appendix B for a summary)
- Service-level PPI activity
- Engagement with partner organisations (e.g. Healthwatch, Patient's Association, local health and social providers)

This section of the Quarterly Report provides an update on key PPI developments/activity.

2.2 Corporate Patient and Public Involvement Programme

A plan of quarterly patient and public involvement projects for 2017/18 was agreed by the Patient Experience Group in December 2016:

- Quarter 1 (April-June 2017): Patient experience in care of the elderly services
- Quarter 2 (July-September 2017): exploring the theme of "customer service"
- Quarter 3 (October-December 2017): providing a positive patient experience to patients with a learning disability
- Quarter 4: "Quality Counts" – informing the Trust's corporate quality objectives for 2018/19

Specific improvement actions will be derived from these activities, but the main aim is to produce generalisable learning that can be used across the Trust to promote the delivery of a positive patient experience. This programme will form a spine of Patient and Public Involvement (PPI) work over 2017/18, with additional PPI activity in response to issues and themes as they arise over the year.

2.2.1 Involvement Network

In November 2016 members of the Involvement Network participated in an NHS Improvement Quality and Safety review at the Trust. These Involvement Network participants have since gone on to volunteer for the Trust's Patient Led Assessments of the Care Environment (PLACE) inspections in 2017.

The "Quality Counts" event was held January 2017, where members of the Trust's Involvement Network engaged with UH Bristol colleagues (including the Chief Nurse, Medical Director) to talk about the attitudes, behaviours and actions that define outstanding customer care. The ideas generated by the Quality Counts event are being used to inform the development of the Trust's corporate quality objectives for 2017/18[1].

2.2.2 Face2Face volunteer interview programme

In a joint project between the Patient Experience and Involvement Team, the Trust's Redevelopment Project Office, and Ecofund Partners Ltd (who worked with the Trust on the new external cladding for the Bristol Royal Infirmary), during February 2017 members of the *Face2Face* interview team talked to patients and members of

[1] Corporate quality objectives are a set of Trust-wide service improvement goals.

the public about the impact the new façade to the front of the Bristol Royal Infirmary has had on their perception of the hospital. The feedback received was generally very positive, as these examples demonstrate:

> "It's so much better. I want to come here now!"
> "Feels welcoming. The entrance in particular reminds me of my hospital back home (Honduras)"

2.2.3 Patient Experience at Heart

Patient Experience at Heart is a facilitated workshop where maternity staff reflect on how they can deliver a positive patient experience. There are plans in place to roll this model out to "care of the elderly services" in the Division of Medicine. It was anticipated that this would take place in Quarter 3, but due to service pressures this was not possible. However, in Quarter 1 (April-June 2017) the thematic focus of the Patient Experience and Involvement Team will be on care of the elderly services (see page 3) and this will involve two Patient Experience at Heart workshops (one in April and one in June).

UH Bristol's Patient Experience at Heart workshops in maternity services have been shortlisted for the 2017 Health Services Journal Value in Healthcare Awards. A presentation will be made to the judging panel at the end of March, with the awards announced in May 2017.

2.3 Service-level Patient and Public Involvement activity

A wide range of PPI activity is carried out at UH Bristol and, at each meeting of the Trust's Patient Experience Group, a Patient and Public Involvement (PPI) Activity Log is reviewed. A notable recent project involves Sexual Health Services in Bristol. This service was subject to a re-tendering exercise in 2016, with the contract awarded to UH Bristol. A number of service changes are planned and colleagues at the Bristol Sexual Health Centre have been engaging stakeholders in conversations about these proposals. This included working with Healthwatch to plan and deliver an information and consultation event at The Care Forum in December 2016. The team are also working with service users to agree the branding of the new service, which goes live on 1 April 2017.

An ongoing series of patient and family engagement events at the Bristol Royal Hospital for Children (#Conversations), led by the management team and staff with support from the Trust's Patient Experience and Involvement Team, has been shortlisted for a national award by the Patient Experience Network.

2.4 Engaging with partner organisations

As noted in the previous Quarterly Report, Healthwatch Bristol carried out an "enter and view" of inpatient areas at South Bristol Community Hospital in October 2016. In general positive feedback was received:

"Inpatient wards 100 and 200 at South Bristol Community Hospital are to be commended for providing a friendly, caring, clean and functional environment for stroke and rehab' patients to recover in. It was clear that the staff team were happy in their work, treated well by UHB and dedicated to aiding patient recovery. Patients and visitors said very complimentary things about the staff team."

(Healthwatch, South Bristol Community Hospital enter and view report, December 2016)

Several improvement opportunities were identified by Healthwatch. In respect of clinical care, these included:

- A review of staffing levels to ensure that there are enough nurses on the ward, and the employment of a "floating" member of the nursing team who can be assigned to different inpatient areas depending on need
- Closer liaison with social care to ensure timely discharge from hospital

Reassurance has been provided to Healthwatch that at least daily reviews of staffing levels are carried out to ensure these are at safe / recommended levels. A "floating" member of staff is already employed in the capacity described above. In terms of discharge from hospital, Healthwatch were advised that a "discharge hub" is in operation that brings together staff from UH Bristol, Bristol Community Health and Bristol City Council, to ensure that care packages and onward arrangements for patients are coordinated effectively.

Most of the recommendations from Healthwatch focussed on non-clinical aspects of care. In particular, it was highlighted that many inpatients at South Bristol Community Hospital have relatively long stays for rehabilitation, so it is important to ensure that they have access to magazines, activities, and the hospital café. It is recognised that there are opportunities to improve in this respect and so a review of non-clinical care at the hospital will take place in Quarter 1 2017/18.

The Trust's Patient Experience Group received South Bristol Community Hospital's full response to the Healthwatch enter and view in February 2017, and will monitor progress against the resulting actions.

3. Patient survey data

3.1 Trust-level patient reported experience

The Trust's Patient Experience and Involvement Team is also responsible for measuring patient-reported experience, primarily via the Trust's patient survey programme[2]. This ensures that the quality of UH Bristol's care, as perceived by service-users themselves, can be monitored on an ongoing basis to ensure that high standards are maintained. It should be noted that the postal survey methodology changed in April 2016, to provide the data a month earlier than had previously been the case: this appears to have had a marginally positive effect on the scores, so caution is needed in directly comparing 2016/17 data with previous years[3]. The key messages from Quarter 3 are:

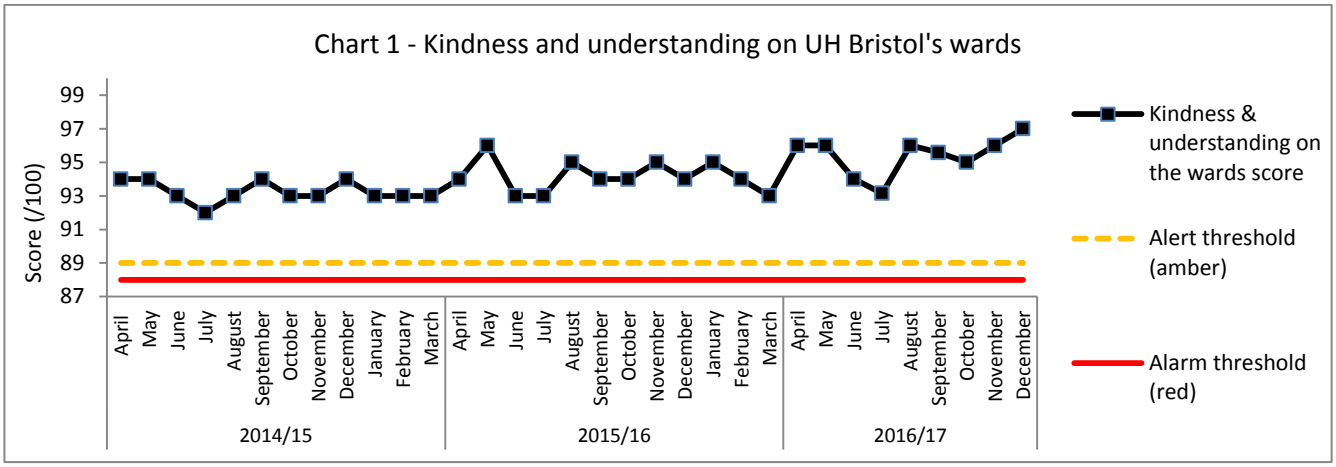
- All of the UH Bristol's Trust-level patient survey measures remained above target - demonstrating the continued provision of a high quality inpatient and outpatient experience (Charts 1-6).
- UH Bristol has a contractual obligation with the Bristol Clinical Commissioning Group to meet specified Friends and Family Test response rate targets. In Quarter 3 the Trust continued to meet these response rate targets (Charts 7-9). However, for the inpatient and day case element of this survey, these rates had started to decline to be just above target by the end of the Quarter. The Heads of Nursing have therefore

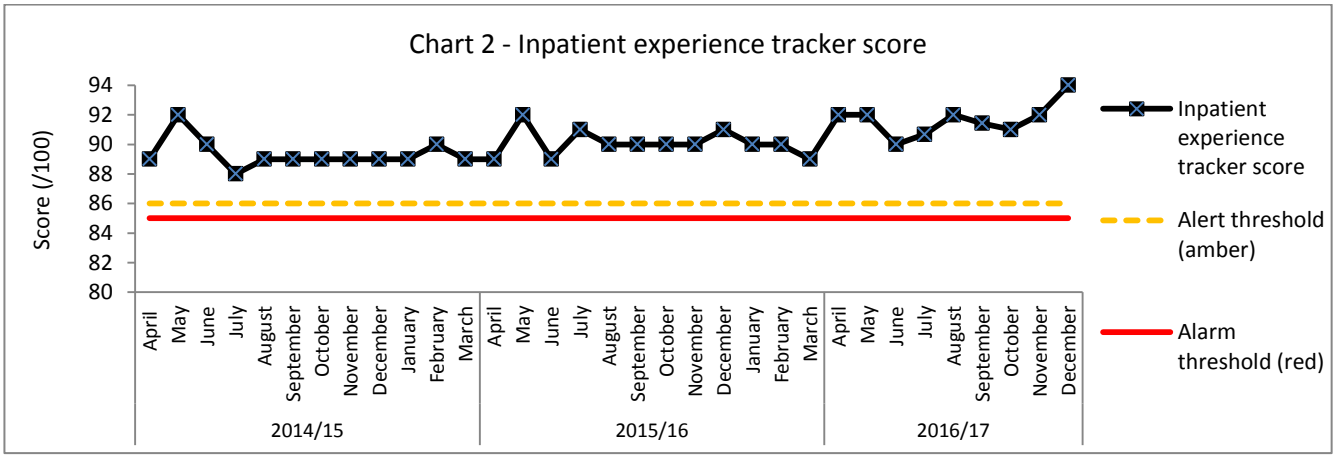
[2] A description of the key Trust surveys is provided in Appendix B. The headline metrics that are used to track patient-reported experience are: being treated with kindness and understanding, the inpatient and outpatient trackers (which combine several scores across the surveys relating to cleanliness, respect and dignity, communication, and waiting times), and the Friends and Family Test score. The postal survey target thresholds are set to detect a deterioration of around two standard deviations below the Trust's average (mean) score, so that these measures can act as an "early warning" if the quality of patient experience significantly declines, and action can be taken in response.

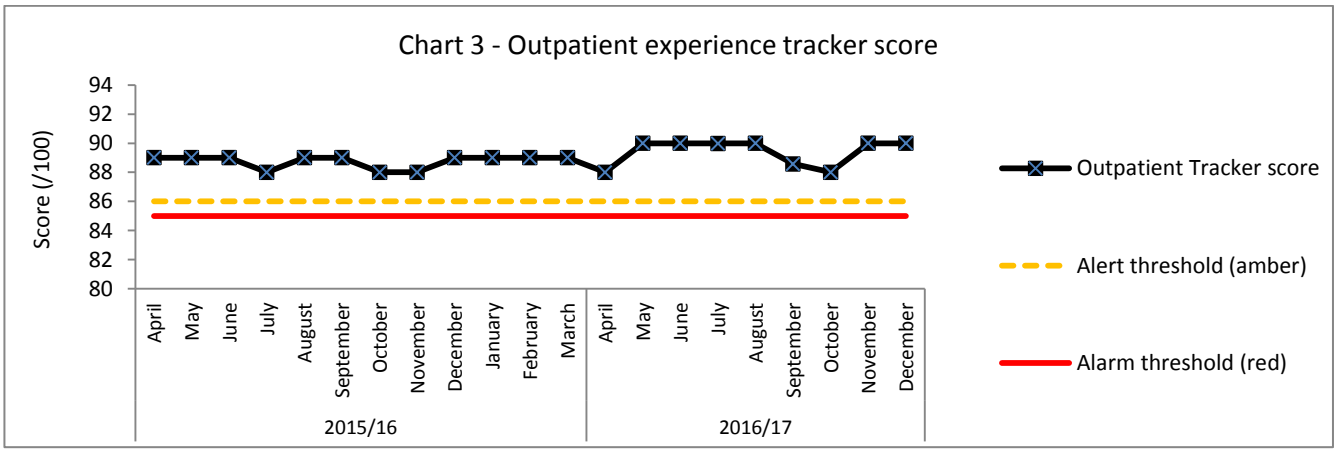
[3] In light of these increases in the scores, a review of the target thresholds will be conducted in Quarter 4 with a view to increasing the minimum target thresholds from 2017/18. It is important to note that in survey terms these effects are marginal: even discounting the inflationary effect of these changes, at a Trust level we would not be scoring below our target levels. The effects at Divisional and site level have yet to be analysed however and the effects may be more marked at this level: an analysis will be carried out by the Patient Experience and Involvement Team in Quarter 4 to assess this.

reminded their teams about the importance of this feedback process and we expect to see an improvement in these rates as a result.

- As noted in previous Quarterly Reports, it has not been possible to set a target FFT score for the Emergency Department Friends and Family Test so far in 2016/17 (Chart 5). This is because of the ongoing trialling of different approaches to collecting feedback in this setting, including cards, touchscreen and more recently SMS (text message). These methods have varying effects on the score, making it difficult to set an appropriate minimum target score. It seems likely that the current mixed-methods model will be the adopted approach going forward and therefore it should be possible to set a minimum threshold for these scores during early 2017/18.







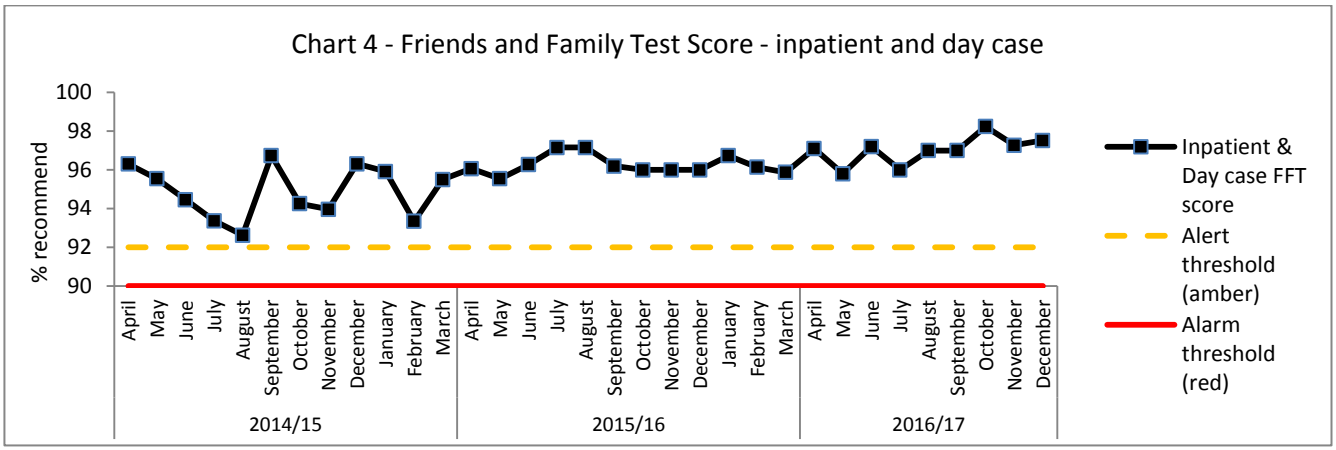


Chart 4 - Friends and Family Test Score - inpatient and day case
% recommend
100
98
96
94
92
90
April May June July August September October November December January February March
2014/15
2015/16
2016/17
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

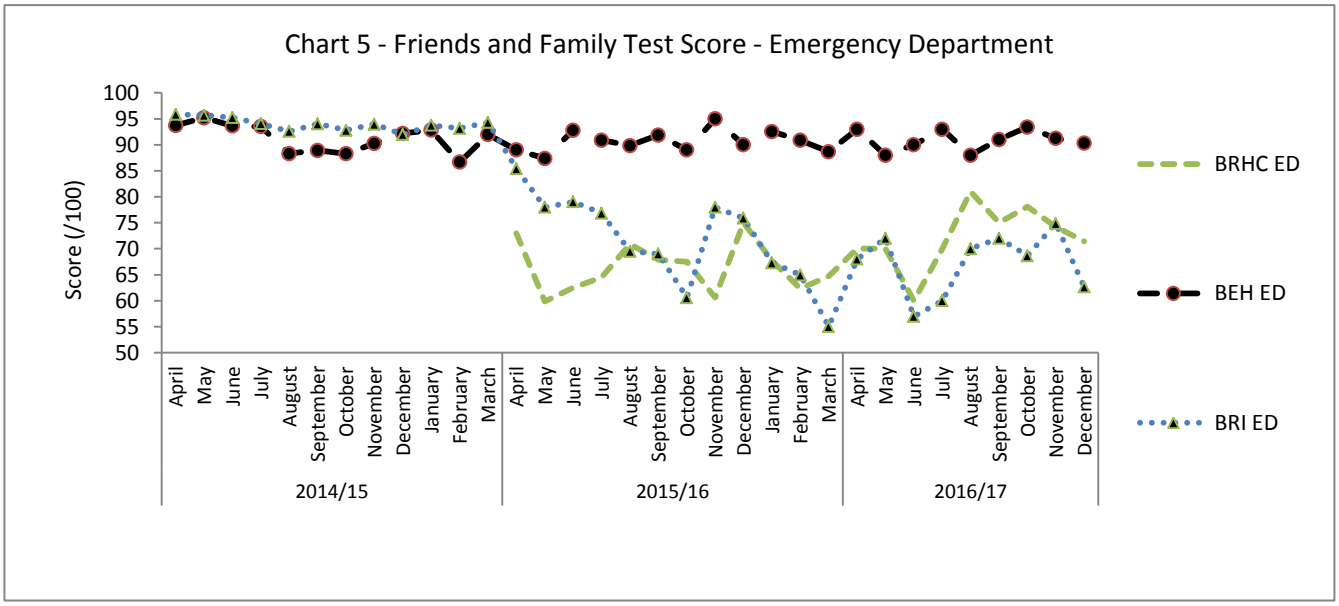


Chart 5 - Friends and Family Test Score - Emergency Department
Score (/100)
100
95
90
85
80
75
70
65
60
55
50
April May June July August September October November December January February March
2014/15
2015/16
2016/17
BRHC ED
BEH ED
BRI ED

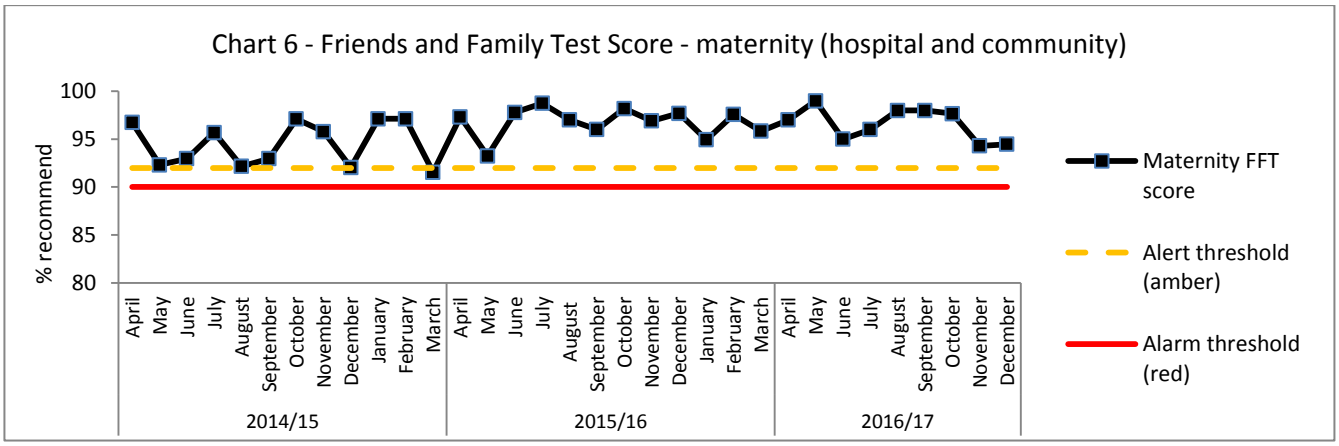
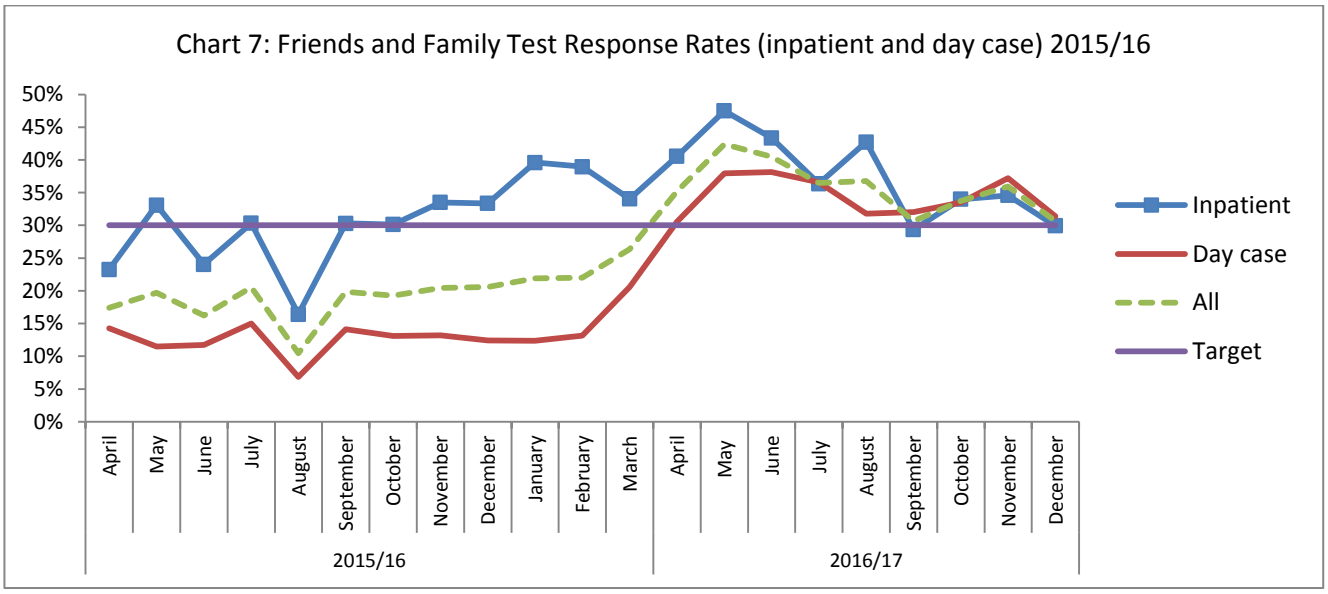
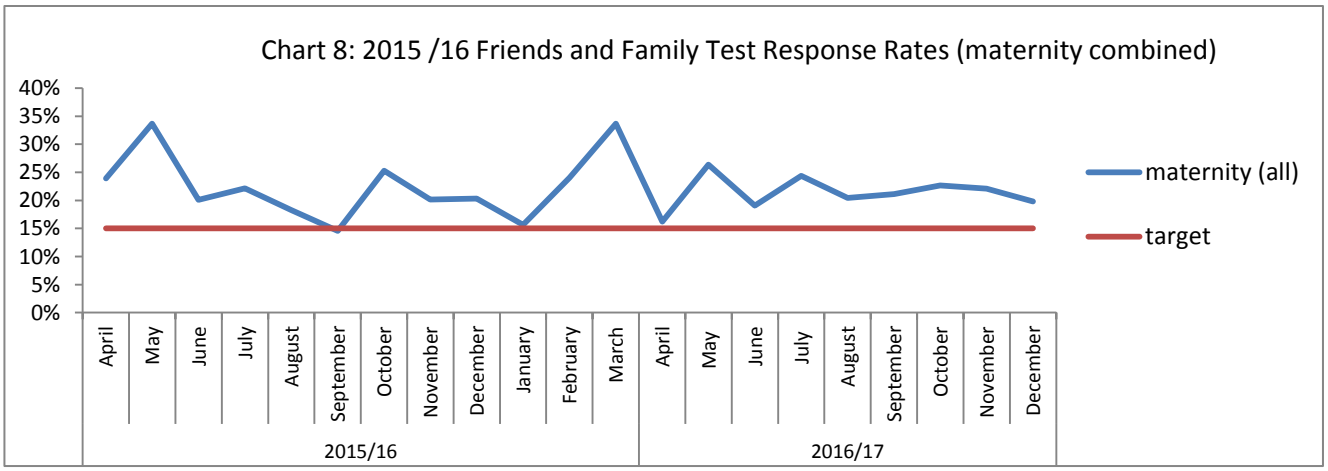
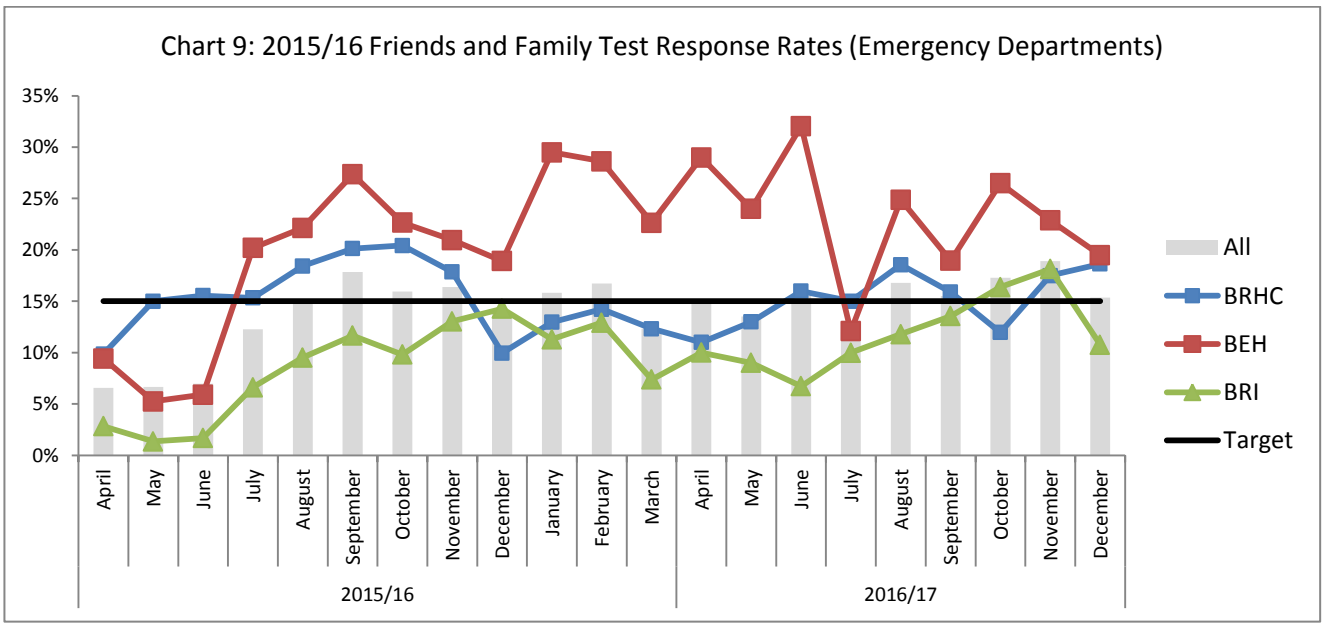


Chart 6 - Friends and Family Test Score - maternity (hospital and community)
% recommend
100
95
90
85
80
April May June July August September October November December January February March
2014/15
2015/16
2016/17
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)







(Key: BRI = Bristol Royal Infirmary; BEH = Bristol Eye Hospital; BRHC = Bristol Royal Hospital for Children; ED = Emergency Department)

8

3.2 Divisional, hospital and ward-level patient-reported experience

3.2.1 Themes arising from free-text comments

Table 1: Quarter 3 themes arising from free-text comments in the patient surveys (the comments are taken from the Trust's postal survey programme, unless otherwise stated)[4]

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[5])	Staff	Positive	69%
	Staff	Negative	9%
	Communication/information	Negative	9%
	Food/catering	Negative	9%
	Waiting / delays	Negative	5%
Division of Medicine	Staff	Positive	68%
	Information/communication	Negative	10%
	Staff	Negative	10%
Division of Specialised Services	Staff	Positive	65%
	Staff	Negative	13%
	Food/catering	Negative	12%
Division of Surgery, Head and Neck	Staff	Positive	71%
	Staff	Negative	12%
	Communication/information	Negative	9%
Women's and Children's Division (excluding Maternity)	Staff	Positive	74%
	Staff	Negative	14%
	Communication/information	Positive	11%
Maternity	Staff	Positive	61%
	Care during labour and birth	Positive	22%
	Staff	Negative	11%
Outpatient Services	Staff	Positive	60%
	Waiting/delays	Negative	11%
	Environment/facilities	Negative	10%
Accident & Emergency Services (sample of 350 Friends and Family Test cards)	Staff	Positive	73%
	Waiting	Positive	23%
	Waiting	Negative	16%

At the end of the Trust's postal survey questionnaires, respondents are invited to comment on any aspect of their stay. The themes from these comments are provided in Table 1 (above). By far the most frequent type of feedback is praise for staff. Key improvement themes focus on communication, staff behaviour and waiting times. Although these categories do not directly overlap with the way that the Trust classifies complaints, there are similarities between these issues and themes seen in the complaints data (see accompanying Quarterly Complaints Report).

[4] The percentages shown refer to the number of times a particular theme appears in the Quarter 3 free-text comments. As each comment often contains several themes, the percentages in Table 1 add up to more than 100%. "Sentiment" refers to whether a comment theme relates to praise ("positive") or an improvement opportunity ("negative).

[5] The maternity inpatient comments have a slightly different coding scheme to the other areas, and maternity is not part of the outpatient survey due to the large number of highly sensitive outpatient clinics in that area of care.

Hospital food regularly features as a "top five" negative comment in our inpatient postal survey. This is a relatively divisive issue for patients: a clear majority (64%) rate the food as very good or good, but clearly people who do not like the food feel strongly enough to raise this as an improvement concern in a written comment. The Patient Experience and Involvement Team recently carried out an in-depth analysis of our survey data relating to hospital food and insights from this will inform a forthcoming tender exercise for the Trust's food service contract.

The Patient Experience and Involvement Team have carried out a thematic analysis of a large sample of Friends and Family Test comments from each of UH Bristol's Emergency Departments received in Quarter 3 (Table 1)[6]. It is encouraging to note that the great majority of comments (73%) contain praise for staff. Perhaps surprisingly, positive comments about waiting times (i.e. the waiting times was short and / or acceptable) easily outnumbered negative comments about waits. A positive development in this respect in Quarter 3, was the installation of new signage in the Bristol Royal Infirmary Emergency Department. These signs, developed by the Design Council, convey information to patients / visitors about what happens at each stage of the "emergency department experience", to ensure people are aware of why they are waiting and what will happen next.

3.2.2 Survey scores at Division and site level

Charts 10-20 provide a view of patient-reported experience at UH Bristol, from a Division to ward-level. Please note that the margin of error gets larger as the data is broken down and so the Trust alert / alarm threshold shown on the charts is only a guide at this level (at a ward level in particular it becomes important to look for consistent trends across more than one of the surveys). The full Divisional-level inpatient and outpatient survey question data is provided in Tables 2 and 3 (pages 16-18).

The Friends and Family Test (FFT) score for postnatal wards was relatively low in Quarter 3 (Charts 12 and 13). The FFT is a useful rapid-time feedback tool, but caution should be applied in using this as a robust measure of patient experience (particularly as none of the other postnatal survey scores showed this decline). However, in the comments received via the Trust's monthly maternity postal survey, there was a notable increase in the number of respondents commenting negatively about staffing levels on postnatal wards (Table 1 / page 9). The Head of Midwifery has reviewed this data and confirmed that November and December were a very busy period and unfortunately this also coincided with a relatively high level of staff sickness. Staffing levels remained within recommended limits, but it is possible that this negatively affected the survey data. A recent assessment of the maternity work force was carried out and showed higher than recommended levels of full-time staff in the maternity department, but that the relative proportion of unregistered to registered staff was higher than recommended. This analysis is currently being finalised in conjunction with the Finance Department and once completed will be shared with Divisional leads for further discussion.

[6] This was based on the Friends and Family Test cards completed in the Emergency Department, as the "written" comments received via the SMS and touchscreen elements of this survey are of relatively low data quality.

Chart 10 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)

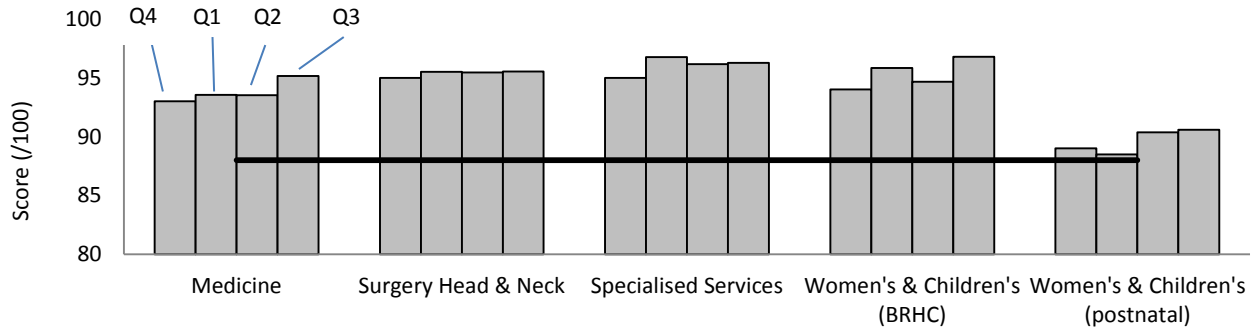


Chart 11 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

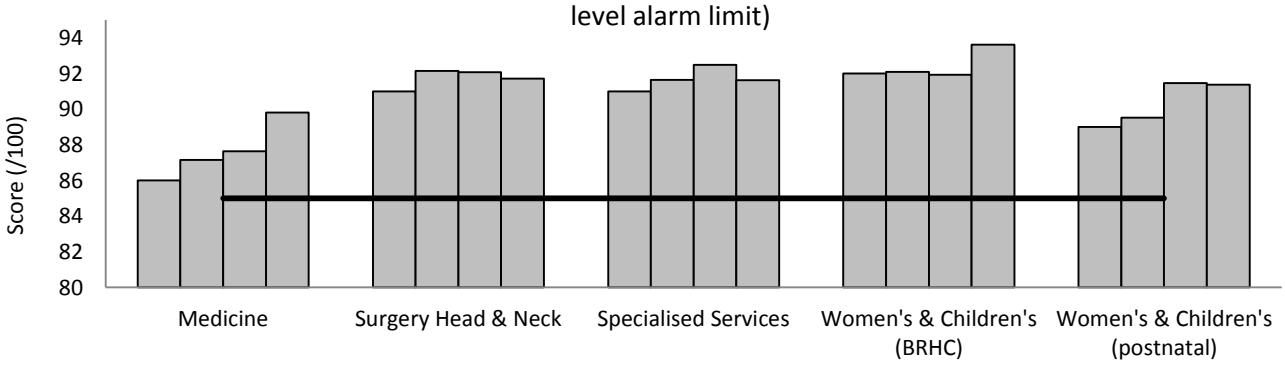


Chart 12 - Inpatient Friends and Day Case Family Test score - last four quarters by Division (with Trust-level alarm limit)

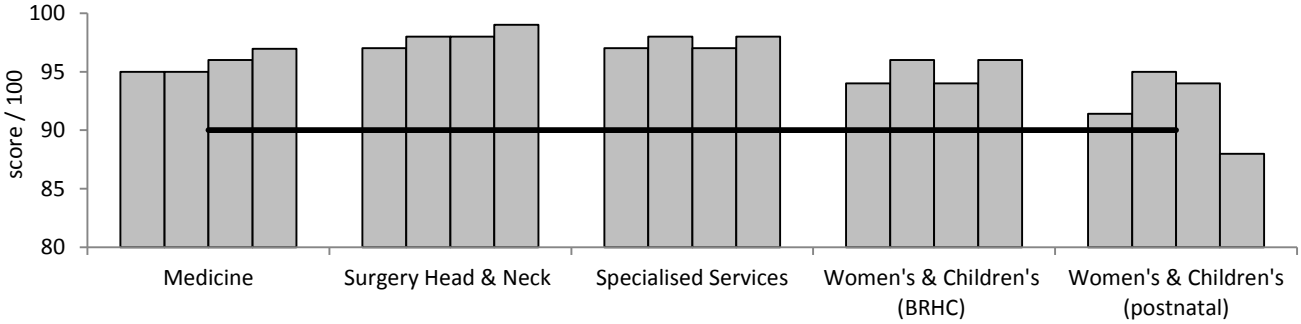


Chart 13 - Outpatient experience tracker score by Division - with Trust-level alarm limit

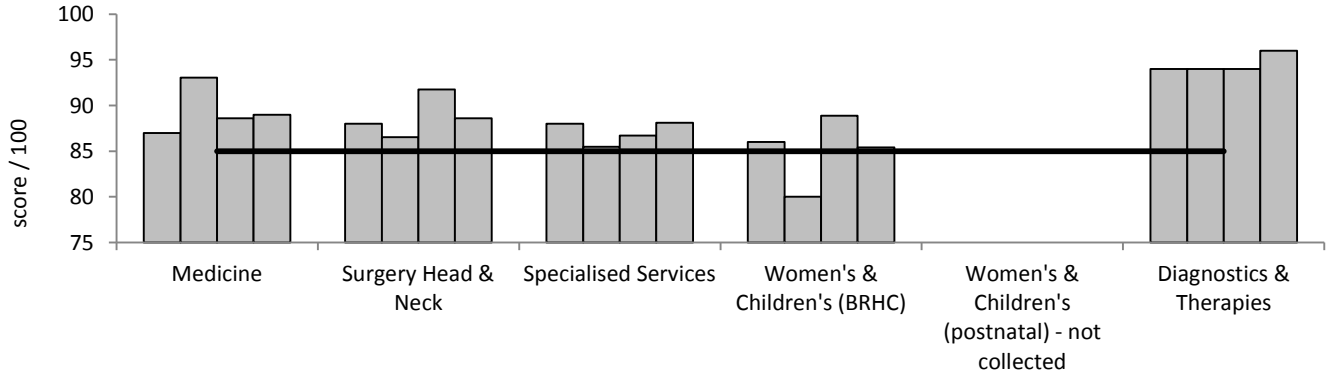


Chart 14: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

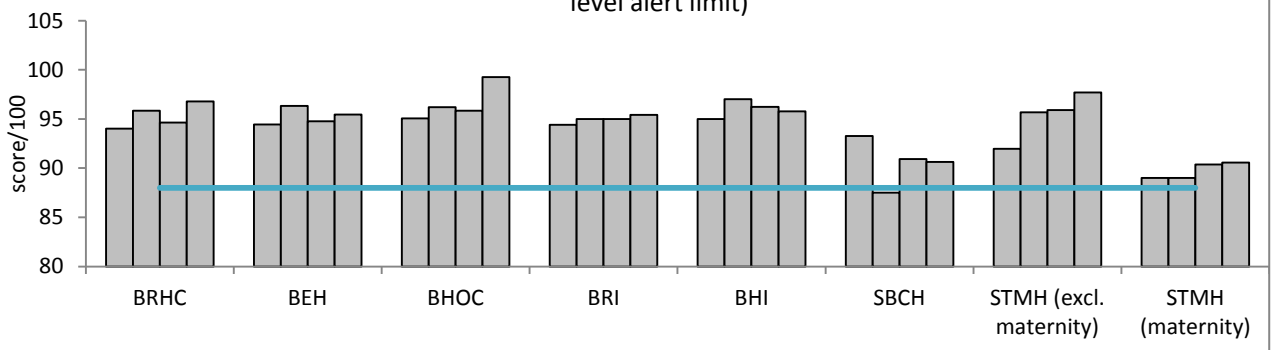


Chart 15: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

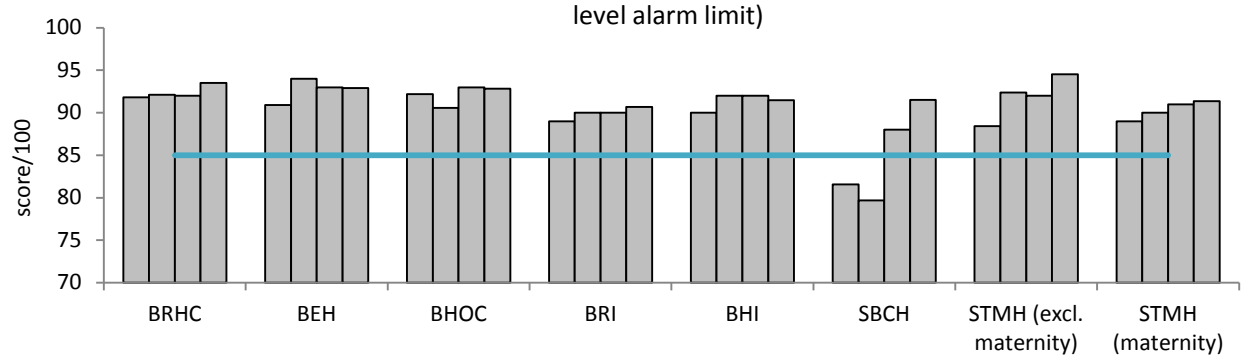


Chart 16: Inpatient and day case Friends and Family Test score (last four quarters; with Trust-level alarm limit)

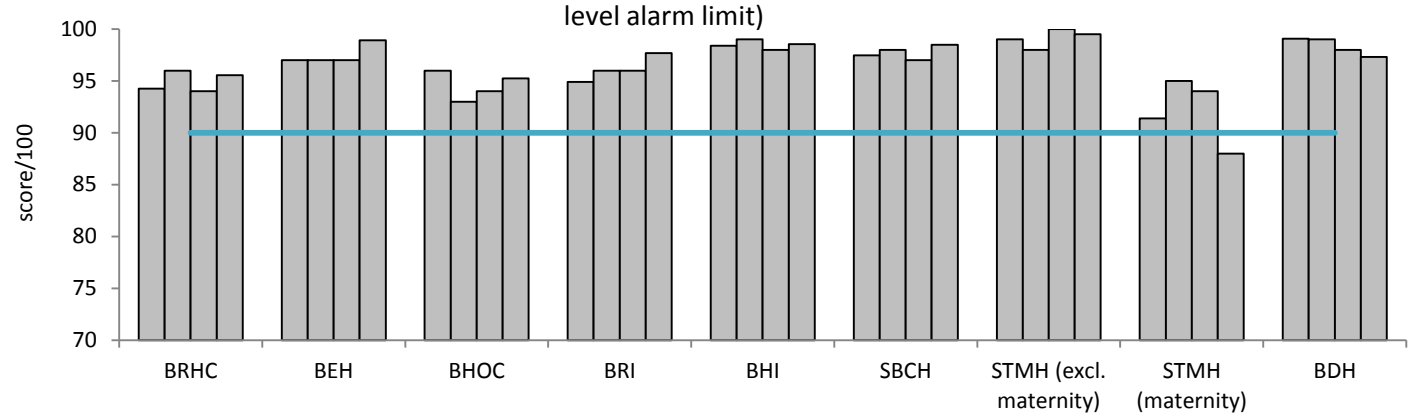
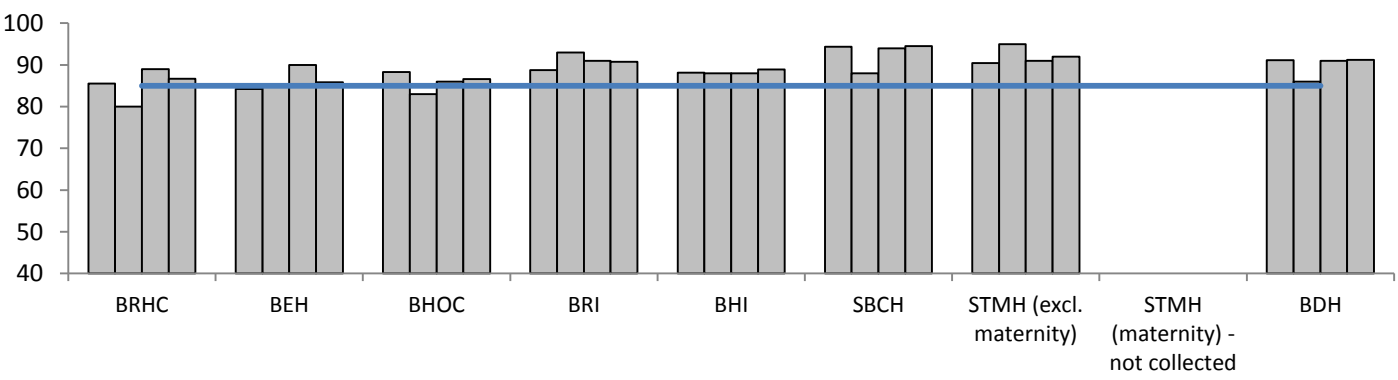


Chart 17: Outpatient experience tracker score by hospital (with Trust-level alarm limit)



3.2.3 Survey scores at ward level

Ward 38A at the Bristol Royal Hospital for Children had a relatively low Friends and Family Test score in Quarter 3 (Chart 20). This is an unusual result for this ward and further analysis suggests that it is primarily an artefact of the FFT scoring methodology: in Quarter 3 the ward received 19 FFT responses, with 84% of respondents saying they would be likely or extremely likely to recommend the care (the Trust's target "recommend" level is 90%). The main reason for the low score was that two parents ticked "don't know" and one ticked that they were neither "likely nor unlikely to recommend". So there were no negative responses as such, but some responses weren't explicitly positive and unfortunately these are counted as negatives in the FFT score calculation. The comments received for 38A in this period were universally positive and the scores from our more robust postal surveys were also within the expected range (Charts 18 and 19). Nevertheless, there are always opportunities to improve patient and family experience and Ward 38A are currently working towards the "You're Welcome" accreditation[7]. This is based on a framework developed by the Department of Health to assess how young person friendly acute hospital services are. It is expected that Ward 38A will achieve this accreditation in March 2017.

As noted in previous Quarterly Patient Experience and Involvement reports, care of the elderly services tend to receive relatively low patient survey ratings compared to other areas of the Trust (though it is important to note that these ratings are still almost always very positive in themselves). In Quarter 3, wards A400, C808 and A528 all appeared as negative outliers (Charts 18-20). It has been difficult to understand these results because they do not correlate with other performance and monitoring data that the Division collects (including visits to these areas to assess the quality of care). The working hypothesis is that these scores are a realistic reflection of the challenges in caring for patients who have complex health / social care needs, which are often accompanied by a cognitive impairment. We continue to test this hypothesis, for example by inviting Healthwatch to carry out an "enter and view" of South Bristol Community Hospital, and the Patient Experience and Involvement Team's focus on care of the elderly services in Quarter 1 (see Section 2 of the current report) will be a further opportunity to do this.

Ward A605 is the Division of Medicine "delayed discharge ward". This was a notable outlier in the Trust's inpatient experience tracker in Quarter 3 (Chart 19). It is acknowledged that providing a positive patient experience in this context is challenging, however the Division are carrying out / planning a number of improvements to this ward, including:

- A Nursing Assistant is now working during the middle of the day, whose role includes providing activities to patients (e.g. painting, walking group, reading dementia club)
- Volunteers are now used to support patients at meal times. Further volunteering opportunities are being developed around providing purposeful activities for patients
- A book trolley has been introduced to the ward
- A small seating area has been put in place on the ward to allow patient to rest away from the bed area
- The ward team are working with dieticians with a view to providing coloured crockery for patient mealtimes

The Division of Medicine consistently achieves relatively low survey scores around telling patients information about operations / procedures (Table 2, page 16). This result has been difficult to interpret because the Division does not routinely perform these types of clinical intervention. The Patient Experience and Involvement Team has therefore carried out a detailed analysis of this data and shared it with the Division. Few Division of Medicine

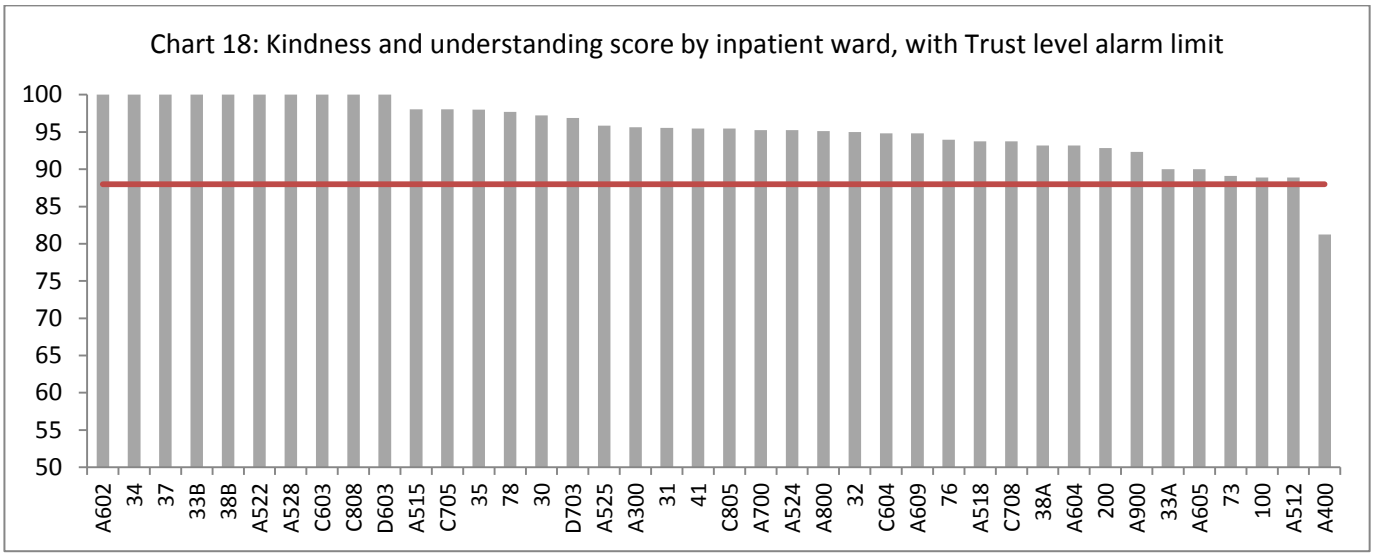
[7] https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services

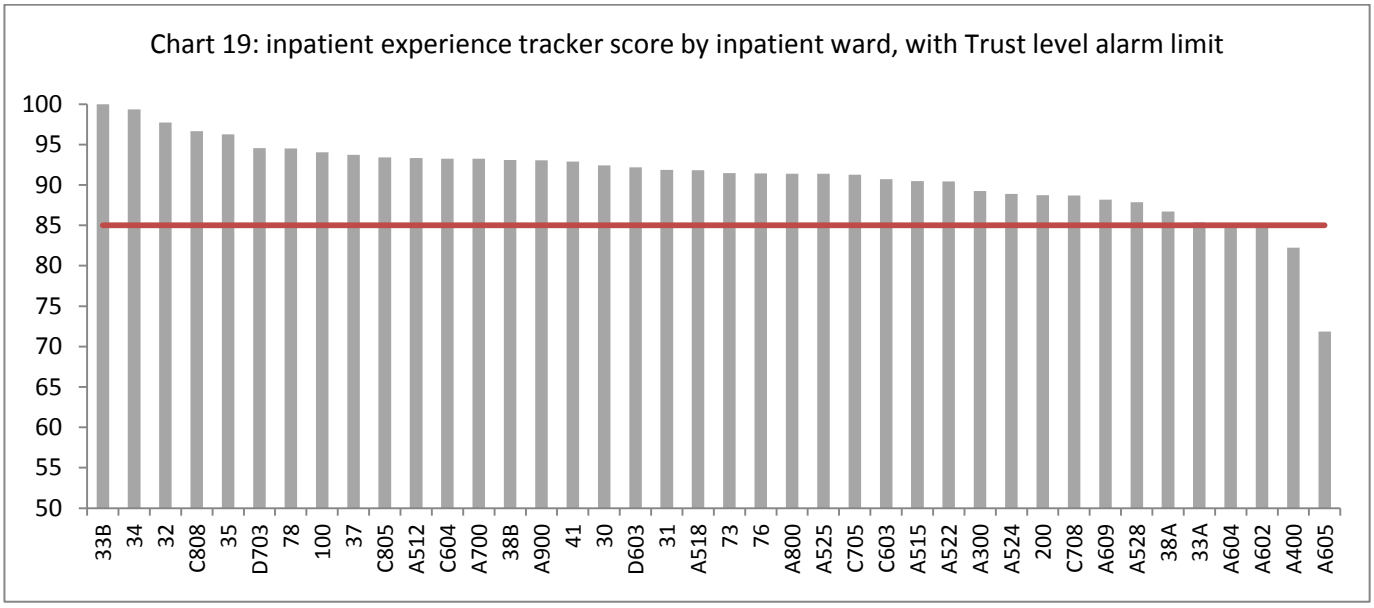
respondents answer this survey question, which in itself can skew the data[8], but the exception here is Ward A515 (acute stroke care). Further discussion with the ward suggests that this might be understood in the context of patients often coming into the ward soon after having a suspected stroke: this tends to involve intensive clinical interventions / tests and it is easy to imagine that whilst clinically necessary, this experience could feel overwhelming. The Ward Sister will share this result with the ward staff to remind them that, wherever possible, the purposes of any tests should be clearly explained to the patient before they are carried out. Opportunities to further explore this issue with patients are being discussed with the Stroke Clinical Nurse Specialist (e.g. using the *Face2Face* volunteer team) and will be incorporated into the Quarter 1 focus on care of the elderly services.

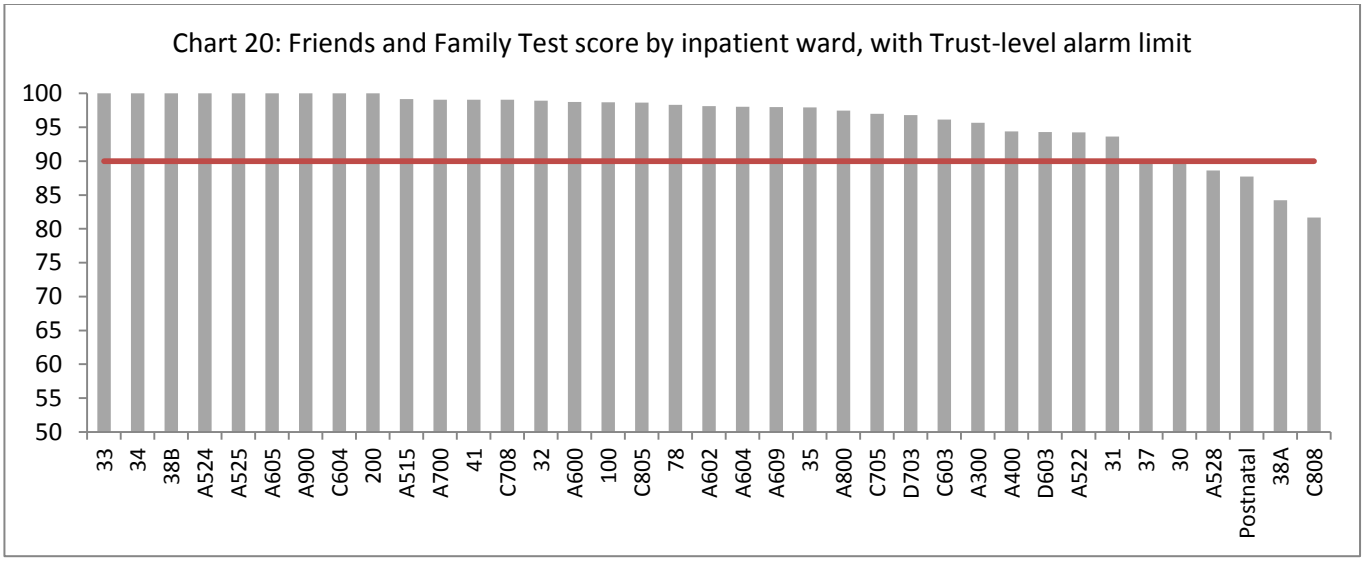
The Division of Medicine also received a relatively low score around ensuring patients were told who to contact if they had concerns after leaving hospital. An analysis of this data shows a large disparity between the highest and lowest performing wards on this measure and this has been shared with these wards as a point of learning.

A cluster of low survey scores are present in the outpatient survey data (Table 3), relating to ensuring patients are kept informed about delays in clinic, either via a member of staff or an information board (ideally both). The Trust recognises these issues and ensuring that patients are kept informed of delays is currently a corporate quality objective, which means that it is a key focus of improvement for the Trust during 2016/17 (a separate report about progress against these objectives is provided to the Trust Board each quarter). For example, standardised clinic information boards have now been implemented in a large number of outpatient departments. Alongside this, a Standard Operating Procedure associated with keeping the information on the boards up to date has been reviewed and re-circulated to clinics. It should be noted that whilst the Diagnostics and Therapies Division doesn't generally have information boards in place (hence their particularly low survey score on this question), relatively few of their patients report delays in clinic.

[8]The data also suggests that many of the Division of Medicine patients who do answer this question aren't following the questionnaire routing correctly, which would ask them to skip this question if they didn't have an operation or procedure: the exception again being ward A515.







(Please note that as per NHS England guidelines the Friends and Family Test data is reported at "postnatal ward" level and is not split down into wards 73 and 76).

Table 2: Full Quarter 3 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are 10 points or more below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for scoring mechanism. Note: not all inpatient questions are included in the maternity survey.

	Medicine	**Specialised Services**	**Surgery, Head & Neck**	**Women's & Children's**	**Maternity (postnatal wards)**	**Trust (excl. Maternity)**
Were you given enough privacy when discussing your condition or treatment?	92	93	95	92		93
How would you rate the hospital food?	67	62	63	64	57	63
Did you get enough help from staff to eat your meals?	91	91	83	81		87
In your opinion, how clean was the hospital room or ward that you were in?	95	95	96	94	93	95
How clean were the toilets and bathrooms that you used on the ward?	92	90	93	91		91
Were you ever bothered by noise at night from hospital staff?	78	81	86	82		83
Do you feel you were treated with respect and dignity by the staff on the ward?	97	97	97	97	92	97
Were you treated with kindness and understanding on the ward?	95	96	96	97	91	96
Overall, how would you rate the care you received on the ward?	88	91	91	92	86	91
When you had important questions to ask a doctor, did you get answers that you could understand?	85	91	90	93	89	90
When you had important questions to ask a nurse, did you get answers that you could understand?	89	89	89	94	93	90
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	74	76	78	82	78	77
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	85	88	86	91	88	87
Were you involved as much as you wanted to be in decisions about your care and treatment?	83	86	86	91	90	86

	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Maternity (postnatal wards)	Trust (excl. Maternity)
Do you feel that the medical staff had all of the information that they needed in order to care for you?	88	91	89	92		90
Did you find someone on the hospital staff to talk to about your worries or fears?	69	74	78	82	85	76
Did a member of staff explain why you needed these test(s) in a way you could understand?	84	86	86	92		86
Did hospital staff keep you informed about what would happen next in your care during your stay?	80	85	84	88		84
Were you told when this would happen?	81	83	81	84		82
Beforehand, did a member of staff explain the risks/benefits in a way you could understand?	80	92	94	95		93
Beforehand, did a member of staff explain how you could expect to feel afterwards?	70	73	80	84		78
Were staff respectful of any decisions you made about your care and treatment?	90	94	94	95		94
During your hospital stay, were you ever asked to give your views on the quality of your care?	27	32	29	34	31	30
Do you feel you were kept well informed about your expected date of discharge from hospital?	78	81	87	89		84
On the day you left hospital, was your discharge delayed for any reason?	62	57	67	65	65	63
Did a member of staff tell you about medication side effects to watch for when you went home?	52	53	67	66		60
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67	81	82	92		81
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	89	92	90	92	91	91
Sample size (number of respondents)	218	428	505	252	205	1608

Table 3: Full six-monthly Divisional-level scores from UH Bristol's monthly **outpatient** postal survey (cells are highlighted if they are 10 points or more below the Trust score). Scores are out of 100 unless otherwise stated – please see appendices for scoring mechanism.

	Diagnostic & Therapy	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Trust
Were you given a choice of appointment date and time?	86	64	88	63	45	72
Was the appointment cancelled and re-arranged by the hospital?	96	93	95	95	98	95
When you contacted the hospital, was it easy to get through to a member of staff who could help you?	75	58	60	55	81	64
When you arrived at the outpatient department, how would you rate the courtesy of the receptionist?	87	85	87	85	85	86
Were you able to find a place to sit in the waiting area?	100	99	99	99	96	99
In your opinion, how clean was the outpatient department?	94	93	94	94	92	94
How long after the stated appointment time did the appointment start?	95	70	68	73	57	74
Were you told how long you would have to wait?	52	31	35	21	36	32
Were you told why you had to wait?	63	53	56	54	63	56
Did you see a display board in the clinic with waiting time information on it?	22	57	53	35	45	43
Did the health professional have all of the information needed to care for you?	93	86	96	91	90	92
Did he / she listen to what you had to say?	99	97	97	97	95	97
If you had important questions to ask him / her, did you get answers that you could understand?	94	92	93	90	93	93
Did you have enough time to discuss your health or medical problem?	93	93	94	91	90	92
Were you treated with respect and dignity during the outpatient appointment?	99	98	97	97	98	98
Overall, how would you rate the care you received during the outpatient appointment?	100	98	99	99	96	99
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	91	88	88	92	88	90
If you had any tests, did a member of staff explain the results in a way you could understand?	78	89	73	76	90	79
Did a member of staff tell you about medication side effects to watch for when you went home?	67	79	63	59	75	67
How likely are you to recommend the outpatient department to friends and family if they needed similar care or treatment?	94	90	92	93	90	92
Total responses	**83**	**88**	**114**	**90**	**47**	**422**

4 Specific issues raised via the Friends and Family Test in Quarter 3

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 4 provides an overview of activity that has arisen from the relatively small number of negative ratings, where this rating is accompanied by a specific, actionable, comment from the respondent.

Table 4: Divisional response to specific issues raised via the Friends and Family Test in Quarter 3, where patients / parents stated that they would not recommend the care provided by UH Bristol

Division	Area	Issue raised	Response
Medicine	BRI Emergency Department (ED)	Sending me home in the rain to walk 5/6 miles after a TIA and rheumatoid arthritis	Unfortunately hospital transport is only available to patients requiring ambulance transport on discharge from the hospital. Patients are offered to use the telephone to arrange a lift with friends and family. There is a taxi service available to patients at their expense from the Emergency Department (ED) and a hospital bus service. We are sorry if this was not explained to this patient and will remind our staff to ensure this happens.
	BRI Emergency Department	7 hours in the corridor before being seen by a doctor with no proper monitoring is not good at all. It was also not nice as I was put next to a dead person on a trolley.	We are sorry that the patient experienced a long delay in the corridor. Unfortunately the demands on our services mean that we do have to care for patients in a corridor until space in a clinical area becomes available. The trust is working on a variety of models to improve the capacity and flow issues faced by patients coming in to our hospitals. We have investigated the comment and have been unable to identify the event described: patients who have died in the ED are cared for in manner to maintain their privacy and dignity, which is done behind a curtained off area if the side room is not available at the time.
	BRI Emergency Department	Lack of first aiders, I collapsed twice in the waiting area and twice I vomited and twice it was fellow patients who came to my aid.	A triage nurse is available to make early assessments of patients and manage any patients in the waiting room, and the ED receptionists can escalate any concerns to the medical and nursing team in the ED. This comment will be shared with the team to as a point of learning.
	100	Personally I didn't enjoy my stay but not because of the staff they were fantastic but the environment wasn't. I was bored with nothing to do.	Following the recent Healthwatch enter and view at South Bristol Hospital *(where ward 100 is situated)*, which raised similar points, we will carry out a review meeting to discuss the issues raised, including the potential to increase activities available to patients.
	C808	Came in to find my mum on the floor, and at night the bed buzzer was pressed and 35 minutes later her son had to go find someone and only found two nurses for the whole ward.	We are very sorry to hear about this experience and have shared it with the ward staff: the patient should not have had to wait this long for a response. There are currently five nurses on at night, but they may be behind curtains or in the single side rooms delivering personal care and therefore may not be visible at all times. Patients who are at high risk of falling are in bays where enhanced supervision takes place.

Division	Area	Issue raised	Response
Medicine (continued)	A300	Some staff singing loudly nearby which is really not OK when trying to comfort an end of life patient. Ward noisy, side room should be standard requirement. No privacy.	It is usually our practice for end of life patients to stay in side rooms, but unfortunately on occasions this cannot be accommodated if the cubicles are required for patients needing isolation. The unit is often noisy due to the large amount of admission and transfers that the unit does 24 hours a day. The staff will be spoken to about singing.
	A300	Ward freezing not offered gown despite requesting. Left to wear day clothes overnight like tramp. Confused old lady shouted at by orderly until I complained at 1 am.	The heating in AMU is an ongoing issue and has been raised with the Facilities and Estates department. The heating system was reviewed by Facilities and Estates in November 2016. The contractor (Laing O'Rouke) visited the ward in early February 2017 to identify potential solutions.
	A300	It would have been really helpful to be given an induction to the ward sheet eg. visiting times, name of ward, telephone and the fact that children can't visit.	All patients on the ward should be given a leaflet about the unit. Staff will be reminded to do this.
Surgery, Head and Neck	Bristol Eye Hospital Emergency Department (ED)	Magazines were quite limited - OK if you like caravans and camping!	The department relies on magazine donations. The Senior Sister will investigate if any newsagent would be willing to donate to the department.
	Bristol Eye Hospital ED	Seats facing away from staff who call number that is collected at reception. It is extremely difficult to hear staff call and I am not elderly I am 45-55!	The seats are facing the TV to provide patients with a more pleasant waiting experience. We are that some of our patients are hard of hearing and walk around the waiting area to call / look for them. This comment has been shared with our staff as a reminder to do this.
	Bristol Eye Hospital ED	There is no indication of waiting time. I understand that this is difficult but if I knew how many people are before me, I could go to buy sandwiches for example.	We do try to keep patients informed at all stages of the flow through ED. The sister/staff in the department will make announcements if particularly busy and we have a yellow board explaining the running of an ED. Unfortunately the number of people in front of someone is not a predictor of waiting times.
	A604	noise at night.	The Division is exploring using a pop up board to identify when patients are sleeping. We are looking to purchase a "hearing ear" that lights up depending on the level of noise within the clinical area. The use of ear plugs and their availability is also being explored.
	A700	My only concern was that no one could find me a bible!	We have clarified the process of obtaining Bibles with the Chaplaincy Team and this information has been shared with the ward team

Division	Area	Issue raised	Response
Bristol Royal Hospital for Children	Emergency Department	Blood on the bed which my four year old touched. How could it not be cleaned?	This has been fed back to the care team and cleaners in the Emergency Department as a point of learning.
	CIU	Two similar comments in October relating to communication about appointments and test results	We are sorry that these families experienced these difficulties. We have not been able to identify these patients to properly investigate / review their experience. Our clinic staff do not recall this as a widespread issue at the time and, as there has not been a consistent trend following these two comments, it seems to have been a temporary problem. The nurse on duty, that we believe was at this clinic at this time, has now left the Trust. In order to ensure that we have a more reliable audit trail in the future, the nurse in charge has asked the team to record any delayed appointments or cancellations on the Trust's risk management system (Datix).
	30A	1) Playroom was shut as no play therapist - surely we can supervise our own children without play therapist. Children could have done with this. 2) Why does it take so long for drug delivery - can't we go to pharmacy ourselves rather than wait 3 hours on ward.	Unfortunately not all parents supervise their children if there isn't a therapist present, which due to the location of the playroom is a safety concern. The ward have created activity trolleys on the ward which contain toys and craft activities for patient to use at any time. The nurses on the ward need to give advice and go through the medications with the parents before discharge. We proactively try to organise medications before the day of discharge, to enable a quick and effective discharge. We are sorry that this respondent experienced a long wait.
Maternity	Ward 73	Mixed experience, no formal introduction to the ward so did not know where toilet and baby room was and did not get breakfast until 11am. Catheter was removed 2-3 hours after advised which meant I could not look after baby.	We are sorry that this patient did not have a formal introduction to the ward: the maternity service normally performs comfort rounds four times a day to make sure that all women have been shown where the toilets, dining room etc are on the ward and are informed about meal times. The ward sisters will re iterate to the staff the importance of this. In addition, a new Welcome Guide is being developed specifically for Maternity services. We are unsure why this lady's catheter was removed later than expected and are sorry for any distressed caused. Having a catheter in situ should not impair the ability to care for a baby, and the ward sister will ask staff to ensure this is discussed with women who have a catheter.
	Ward 76	Spouse cannot stay overnight.	From January 2017 the maternity service is officially launching spouses/partners staying on the post natal wards.

Division	Area	Issue raised	Response
Specialised Services	C705	The nursing care was excellent, but the noise in the ward was unbearable at times. 2 patients suffering from dementia. One in the next bed kept me awake all night. Feel exhausted and annoyed no provision made to keep them quiet.	These comments will be shared with the ward. Staff encouraged to review situations such as this and try to move patients into appropriate areas to facilitate rest.
	D703	Many staff do not understand what is needed for sickle cell care. Even after telling the staff over and over.	A sickle cell CNS has been recently employed and will be delivering and supporting new staff with education.
	D603	The room was too hot, the night staff also noisy when doing their ward round. The washing facilities are outdated compared to D703.	Comments will be shared with the team so that they can be more aware of noise levels. The Division are currently exploring options to update the décor in D603 and aim to progress these in 2017.

5 Update on key issues identified in the previous Quarterly report

Previous Quarterly Patient Experience reports identified various issues relating to survey scores that required further attention. Table 5 provides a summary and update on these issues.

Table 5: update on key issues identified in the previous Quarterly Patient Experience report

Issue / area	*Main action(s) cited*	*Outcome*
Low survey scores on Ward 38b (paediatric neurology).	A member of the LIAISE Team to visit Ward 38b and talk to parents about their levels of satisfaction with their experience, and identify improvements where necessary. This action is from Quarter 4 2016/7, but was delayed due to ward moves.	This visit took place in February 2017. An immediate "quick win" was identified and as a result the ward now has a portable hoist. However, these initial conversations with families suggested that there are a number of improvement opportunities. Further visits from LIAISE, this time with the Matron, are planned for Quarter 1 17/18, to fully understand these issues and develop an appropriate response.
Relatively low survey scores in South Bristol Community Hospital and care of the elderly wards	Healthwatch South Bristol Community Hospital enter and view in October 2016	The enter and view was carried out and a summary of findings is presented in the current report. The outcomes / actions will be monitored by the Patient Experience Group
Outpatient Friends and Family Test response rate	To explore funding for an SMS based solution to increasing the outpatient Friends and Family Test response rate, in line with 2017/18 commissioning contractual requirements	This funding bid has been submitted and is being considered. We expect the outcome to be determined in March 2017.
Patient Experience at Heart workshops in care of the elderly wards	To carry out these patient-focussed workshops with members of staff in the service during Quarter 2/3 2016/17.	As noted in the current report, staffing pressures mean that this has not taken place. However, it will be incorporated into the Quarter 1 focus on care of the elderly services.

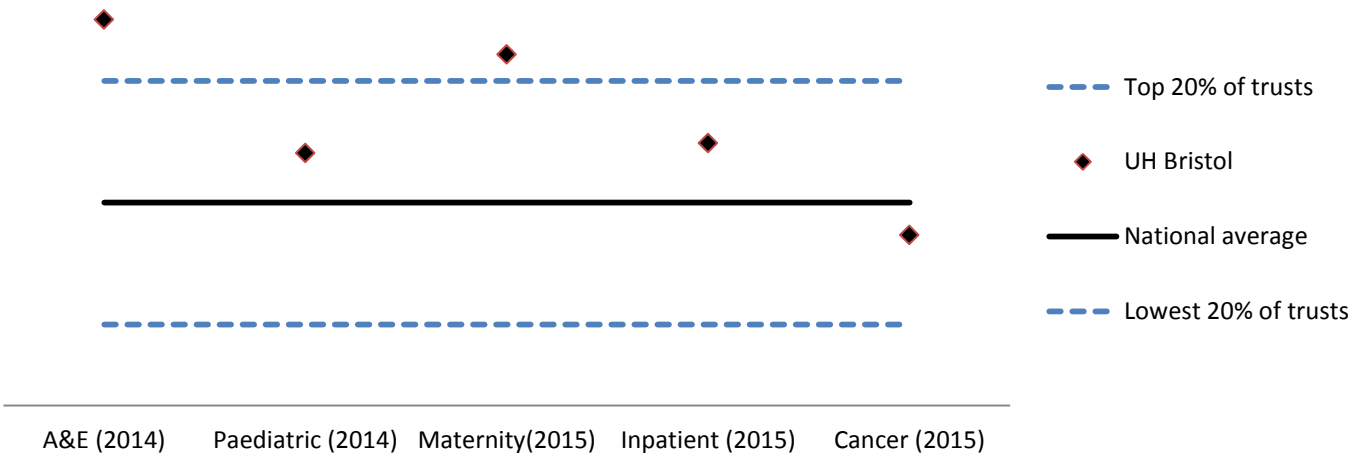
Issue / area	*Main action(s) cited*	*Outcome*
Setting a minimum target score for the Emergency Department Friends and Family Test	As new methodologies continue to be trialled in this setting, with varying effects on the scores, it has not been possible to set a target threshold	With the successful introduction of SMS surveying in the Bristol Royal Hospital for Children and Bristol Royal Infirmary Emergency Departments, we anticipate that it will be possible to set a target during Quarter 1 2017/18.
Ward 37	Relatively low survey scores for this ward in Quarter 2. These were explored by the Division but could not be triangulated with other quality data. It therefore appeared to be a "statistical blip".	The scores are now within the expected range. They will continue to be monitored by the Patient Experience and Involvement Team, but it does appear that they were a statistical blip.
Ward A400	Lowest kindness and understanding score in Quarter 2.	The ward continued to achieve low scores in Quarter 3. However, the Division have reviewed this data and it does not triangulate with other quality metrics. The Trust's Patient Experience Team Manager and Head of Nursing visited the ward together in February 2017 to discuss the results, but it is still not clear why they are occurring. A400 will be included in the focus on care of the elderly services in Quarter 1
Ward C808	Lowest inpatient tracker score in Quarter 2.	As discussed in the current report, the survey results for care of the elderly services are consistently lower than the "Trust average". This will be the focus of Patient and Public Involvement activity in Quarter 1
Develop a timetable of Patient and Public Involvement activity for 207/18.	To develop a core quarterly activity schedule.	This has been done and approved by the Patient Experience Group. Details are provided in the current report. Outcomes will be reviewed by the Patient Experience Group and summarised in forthcoming Quarterly Patient Experience and Involvement Reports.

6 National Patient Surveys

The Care Quality Commission's (CQC's) National Patient Survey programme is a mandatory survey programme for acute English trusts. It provides a robust national benchmark against which the patient experience at UH Bristol can be compared to other organisations. Chart 21 provides a broad summary of the Trust's position[9]. The Trust Board receives a full report containing an analysis of each national survey and UH Bristol's response to these results (see Appendix A for a summary).

There have been no further national survey results since the last Quarterly Patient Experience and Involvement Report was published and therefore Chart 21 is provided for information only.

Chart 21: Indication of UH Bristol patient-reported satisfaction relative to the national average



[9] It is difficult to directly compare the results of different surveys, and also to encapsulate performance in a single metric. Chart 21 is an attempt to do both of these things. It should be treated with caution and isn't an "official" classification, but it is broadly indicative of UH Bristol's performance relative to other trusts.

Appendix A: summary of national patient survey results and key actions arising for UH Bristol (note: progress against action plans is monitored by the Patient Experience Group)

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan review*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2015 National Inpatient Survey	61/63 scores were in line with the national average. One score was below (availability of hand gels) and one was (privacy when discussing the patients treatment or condition)	July 2016	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Asking patients about the quality of their care in hospital	July 2017
2015 National Maternity Survey	9 scores were in line with the national average; 10 were better than the national average	March 2016	Six-monthly	• Continuity of antenatal care • Partners staying on the ward • Care on postnatal wards	January 2018
2015 National Cancer Survey	45/50 scores were in line with the national average; one score was above the national average (being assigned a nurse specialist); four were worse (related to holistic care)	September 2016	Six-monthly	• Support from partner health and social care organisations • Providing patients with a care plan • Coordination of care with the patient's GP	September 2017
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	August 2017
2015 National Paediatric Survey	All scores in line with the national average, except one which was better than this benchmark	November 2015	Six-monthly	• Information provision • Communication • Facilities / accommodation for parents	November 2017
2011 National Outpatient Survey	All scores in line with the national average	March 2012	n/a	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments	No longer part of the national programme

Appendix B – UH Bristol corporate patient experience programme

The Patient Experience and Involvement Team at UH Bristol manage a comprehensive programme of patient feedback and engage activities. If you would like further information about this programme, or if you would like to volunteer to participate in it, please contact Paul Lewis (paul.lewis@uhbristol.nhs.uk) or Tony Watkin (tony.watkin@uhbristol.nhs.uk). The following table provides a description of the core patient experience programme, but the team also supports a large number of local (i.e. staff-led) activities across the Trust.

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	Before leaving hospital, all adult inpatients, day case, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level. A new monthly outpatient survey commenced in April 2015, which is sent to around 500 patients / parents per month.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view.
	Involvement Network	UH Bristol has direct links with a range of patient and community groups across the city, who the Trust engages with in various activities / discussions
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

The methodology for the UH Bristol postal survey changed in April 2016 (inclusive), and so caution is needed in comparing data before and after this point in time. Up until April 2016, the questionnaire had one reminder letter for people who did not respond to the initial mail out. In April we changed the methodology so that the questionnaire had no reminder letters. A larger monthly sample of respondents is now taken to compensate for the lower response rate that the removal of the reminder letter caused (from around 45% to around 30%). This change allowed the data to be reported two weeks after the end of month of discharge, rather than six weeks. It appears to have had a limited effect on the reliability of the results, although at a Trust level they are perhaps marginally more positive following this change (these effects will be reviewed fully later in 2016/17, and the target thresholds adjusted if necessary). The survey remains a highly robust patient experience measure.

Appendix C: survey scoring methodologies

Postal surveys

For survey questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the survey questions have three or more response options. Based on the approach taken by the Care Quality Commission, each one of these response options contributes to the calculation of the score (note the CQC divide the result by ten, to give a score out of ten rather than 100).

As an example: Were you treated with respect and dignity on the ward?

	Weighting	**Responses**	**Score**
Yes, definitely	1	81%	81*100 = 81
Yes, probably	0.5	18%	18*50= 9
No	0	1%	1*0 = 0
Score			*90*

Friends and Family Test Score

The inpatient and day case Friends and Family Test (FFT) is a card given to patients at the point of discharge from hospital. It contains one main question, with space to write in comments: How likely are you to recommend our ward to Friends and Family if they needed similar care or treatment? The score is calculated as the percentage of patients who tick “extremely likely” or “likely”.

The Emergency Department (A&E) FFT is similar in terms of the recommend question and scoring mechanism, but at present UH Bristol operates a mixed card and touchscreen approach to data collection.

University Hospitals Bristol NHS Foundation Trust

Report to the Council of Governors meeting to be held on 28 April 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

		Agenda Item	8.2
Meeting Title	Council of Governors	**Meeting Date**	28 April 2017
Report Title	Independent Review of Children's Cardiac Services progress report		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

Action/Decision Required (please tick any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose

This paper provides an update to the Council of Governors on the delivery of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan

Key issues to note

The April 2017 Steering Group approved the closure of twelve recommendations:

- recommendation 9
- recommendation 11
- recommendation 12
- recommendation 13
- recommendation 14
- recommendation 16
- recommendation 21
- recommendation 27
- recommendation 28
- CQC action 1

- CQC action 4
- CQC action 5

The aim remains to complete all the actions by June 2017.

Recommendations

Governors are asked to:

- **Note** the report.

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

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

Date papers were previously submitted to other committees				
Nominations and Appointments Committee	**Quality Focus Group**	**Governor Strategy Group**	**Constitution Focus Group**	**Public Trust Board meeting 30/3/17**

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

1.0 Introduction

This paper provides an update to Board members on development of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan.

2.0 Programme management

The tables below details a high level progress update of delivery against the agreed programme plan for the three delivery groups. The plan shows the progress of the work that is ongoing to deliver the actions to support the closure of the recommendations. It also shows where delivery of the actions is not within the initially set timescales.

Table one shows that no recommendations were closed since the last report, one further recommendation moved to red as it was not at a stage to support completion at the delivery group meeting; four actions remain amber rated with six still on target and 9 fully completed. The delivery group status reports and action plans show where the variations are. A more detailed explanation of the reasons for the change in status to a red rating is detailed later in the report. Of the thirteen red rated recommendations nine were closed at the March meetings of the relevant delivery groups and supported for closure by the steering group meeting on the 4th of April.

Table 1: Status all actions

	Actions in Progress						Recommendations Closed by Steering Group
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	16	1	11	4	**0 of 32**
Oct '16	0	0	26	5	1	0	**0 of 32**
Nov'16	0	5	19	8	0	0	**0 of 32**
Dec'16	0	5	19	8	0	0	**2 of 32**
Jan'17	0	18	6	8	0	0	**5 of 32**
Feb'17	12	5	6	9	0	0	**8 of 32**
Mar'17	13	4	6	9	0	0	**8 of 32**

Table 2: Status Women's & Children's Delivery Group (total= 18)

	Actions in Progress						Recommendations Closed by Steering Group
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	13	1	4	0	**0 of 32**

Oct '16	0	0	15	3	0	0	**0 of 32**
Nov'16	0	3	9	6	0	0	**0 of 32**
Dec'16	0	3	9	6	0	0	**2 of 32**
Jan'17	0	9	3	6	0	0	**5 of 32**
Feb'17	6	3	3	6	0	0	**5 of 32**
Mar'17	7	2	3	6	0	0	**5 of 32**

Table 3: Consent Delivery Group (total= 5)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	1	0	1	3	**0 of 32**
Oct '16	0	0	5	0	0	0	**0 of 32**
Nov'16	0	0	5	0	0	0	**0 of 32**
Dec'16	0	0	5	0	0	0	**0 of 32**
Jan'17	0	4	1	0	0	0	**0 of 32**
Feb'17	4	0	1	0	0	0	**0 of 32**
Mar'17	4	0	1	0	0	0	**0 of 32**

Table 4: Status Incident and Complaints Delivery Group (total= 5)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	1	0	4	0	**0 of 32**
Oct '16	0	0	5	0	0	0	**0 of 32**
Nov'16	0	2	3	0	0	0	**0 of 32**
Dec'16	0	2	3	0	0	0	**0 of 32**
Jan'17	0	3	2	0	0	0	**0 of 32**
Feb'17	1	2	2	0	0	0	**0 of 32**
Mar'17	1	2	2	0	0	0	**0 of 32**

Table 5: Status Other Actions governed by Steering Group (total=4)

	Actions in Progress	RECOMMENDATIONS CLOSED BY

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	STEERING GROUP
Sept '16	0	0	1	0	2	1	**0 of 32**
Oct '16	0	0	1	2	1	0	**0 of 32**
Nov'16	0	0	2	2	0	0	**0 of 32**
Dec'16	0	0	2	2	0	0	**0 of 32**
Jan'17	0	2	0	2	0	0	**0 of 32**
Feb'17	1	0	0	3	0	0	**3 of 32**
Mar'17	1	0	0	3	0	0	**3 of 32**

Exception report- Red actions

Recommendation 7 – (Management of follow up appointments) All actions to deliver the recommendation have been completed as has the validation of the outpatient backlog; next steps will be to provide a recovery trajectory for the backlog at the next delivery meeting with a view to signing off the recommendation by May 2017. The risk relating to the potential impact on delivery of the recommendation remains on the risk register.

Recommendation 18 – (risk assessment of cancellations) a request to close was submitted to the March '17 delivery group with associated supporting documentation to support the cancellation process in place in the hospital; the group were unable to establish from the evidence presented whether the process was embedded in practice within cardiac services and therefore did not approve the request to close. Further communication with the cardiac team and scrutiny of the process in place is planned prior to the next delivery group; the timescale for delivery has been extended to May '17 in order to ensure that any actions required to deliver the recommendation can be implemented and reviewed for efficacy.

CQC 2 – (provision of a formal echocardiogram report following surgery) the initial audit, completed in December 2016, of compliance demonstrated 73% of patients had the formal report in their records on admission to PICU; the audit was repeated in February 2017 and demonstrated an improvement to 83% with evidence in the other 27% of a record of echocardiogram being undertaken. The delivery group felt that 100% compliance with the use of the formal report template was required prior to sign off. A further audit will be undertaken and presented to the April delivery group with a view to proceeding to closure of the recommendation by May '17

Recommendation 24 – a request to close was submitted to the April steering group however the CCG representative was unable to attend and there were outstanding queries the meant the recommendation could not be closed and therefore this has been rolled to the May steering meeting.

All other red rated recommendations were supported for closure by the delivery groups and April steering group.

3.0 Risks to Delivery

One new risk to delivery was added to the project risk register:

- Risk to the completion of recommendation 2 with agreed timescales due to the requirement to review the roles and responsibilities of the existing NCHDA data team in order to establish how the additional requirements can be met from within existing resources. The score of this risk was agreed at the steering group to be 6.

4.0 Parent and young person's reference group and family involvement activities

- A listening event took place in conjunction with the Heart Children Gloucester group on 22nd March 2017 with over 50 families in attendance and 19 new families signing up to receive the LIAISE welcome pack and ongoing information. Next steps are to use the successful format from Gloucester to inform development of the Exeter listening event planned for May 2017.

- The foetal pathway questionnaire has been reviewed by the virtual reference group and sent to families for completion; feedback will be collated by the Network group and used to inform next steps for foetal service development and also to support the completion of recommendation 4.
- The network website is currently out to tender with a view to going live in July 2017, the website will signpost families to the hospital website and the information held there.
- Letters are being sent to patients who responded to the young person's survey advising them of the services that we will be offering to them following their feedback. In addition a letter has been devised to give to any new patients who show an interest in helping to develop services advising how to become part of the young persons reference group.

5.0 Wider Communications

The progress review document has been drafted to provide an overview of progress to date for staff, families and members of the public and will shortly be added to the Trust website.

7.0 Recommendations closed

The April 2017 Steering Group approved the closure of twelve recommendations:

- recommendation 9
- recommendation 11
- recommendation 12
- recommendation 13
- recommendation 14
- recommendation 16
- recommendation 21
- recommendation 27
- recommendation 28
- CQC action 1
- CQC action 4
- CQC action 5

Appendix 1

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – March 2017

1. Women's and Children's Delivery Group Action Plan

W&C Recommendation's delivery timeframe

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations	**8-** Outpatients experience **Approved as closed by Steering Group (09/01/17)**	**18-** Cancelled Operations risk assessment **-** timescale change request to Feb'17 **Change req to Mar'17 Final SOP and new Next steps SOP with transformation team** Mar'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly; request for a further delay to May 17 to enable the demonstration of embedding in practice.	**16-** communication with families about team working/ involvement of other operators timescale change request to Feb'17 **Change request to Mar'17 Intervention leaflet amendment & printing as a trial pending additions** Mar'17 information booklets complete and approved through the divisional assurance process; some FI comments to include and then print, trial and evaluate; RTC supported by delivery group. Subject to steering group sign off an official launch date will be established and communicated to all staff.	**7-** periodic audit of follow up care timescale change request to Feb'17 **Change request to May'17 in view of numbers of outpatients and inpatients requiring validation to establish risk – added to RR** Mar'17 initial validation of data completed; next steps to return to April mtg to consider alternative accommodation for additional clinics and associated costs and equipment requirements		**21-** (Commissioner) - provision of a comprehensive service of Psychological support, Trust-Expression of Interest submission **(green-provider actions)** Mar'17 RTC supported by the delivery group in view of successful recruitment	**2-** NCHDA data team staffing Mar'17 recommendation added to IR risk register (is also on divisional risk register) as no current solution in place to provide additional resource to the data collection team.		
		20- End of life care and bereavement support **(approved as closed by Steering group 07/02/17)**	**23-** reporting and grading of patient safety issues **(approved as closed by Steering group 07/02/17)**	**9 &11-** Benchmarking exercise (gaps/actions/implement plan) timescale change request to Feb'17 **Change request Mar'17 – benchmarking almost complete – action plan to be devised** Mar'17 feedback provided to support the RTC of recommendations with the caveat that, as the action plan is a work in progress it would be held and progressed by the cardiac business meeting.			**3 & CQC 5-** review access to information – diagnosis and pathway of care Mar'17 rec. 3 progressing to plan CQC 5 supported for closure in view of the production of information sheets to support over 33 different operations; FI comments to be incorporated and then print, trial and evaluate		

		CQC 3- Pain and comfort scores **Approved as closed by Steering Group (06/12/16)**	**CQC 4** CNS recording of discussions with families in notes timescale change request to Feb'17 **Change request to Apr 17 to allow for additional training** Mar17 delivery group supported RTC in view of provision of medway communications page in use and accessible to all appropriate staff, plan to audit quality of records and return to delivery group.	**CQC 6-** Discharge planning to include AHP advice **(approved as closed by Steering group 07/02/17)**			**4-** Support for women accessing fetal services between Wales and Bristol – *timescale change request to Jun '17* *Mar'17 update, FI review of questionnaire complete, letter produced to*		
		CQC 2 Formal ECHO report during surgery *change request to Mar'17 to allow re-audit* *Mar'17 re-audit shows an improvement in the use of the echo forms however they are still not in use 100% of times. Request to amend delivery date to May'17 to allow for reaudit*					**5-** Improved pathways of care paed. cardiology services between Wales and Bristol – *timescale change request to May '17*		

	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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							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 Feb Meeting – review of current resources (FU/VM) Mar'17 added to IR RR in view of concerns over ability to meet recommendation requirements due to lack of support for additional resource
3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.	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	**Green - Complete**	Clinic letter with links (examples Feb mtg docs)
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Green - Complete**	Revised Catheter and Discharge leaflet Feb mtg – this may replicate work in recomm 16 CNS team to check (JH/ST)
							Enhance existing information with a visual diagram displaying pathways of care (FI).	Specialist Clinical Psychologist	Apr' 17	**Blue- on target**	Pathways of Care devised – update to come to Mar'17 mtg re opportunities to link with Network website to enable interactive

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											functionality VG/LS to discuss timescales to share with Virtual group Mar'17 visual pathways shared at listening event – supportive of structure and content; charitable funding secured; designer commissioned with a timescale of draft drawings by April 17 mtg for RTC
							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	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	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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth				two hospitals / commissioning bodies Risk that operational challenges in delivery of the fetal cardiology service in UHW prevent focus on the achievement of this recommendation business plan						
							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**	
							University Hospital Wales to define how additional foetal sessions will be delivered and who from foetal 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~~ Revised to Mar '17. UHW have appointed lead, but have not yet resolved operational issues	**Green - Complete**	Feb mtg – outline plan for foetal sessions, process to manage referral through acceptance criteria in short term
							Foetal working group to define changes / new pathways, taking account of patient feedback	Working group	~~Jan '17~~ Revised to Feb '17. Working group established, but struggling to coordinate diaries for meeting	**Amber – behind plan**	Feb mtg - Changes defined; joint review of approach to counselling; establishment of joint service review meeting Outstanding – patient feedback; survey complete ready to go to QIS group before circulation Mar'17 foetal survey being sent

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											out having been for FI feedback which has been incorporated.
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Jun 17due to delay in engagement with UHW and the operational challenges in their fetal service	**Amber – behind plan**	As above
							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**	Feb mtg -Focus group to come from survey results Mar'17 as above
							New pathways in place	CHD Network Clinical Director and Network Manager	~~Apr '17~~ Revised to Jun 17	**Amber – behind plan**	Feb mtg - Summary paper showing previous and new ways of working, detailing an assessment of the benefits; Pathways to follow completion of actions above
5	The South West and Wales Network should regard it as a	CHD Network Clinical	Apr '17	**Amber – behind plan**	Risk that we are unable to get	Final completion delayed to May 17 due to initial	Network Manager and Network Clinical Director to contact Welsh Commissioners and University of Hospital of Wales to meet to	CHD 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**
	priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	Director			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	delay getting engagement from UHW	discuss and agree process including method of monitoring its implementation				
							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	**Green-complete**	Minutes of meeting and action plan
							To define the opportunities for improvement in coordination and the actions to achieve this	CHD Network Manager	Dec 16	**Green-complete**	Action plan
							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	**Green - complete**	Feb mtg - Proposal sent to virtual ref group, 1 response to date which will be incorporated into plans; any further feedback received will be incorporated
							Deliver actions to improve coordination	CHD Network Manager	May 17	**Blue- on target**	Feb mtg - improved in-pt transfer process; joint audit and training; improved IT for sharing images; standardised patient information; further changes required to meet recommendation
7	The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up	Deputy Divisional Director	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	None	Timescale change request to Feb'17 to provide assurance about backlog validation Timescale change request to May 17 in	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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	appointments.					view of requirement to validate backlog to establish risk – item added to risk register					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 Feb mtg – validation work ongoing; added to RR (VM/FU) action can be RTC once complete and any risks established Mar'17 validation complete; options for delivering additional activity being scoped as described above.
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)** **22/11/16- approved for closure by W&C delivery group**			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 resources available, the Children's Hospital should benchmark itself against comparable centres and make	Divisional Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Risk that other sites are unable to share data required to complete a comprehensive benchmarking exercise	Request to delay to Feb '17 due to late return of benchmarking Request to delay to Mar'17 as some benchmarking data received	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	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Feb mtg - Benchmarking data collection analysis ongoing Site visits dates to be agreed for Mar mtg (JD) Mar'17 RTC supported by delivery group with the caveat

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	the necessary changes which such an exercise demonstrates as being necessary.				Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.	late; analysis ongoing with visits to be planned by Mar'17					that the action plan is held by the cardiac business meeting for completion
							Identification of actions required to address the gaps	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Gaps to be identified from completion of analysis; action held by Cardiac business group (JD)
							Progress to implementing any changes in practice that are deemed necessary	CHD Network Manager and Divisional Director	Jan '17 Revised to Feb '17. Delayed responses from other centres	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	As above, change implementation plan to be devised following gap analysis (JD)
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	CHD Network Clinical Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	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 Mar'17 benchmarking complete; RTC supported by 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**
	communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)										
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	**Red – second revision of timescales**		Request delay to Feb'17 to allow update of catheter leaflets in line with surgery ones Request delay to Mar'17 to allow completion of intervention leaflet and consideration for any others requiring this information to be included.	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	**Green-complete**	Revised 'Preparing for Surgery' leaflet and email to surgeons about new guidance VG/LS to add updated leaflets to website Consider revision of ward 32's leaflet to replicate changes made (ST) Complete changes to interventional leaflet (AP) and produce in draft as a trial for use with patients (ST). Mar'17 Booklets produced and formatted; shared widely for family

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											input; signed off by business meeting with all comments incorporated prior to printing, trial and evaluation – RTC supported by delivery group
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	**Red – second revision of timescales**		Request delay to Feb'17 to allow implementation of new cancellation policy Request delay to Mar'17 to allow development of next steps SOP to support process Request to delay to May '17 to enable the demonstration of the implementation of the process to risk assess patients adequately	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 Sops for cancellation and next steps being reviewed/devised for presentation at Mar'17 mtg (ST) March'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly

	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 Mar 17 update Recruitment completed RTC supported by delivery group
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	**Green-complete**	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	**Green-complete**	Training plan and log of attendance
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**		Mar '17 Delayed to allow audit to demonstrate improvement	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~~ Revised to Mar 17	**Amber-behind target**	Repeat audit results expected at Mar'17 delivery group with a view to proposing closure of

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											recommendation (JM/BS) Mar'17 audit shows improvement however not 100% compliance at present therefore further communication to clinicians and reaudit prior to closure
CQ C. 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
CQ C. 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	**Amber-behind target**		Request delay to Feb'17 to ensure process is robust Request delay to Apr'17 in view of potential training needs for staff	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~~ Feb 17 revised timescale for wider issue	**Green-complete**	Examples of stickers in notes and Heartsuite entries Audit of compliance to be undertaken by MG/VG pre Mar mtg Process to provide consistent recording in accessible patient records to be established (ST) Mar'17 Medway record in place and in use; RTC supported by delivery group subject to audit of quality of records

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											to return to delivery group April 17 (MG/VG)
CQ C. 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 Mar'17 Information sheets produced and formatted; shared widely for family input; signed off by governance meeting with all comments incorporated prior to printing, trial and evaluation; RTC supported by delivery group.						
CQ C.6	Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan '17	**Green-complete**		Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services	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
							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	**Green-complete**	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

Appendix 2 - Trust wide Consent Delivery Group Action Plan – Senior Responsible Officer: Jane Luker, Deputy Medical Director

TW Consent delivery timeframe – March 2017

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations			**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. Request to delay completion to Mar 17 due to ongoing discussion about inclusion of details in patient information Mar 17 update – request to close submitted to April steering group	**13-** Review of Consent Policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought Mar 17 update - Request to close submitted to April steering group				**17-**That the Trust carry out a review or audit of (I) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent	
				14- Review of 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 Mar 17 update - Request to close submitted to April steering group					
				CQC1- Recording the percentage risk of mortality or other major complications discussed with parent/carers on consent forms Mar 17 update - Request to close submitted to April 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
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	Red		Request to delay to Feb '17 to enable new guidance to be incorporated into cardiac surgery leaflet Feb 17 – Req to delay to Mar 17 Details not currently in cardiac surgery or intervention leaflet	**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	**Green**	Parent/Patient information booklet to be sent with letter to families Feb 17 Not currently added to patient letter or information
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	Red	E-learning lead is currently on long term sick which has led to a delay in updating e-learning material	Request to delay to Feb '17. Actions are complete, but need to be reviewed and signed off by Delivery Group. Request to delay to Mar 17 steering as consent group have not met; plan to agree evidence virtually in order to progress	**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	**Green Completed**	Training and communications plan Multi professional Consent workshop 6th April 2017
							13.4 Advice from legal team and safeguarding on revised consent policy and e-learning	Deputy Medical Director	Nov '16	**Green Completed**	Legal and safeguarding agreement and comments on consent policy and

	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**
											e-learning
							13.5 Update e-learning for any changes to consent policy and process	Deputy Medical Director	Jan '17	**Green Completed**	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 – Red – delayed, date completion now anticipated to be Mar 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 relating to consent	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	**Green Completed**	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	**Green Completed**	Correspondence with Royal College of Anaesthetists and Associations AAGBNI Guidance on Consent January 2017
							17.3 Implementation plan for trust wide consent process	Paediatric Anaesthesia consent group	May '17	**Green Completed**	Business case for paediatric pre-op assessment – planned for April 2017 therefore rtc to be submitted for May 17 meeting

	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**
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	**Red**		Request to delay to Feb '17. Actions have been completed, but there was insufficient time to get new consent forms printed in time for January sign off. Request to delay to Mar'17 mtg to allow for all consent forms to be amended This Recommendation will go to next consent group meeting for approval to sign off	**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	**Green**	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	**Green**	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	**Red**	Information and consent forms available to parents Which outline the procedure and include percentage risks. Thses will supplement consent forms

Appendix 3 Trust wide Incidents and Complaints Delivery Group Action Plan – Senior Responsible Officer; Helen Morgan, Deputy Chief Nurse

TW Incidents and complaints delivery timeframe – March 2017

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
			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. *Request to delay to Feb ' 17* *Feb mtg – sufficient evidence to complete recommendation to close for March meeting but now red as did not meet revised date;* *Evidence complete, RTC to Apr steering*	**26-** Development of an integrated process for the management of complaints and all related investigations- *timescale changed from Jan '17 to Jun '17* Mar mtg progress noted; work still to do re integrating adult information and further FI following inclusion of their comments to date			**29 -** 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. Mar mtg – evidence complete; awaiting outcome of QAC to recommend next steps before RTC		**27-** Design of the processes (26) should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue Mar mtg – evidence complete; action plans for ongoing monitoring in place therefore RTC to be submitted to the Apr steering group
			30 - Review its procedures to ensure that patients or families are offered not only information about any changes in practice, seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation- *timescale changed from Dec '16 to Apr'16* *Mar mtg progress noted; work still to do*						

	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	**Green – complete. 10.01.17 5/8 members approved, remainder virtually.**	Document approved within the Division via Quality Assurance Group. Monitored weekly at the Bereavement Group. Audit Apr 17 Audit of compliance complete; action plan sits with bereavement group
							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	**Green action complete** **Mar mtg action complete**	Unformatted version sent to VRG group for comment on content with an associated leaflet

	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**
											to demonstrate format; comments incorporated to add in adult version and resend to VRG
							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	**Green action complete Due for presentation at February 17 meeting Now rated red as not approved at meeting Mar mtg – action complete**	Draft guidance presented; comments from group members to be incorporated and represented at March 2017 meeting SOP completed; to go to Mar QAC and implement; audit initially at 6/12 but then annually
							26.6 Develop the above **staff** guidance for **adult** patients and families (minus CDR)	Head of Quality (Patient Safety)	Dec '16	**Green – action complete**	As above Complete, signed off by CQG
							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**	Leaflet produced but ongoing discussion around the process of sharing a draft RCA with family Links to rec 30
							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**	As above
							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**	Ongoing work on how to achieve this

	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	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 Action approved 10.01.17 pending any further comments within 1 week.**	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				
							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**	Training updated for pt safety, RCA, induction and complaints – add link to new documents developed as part of this action plan and then complete. BRHC training programme complete Plans for next steps to combine training for pt safety for BRHC and adults. Evidence to be provided for where & to whom training is being delivered then RTC
28	That guidance be drawn up which identifies when, and if so, how, an 'independent	Chief Nurse	Dec '16	**Red – behind target.**		Request to delay to Feb ' 17	**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	Nov '16	**Green- complete Action approved 10.01.17**	Reports of the Reviews undertaken and available in evidence folder

	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**
	element' can be introduced into the handling of those complaints or investigations which require it.							Safety Manager	Nov '16		
							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	**Green – Complete Action approved 14.2.17**	Complaints policy Serious Incident Policy (appendix 9, pg. 33) Email from CS to all divisions on 6th February 2017
							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 February 2017.	Head of Quality (Patient Experience and Clinical Effectiveness)	Mar '17	**Green – complete**	Focus meeting planned but not until May 17 due to pt assoc availability; letter of invitation to be added to evidence; ongoing assurance to be held by PEG RTC to be completed
							28.4 Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green-complete**	This action has been completed
29	That as part of the process of exploring	Chief Nurse	Apr '17	**Blue-on**			29.0 Visit the Evelina to understand their model for mediation and possible replication at UHBristol. A	SRO for I&C	Feb 17	**Green - Complete**	Medical Mediation

	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**
	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.			**target**			report will be presented following the visit to consider next steps and possible resource implications. - Action reviewed and agreed to receive a presentation from the Medical Mediation Foundation who provide the Evelina service.				Foundation meeting completed on 9/3/17. Feedback written up and sent to BRHC Quality Assurance Committee 17/3/17 for recommendation re next steps; RTC completed
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)	Apr '17	**Blue- on target**	Links to other engagement work; likely to be completed in conjunction Mar mtg discussed all actions link to Rec 26 (points 4,7,8 & 9) Process exists within Being open policy/Duty of Candour policy. Adult sheet to be added to options available for April 17 Del group RTC
							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**	Evidence pro forma of questions used. Agreed additional action 30.3 before closing. Mar mtg - Audit data to date shows process in

	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**
											place and in use – more detailed audit to sit with the complaints work plan & feed into PEG
							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	**Green-complete**	Audit results due to be presented at March 2017 delivery group Mar mtg - Audit data to date shows process in place and in use – more detailed audit to sit with the complaints work plan
							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	**Green-complete**	Mar mtg – action outwith original scope of Rec and will enhance effectiveness but not fundamental to completion. Process in place to ensure that complainants are asked to attend focus group. First focus group scheduled for May 17 and ongoing will sit within the complaints work plan for ongoing work and scrutiny through PEG

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

Other Recommendation's delivery timeframe March 2017

MONTH	Sept'16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17
Recommendations	**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. – **complete Sept 16 signed off by steering group Mar 17**	31 That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care. **Completed Oct 16; signed off by steering group Mar 17**		32 That the Trust re designate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care. **Completed Feb 17, signed off by Steering group Mar 17**	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. Mar 17 Added to the IR risk register in view of delayed completion of action by CCG, CM in communication with CCG leads			

	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	Trust Secretary	Sept '16	**Green-complete**			Review of current arrangements and processes (Sept '16)	Trust Secretary	Sept '16	**Green-complete**	Executive Lead Role description April 2015 Board annual report BRCH 2015/2016 Steering group Mar 7th agreed closure of action

	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**
	routinely report on this matter to the Board.										
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	**Red**		Proposal for addressing developed./in the process of being approved via NHSE governance framework.	Discussion with commissioners about the issues and agreement to mitigate a similar occurrence	Commissioners and Trust	Jan '16	**Red**	Added to the IR risk register in view of delayed completion of action by CCG; CM in communication with CCG leads RTC submitted with supporting documentation, unable to be presented at April steering therefore returning to May steering group for discussion
31	That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care.	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 Steering group Mar 7th agreed closure of action
							Presentation to Health and Overview Scrutiny Committee	Chief Executive, Medical Director, Chief Nurse and Women's and Children's Divisional Director	Aug '16	**Green-complete**	Meeting minutes - August 2016 & February 2017 Two visits – February 2016 Steering group Mar 7th agreed closure of action

	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**
							Presentation to the Bristol Safeguarding Children's Board	Chief Nurse	Oct '16	**Green-complete**	Minutes of BSCB Sept 2016 Steering group Mar 7th agreed closure of action
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	**Amber**		To be signed off as complete at March 7th meeting	Adoption of the term "Safety of Patients" in place of "Patient Safety" going forward and communication of preferred term Trust wide . Terms of Reference of Patient Safety Group Revised and approved by CCG Feb 2, 2017 Role descriptions for Patient safety staff revised and to be approved by end Feb 2017	Medical Director	Feb '17	**Green-complete**	Steering group Mar 7th agreed closure of action

Key	
R	Milestone behind plan, requirement to revise delivery date on more than one occasion; impact on recommendation delivery date and/or benefits delivery
A	Milestone behind plan, delivery date revised on one occasion
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)