University Hospitals Bristol NHS
NHS Foundation Trust
Trust Headquarters
Marlborough Street
Bristol, BS1 3NU
Tel: 0117 342 3601
Fax 0117 925 6588
Email:Carolyn.mills@uhbristol.nhs.uk
Web-site: www.uhbristol.nhs.uk

CM/

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Morgan Daly
Director of Community Services
Healthwatch
The Vassall Centre
Gill Avenue
Fishponds
Bristol BS16 2QQ

Dear Morgan

Healthwatch Response to Independent Reports

Thank you for your letter in response to the recent publication of two independent reports, the reports of the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and an independent review of allegations related to the management of a specific complaint.

I am responding on behalf of Robert Woolley as the Executive Director with lead responsibility for delivery of the recommendations from the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and also the lead Director for the Trusts Patient Complaints and Support Team.

The Trust fully accepts the findings of both reports and welcomes their publication as a way to learn from our mistakes. We will act with determination and pace to deliver the recommendations within these reports.

For ease of response I have used the headings that you used to structure your letter to us.

Complaints

The Trust recognises the importance of getting right how we handle complaints about our services. Complaints enable us to learn about patient experience, we know how we enable people to complain, and how we respond when they do, is itself a vital part of patient experience; it speaks volumes about our values and the kind of organisation we aspire to be.

We will be considering carefully the findings of the independent review of children's cardiac services in Bristol, specifically how they relate to lessons about our complaints process and what they tell us about how we can become a more patient-focussed organisation. As part of our conscious move towards a customer service culture, more than ever we want to convey the message that patients and their families are encouraged to raise concerns without prejudice. In particular, we want to look at ways of involving patients in helping to design the solutions to the concerns they raise, and in wider quality improvement activities in the Trust. We are also committing to explore how we might offer appropriate independent review of patient concerns and what the trigger points for this would be.

Work has commenced to develop and implement a programme plan which addresses all the recommendations set out in the Independent Review of Children's Cardiac Services at the Bristol Royal Hospital for Children. The plan will be completed by the end of September, it will detail actions, timescales and responsibilities that will ensure recommendations are fully responded to. The delivery of the plan will be overseen by a steering group chaired by myself. The role of the steering group is to ensure that:

- the actions fully address the body and spirit of the report
- all actions are completed in a timely and well-coordinated way
- there are comprehensive and auditable processes established to enable scrutiny of performance and the delivery of actions by the Trust Board
- that the reporting demonstrates the ways in which stakeholders are informed and engaged as appropriate in the governance and delivery of actions.
- there is a defined process to establish and build a comprehensive portfolio of evidence in support of actions taken and the improvements in place.

Monthly updates on the overall progress made to improve the quality of our complaints processes in the specific areas identified in the Independent Review, points 1.2,1.3,1.4 and 1.5 in your letter, will be provided via a monthly report to our Trust Board, which will be available via our public board papers. I can ensure that these are sent to you directly if this would be preferable.

In addition the Trust has a Patient Experience Group where updates on progress against all other complaints development/improvement work are reported. Healthwatch South Gloucestershire and Bristol have a representative, on that group who receives all the relevant work plans and reports. Again, I can ensure that these are sent to you directly if this would be helpful.

In response to your question regarding the Trust's performance in ensuring that complaints are dealt with in a timely manner, I have attached the Trust's complaints report for the last quarter which includes on page 6 details of our complaints performance. We are committed to meeting our KPIs in all areas and review all exceptions of this to understand the reasons for any delay and address where appropriate/possible. In line with Clywd-Hart recommendations the Trust reports in detail our performance process of managing complaints, and the outcomes and learning arising from complaints, quarterly to our Trust Board.

I can confirm that UH Bristol is fully aware of the 12 good practice standards identified by the Patients' Trust. Last year the Trust undertook a piece of work with the Patients' Association; they reviewed with users our complaints process. This work was based around best practice standards in complaints management and focussed on where we our service was good and where we could improve.

I realise that the Trust has got things badly wrong for some patients and their families and our care in regard to how we listened to, and responded to their concerns fell below acceptable standards

which is deeply regrettable. We will do all we can to learn from our mistakes and endeavour to ensure that all patients and their families who complain about our services are listened to and receive a response that is open and transparent and that this is done in the agreed timescales.

Openness/transparency

Openess and transparency is a key tenet of both professional codes of conduct and our Trust values.

I can confirm that written guidance for preparation, conduct and meetings with patients and families has been developed as one of the actions taken as a result of the learning from the BC incident. This guidance has been shared widely within the Trust via generic and person specific.

All medical staff received the guidance via an e-mail from the Medical Director. The guidance is available on the Trust's intranet and has been included in the Trust's duty of candour policy.

Involving patients, carers and families

Thank you for your acknowledgement of the work that has been undertaken to involve parents and young people in the implementation of recommendations as outlined in the Independent Review of Children's Cardiac Services and Care Quality Commission report. Regular updates on the progression of this work will be in our monthly public board reports and will more detail will be available on the Trust's web site.

The Trust is in the process of setting up a parent and young person's reference group. This is part of a much wider parent and young person's involvement plan which has been developed by the BRHC, which is currently engaged in service improvement work related to the independent cardiac review recommendations. The principle of this programme is to build on the existing framework for family involvement currently within the children's hospital and to use the recommendations from the review to further strengthen this partnership. The key objectives of this engagement group are to

- To establish the expectations of parents and young persons as to how they would like to be involved in the implementation of the recommendations and the shaping of future cardiac services
- To engage and involve parents and young persons in an open, transparent and inclusive manner.
- To establish a structure that enables parents and young persons to meet regularly to and to be involved in the improvement work.
- To ensure that meetings occur at a minimum of quarterly and at a time, place and manner that is convenient for parents, young persons and supporting staff for the duration of the project.
- To ensure there are opportunities for parents and young persons to be involved virtually if they are unable to attend events/meetings in person.
- To assure the Independent Review of Children's Cardiac Service Steering Group that the views of Parents and Young Persons have been heard and that the development of the actions to implement the recommendations reflects what is important to patients and families.

The effectiveness of our involvement work will be primarily measured by feedback from parents and young people that they have had an opportunity to be involved and shape service improvement work and that the outcomes meet their needs.

In regard to the last point in your letter I can confirm that as a result of your report July/August

2014 and the recommendation to ensure that advice from all professionals involved with individual children is included in discharge planning, I have located two reports (Healthwatch Special Inquiry into Discharge Meetings and Healthwatch Special Inquiry - discharge) and confirm that the Trust took the recommendations and acted on them where appropriate. I am unable to find the particular quote from your letter, but am confident that discharge planning within the Trust is a multi-professional process across providers to ensure that all the needs of children and their families are met on discharge.

Yours sincerely,

Carolyn Mills
Chief Nurse