East Suffolk and North Essex NHS Foundation Trust

# Public Board of Directors

**12 January 2023**

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| **Report Title:** | Patient Experience |
| **Executive/NED Lead:** | Giles Thorpe, Chief Nurse |
| **Report author(s):** | Tammy Shepherd, Head of Patient Experience |
| **Previously considered by:** | N/A |

☐ **Approval** ☑ **Discussion** ☑ **Information** ☐ **Assurance**

## Executive summary

Having been on a day out in London, Ellie alerted George that there had been no movement from their baby. They decided to come home and attended the maternity department. Following numerous tests undertaken by clinical staff, Ellie and George were informed that there was not any sign of life from their daughter Olive.

Unfortunately, due to covid restrictions, Ellie had been on her own for some of the tests. George was allowed in to be with Ellie soon after. Ellie and George then made their respective calls to their family loved ones.

Clinicians discussed what would happen over the next few days and talked through the funeral process. Although they both felt this was supportive, it was not the right time to be having these discussions and they both felt that this information could have been delayed to allow them both time for this awful news to be digested.

They were given the choice of when to come back to the hospital and they agreed that they would return on Sunday. Once back in the care of Ipswich Hospital, Ellie was given the medication and informed what would happen. Ellie and George had a designated midwife and student and they were both happy with this process as it stopped changing staff through what was a very upsetting experience.

Following Olive being born sleeping, the family were all allowed to spend the next three days with their daughter. A cold cot was provided and support given. They were happy that they were on a different floor from maternity so did not have the additional stress of hearing other babies.

Family were able to visit and they were given quality time to spend with their daughter. They also had a naming ceremony, which was undertaken by the Chaplains.

Ellie stated that the Ipswich Baby Bereavement Group have been a huge support to them after Olive's birth / death up to now. They have truly made the whole experience much easier as they have weekly support meetings, as well as being part of the community of bereaved parents.

They also had support with organising and paying for Olive's funeral by the bereavement midwives as well as close contact with the Chaplains who held the service and memory boxes, which were provided, were lovely and gave them lasting memories of their daughter.

Ellie and George stated that although the room they had was fantastic, as they had Olive during the summer's heatwave and the room had many windows, the heat caused Olive to deteriorate quite quickly. They moved into another room, which was on the side of the building, which was much cooler following the naming ceremony as Olive remained in the mortuary.

Ellie reported that when they arrived on the Sunday to be induced, the receptionist on the maternity reception was quite rude before they had made it through the door, asking 'what we were doing?' and 'why we were there?'

**EW's Experience of Care:-**

**What worked well?**

- Designated midwife and student for support;
- Cold cot;
- Family being allowed to be in attendance;
- Not being on the same floor as other birthing mothers;
- Naming ceremony;
- Overall support from staff;
- Support with funeral;

**What didn't work so well?**

- Early discussions in relation to funeral arrangements, this could have taken place with Ellie and George after;
- Covid restrictions and having tests without George in the first instance;
- Weather and room;
- Rude member of staff during a very difficult experience for Ellie and George;

| **Action Required of the Board/Committee** |
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| The Board is invited to note and discuss the patient experience. |

| **Link to Strategic Objectives (SO)** | | **Please tick** |
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| SO1 | Keep people in control of their health | ☑ |
| SO2 | Lead the integration of care | ☑ |
| SO3 | Develop our centres of excellence | ☑ |
| SO4 | Support and develop our staff | ☑ |
| SO5 | Drive technology enabled care | ☐ |

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| **Risk Implications for the Trust** *(including any clinical and financial consequences)* | There is a risk that a failure to have meaningful patient or staff stories in place and associated effective complaints practices and management arrangements in place there is a risk of recurrent poor experience and potential harm being caused to patients. There is an associate risk of onward referrals to the PHSO, legal claims and reputational damage. The Board listening to stories of patients' and staff's lived experiences ensures that the Trust is committed to keeping the patient, their families and the staff caring for them at the very heart of its decision-making. |
| **Trust Risk Appetite** | The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of "no harm" at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation actions are strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients. |

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| **Legal and regulatory implications** *(including links to CQC outcomes, Monitor, inspections, audits, etc.)* | A failure to ensure appropriate governance practices are in place to support positive patient and staff experience may lead to a breach against Regulation 16: Receiving and acting on complaints and Regulation 18: Staffing as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015. |
| **Financial Implications** | A failure to ensure that the Board has oversight of current patient and staff experiences may lead to ongoing and unresolved concerns, which may lead to legal claims or PHSO rulings being raised against the Trust, with associate financial penalties. |
| **Equality and Diversity** | In order to ensure that the Trust does not directly or indirectly discriminate all the needs of patients and staff must be considered, in accordance to the Equality Act 2010 and EDI agenda in relation to protected characteristics.<br><br>The patient and staff stories that are shared with the Board are reviewed to ensure that this does not happen, and that learning is shared to ensure all considerations are given to:<br><br>• age.<br>• disability.<br>• gender reassignment<br>• marriage and civil partnership.<br>• pregnancy and maternity.<br>• race.<br>• religion or belief<br>• sex<br>• sexual orientation |