Patient Story - Complaint

Author: Director of Safety and Risk Sponsor: Andrew Furlong **Trust Board paper C**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board	Quarterly	Patient Story from SI or complaint for presentation and discussion

Executive Summary

Context

As part of the Board's wish to regularly hear the patients' voice and really understand and learn from when things go wrong, it was agreed that the Director of Safety and Risk would bring patient stories quarterly to the Board which detailed a safety incident or complaint with the purpose of hearing and understanding the human story behind it.

Today Mrs Insley is attending Trust Board herself to present her story of her uncle Mr Reginald Thompson. Mrs Insley put in a complaint in February 2019 about her uncle's care between the 21st December 2018 and the 24th February 2019 which about him being moved from provider to provider, including 5 admissions to UHL until he sadly died in March 2019, aged 94 years old.

This case was published in both the local and national press and via local radio.

The Trust initially responded to the complaint in writing at the request of Mrs Insley and then we also met with the family in August 2019.

Questions

1. What have we learned from this complaint?
2. What actions have we taken as a result of this complaint?

Conclusion

1. Having reviewed each admission and discharge that took place in detail, it was felt that when looking at each hospital episode in isolation, the staff in all settings (i.e. in UHL and LPT) made decisions that are clinically sound. However, there was a failure to step back and see this whole period as one episode of care rather than separate admissions, which led to a failure to recognise that Reginald was becoming increasingly frail and that he was nearing the end of his life. We should have recognised this much sooner and there should have been a frank discussion with Reginald and his family to agree a future plan of care for him. Although there were opportunities to do this, both at the LRI and in the Community Hospitals, these opportunities were missed. Nobody from a clinical perspective took a step back to stop and consider Reginald's overall journey and, as a result, his transfers backwards and forwards continued. We are very sorry that this occurred and for the distress that this caused to Reginald and his family.

   During the meeting it was acknowledged that our staff, during Mr Thompson's admissions, did not communicate in a proactive way with him or his family. The staff did not listen and hear their concerns; we also acknowledged that our staff did not act upon his multiple admissions in a timely fashion.

2. When we review such events it is essential that we consider the learning from this and what actions we can take to make the required changes and/or improvements. In light of this, Dr Marsh has personally met with Mr Dexter from LPT to discuss this and to consider what actions both UHL and LPT can take in response to the concerns you raised and our subsequent findings. Following that meeting the following actions were proposed:

   Joint discussions with LPT as part of our regular monthly interface meetings to focus on:-

   - Looking at how to improve the use of clear escalation plans between LPT, UHL and the community. There is also a wider system task force looking at this.
   - To look again to see if we can get access to each other's servers so that it is clear when a patient has been admitted to show all of their recent admissions. (Currently at UHL we can see previous admissions and letters to UHL but not to LPT).

- Improve the availability of contact details of family/next-of-kin to allow ease of communication.

There is already a plan in place for this to happen.

LPT have, also, confirmed that they will be running a workshop for their ANPs to specifically look at this case to ensure that they take appropriate action in the future, to include escalation planning.

That this case will be shared at a local meeting within the Geriatric Service and the wider clinical management group of Emergency & Speciality Medicine.

3. Dr Marsh and her senior team with Emergency and Specialist Medicine CMG will explore how communication can be improved using QI methodology / process. As part of this they have:-

- Ensured there is feedback to all staff within Emergency and Specialist Medicine CMG about actively listening to patient's relatives when they raise concerns about discharge.
- Shared this story with the teams across Emergency and Specialist Medicine CMG especially around the need to proactively listen to families.
- Discussed how they can facilitate patient's being moved back to a ward if the patient is readmitted following discharge.
- Invited the family to share their story more widely with our staff via a video recording.

Input Sought

Trust Board members are invited to listen to this patient story and discuss the issues raised. The Board is also asked to note the learning and actions detailed in the paper.

For Reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Not applicable]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Not applicable]
Estate investment and reconfiguration	[Not applicable]
e-Hospital	[Yes]
More embedded research	[Not applicable]
Better corporate services	[Not applicable]
Quality strategy development	[Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required

Complainant involved in presenting her own story

- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A

- If an EIA was not carried out, what was the rationale for this decision? N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None	X	

5. Scheduled date for the **next paper** on this topic: [April 2020]

6. Executive Summaries should not exceed **5 sides** [My paper does comply]