

Public Board of Directors

Date of meeting: Thursday 04 July 2024	
Title of Document: Patient Experience Story	
To be presented by: Anne Rutland, Interim Chief Nurse	Author: Tammy Shepherd, Head of Patient Experience
1. Status: For Approval/Assurance/Discussion/Information	
2. Purpose: To hear the patients experience and recognise improvements and planned ongoing work within the service	
Relates to:	
Strategic Objective	SO1: Keep people in control of their health SO3: Develop our centres of excellence
Operational performance	N/A
Quality	Delivering a positive patient and relative experience is a key part of ensuring high quality clinical care. It is key that Board is sighted on direct experience of care, which are both positive and negative; to gain assurance that when a poor experience occurs action is taken to improve.
Legal, Regulatory, Audit	Oversight of patient experience forms part of the Trust's requirements in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 16: Receiving and acting on complaints, and Regulation 17: Good governance.
Equality and diversity	By ensuring Equality and Diversity is noted in patient experience will form the Trusts commitment to the ED&I agenda with the protected characteristics: <ul style="list-style-type: none"> • Age • Disability • Gender reassignment • Harassment • Lifestyle • Marriage & Civil Partners • Pregnancy and Maternity • Racial • Religious beliefs • Sex / Sexual Orientation
Finance	By ensuring a positive patient experience, the risk of ongoing escalation of concerns towards legal claim and financial remedy is reduced.
Governance	As part of a well-led organisation, it is important that the Board is sighted on patient experience stories, in order to connect back information regarding quality and operational performance to patients and families.
NHS policy/public consultation	N/A
Accreditation/	Evidence of the Board's interest in patient experience forms part of

Inspection	the CQC Well-Led review and relates to the relevant fundamental standards as evidenced above.
Anchor institutions	N/A
ICS/ICB/Alliance	N/A
Board Assurance Framework (BAF) Risk	BAF Risk 4: If ESNEFT does not have the correct quality assurance mechanisms in place, then it may fail to maintain or improve the quality and safety of patient services, resulting in poor patient care, increased health inequalities, experience and potential harm.
Other	

Patient Experience Story to the Board

Mr Kevin Savage (son) is attending the board meeting in public to share his feedback in relation to the care his father Mr Sidney Savage received on St Osyth Priory Ward at Clacton Hospital. Mr Sidney Savage had been diagnosed as terminally ill and was receiving palliative end of life care. Sadly, Mr Sidney Savage has since passed away.

Whilst being cared for at Clacton, due to some blood test results, Colchester Hospital felt that he would be better placed under their care. Against the wishes and requests of the family, Mr Savage was transferred. The family were not informed and when they arrived at Clacton hospital and found his bed empty and ready for the next patient, this caused great upset for Mr Savage's 83 year old mother & Mr Savage. To compound matters there was a lack of empathy from some of the staff in St Osyth Priory ward towards why there was no communication from them to inform Mr Savage of his father's transfer.

The family were also concerned about the clinical decisions that were made by staff around permitting a patient in end of life care to be transferred to Colchester and the benefits of treatment versus the disruption and discomfort this would bring.

Mr Sidney Savage was also provided with a blanket from the Blanketeers which provided both him and the family with great comfort, unfortunately the blanket went missing from Easthorpe ward.

What didn't go well:

- Staff didn't listen to the wishes and requests for Mr Savage not to be moved and to be left in peace;
- Blanket missing which the family wanted to keep for the memories of their father and husband;
- Clinical decision making;
- Communication.

What went well:

- Easthorpe ward were incredibly aware of the situation and managed the last few days of life in a caring and empathetic way and afforded them the time to spend with their loved one;
- The blanket was a lovely gesture just very unfortunate that they didn't get to keep it;
- Free parking offered by the Trust to support the family during a really sad and sensitive time.

4. Recommendations / Actions

That the Board of Directors note the patient experience story and the improvements and ongoing improvements planned within the division.