

## Board of Directors

### Item 5.4

**Subject:** Integrated incidents complaints and claims (IICC) report – Q1/Q2 2023/24

**Date of Meeting:** 29<sup>th</sup> November 2023

**Presented by:** Karan Wheatcroft, Director of Risk and Improvement

**Purpose:** To note

BAF Reference	Impact on BAF
BAF 1	Assurance regarding the process, management and learning from incidents, complaints and claims.

Level of assurance (please tick one)					
To be used when the content of the report provides evidence of assurance					
✓	<b>Acceptable assurance</b> Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	<b>Partial assurance</b> Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	<b>Low assurance</b> Evidence indicates poor effectiveness of controls

### 1. Executive Summary

This paper provides the Board of Directors with quantitative and qualitative analysis of reported incidents, complaints and claims (IICC). The report focusses on Quarters 1 and 2 2023/24, compared with Q3/Q4 of 2022/23.

Incident reporting, learning from incidents, complaints and claims and improving the safety culture, remains a priority for the Trust. Bi-monthly learning and sharing meetings take place and the organisational learning session has been incorporated into the monthly team brief. All staff are invited to present learning from incidents, complaints, claims and patient experience events. In addition, a learning database has been created which brings together all the learnings from complaints, incidents and learning from deaths to allow themes to be understood and learning to be identified. All divisions also hold regular audit meetings, where sharing of learning takes place.

To note, during Q1 the Trust remained to use the Datix incident reporting system, and for Q2 we transitioned to our new system, InPhase. Due to issues collating legacy data for Q1 to present in the usual way, some visual graphs are not available, however a narrative has been provided. LHCH went “live” with the new Patient Safety Incident Response Framework

(PSIRF) on 9<sup>th</sup> October 2023, therefore going forward the IICC report will present slightly different to its current format, and as PSIRF encourages and allows – much more qualitative data, including the learnings and improvement will be presented. Under PSIRF we will no longer be carrying out comprehensive investigations and reporting externally on Serious Incidents (SI's), as carrying out an investigation following a patient safety incident is no longer the default position. A patient safety incident investigation is just one type of learning response and encourages providers to refer to the national 'learning response toolkit' for support.

In terms of when a patient safety incident investigation (PSII) should take place, PSIRF leaves this up to organisations to decide for themselves, depending on the circumstances and factors such as their patient safety profile - for example, a PSII may be indicated where factors contributing to an individual incident are not well understood.

The Board of Directors are asked to note the report and receive assurance of the arrangements in place for the management and learning from incidents, complaints and claims.

## **2. Background**

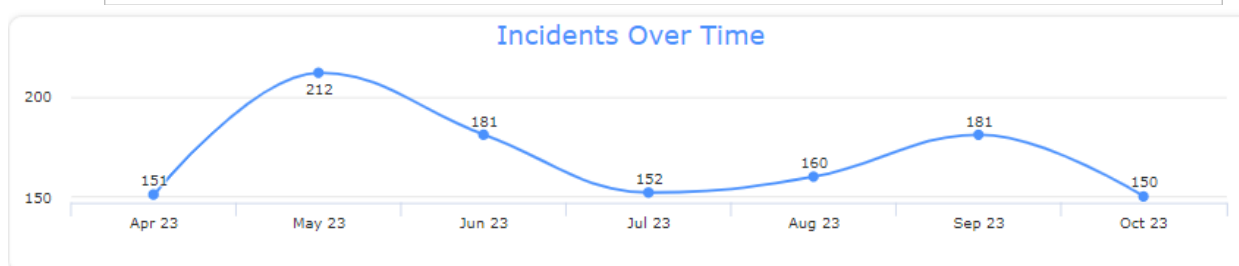
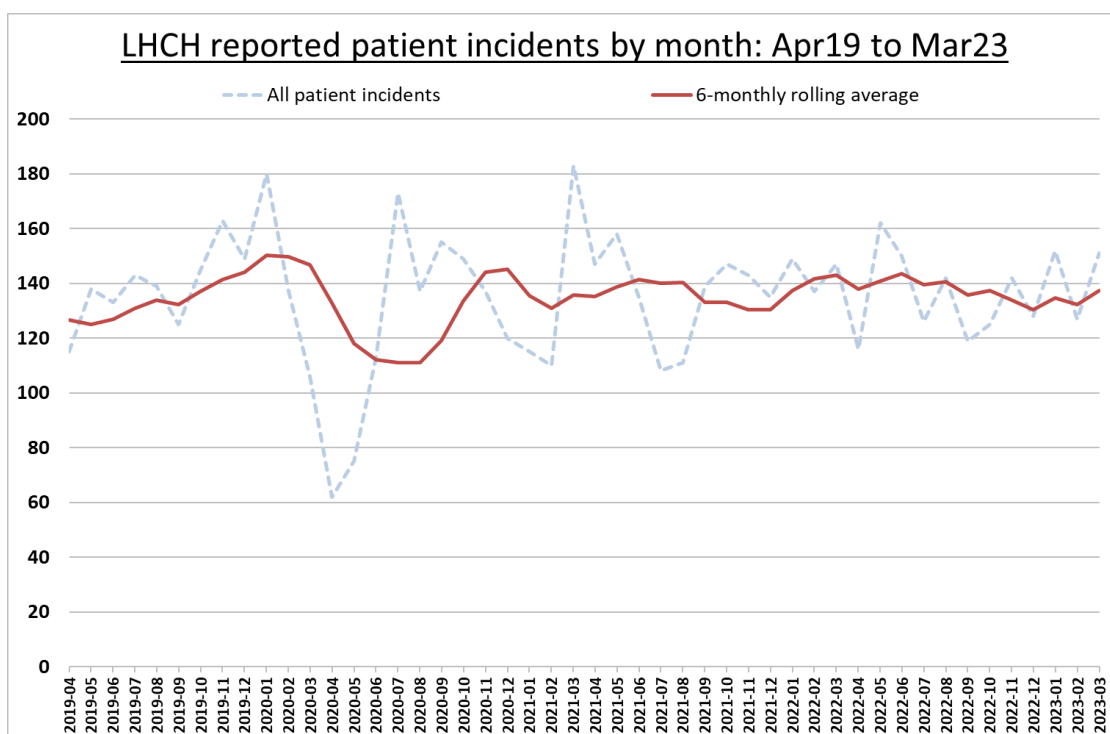
This report is presented to the Board of Directors six monthly providing concurrent information pertaining to incidents, complaints, and claims, reported within the organisation.

## **3. Incident Reporting Culture**

Since the introduction of Datix in May 2016, incident reporting has remained steady and there is a continued emphasis on the importance of incident reporting in safety huddle and at team brief. A new incident reporting system came into effect in at LHCH in July 2023, InPhase, and since the transition, incident reporting numbers has remained consistent. This has been supported by a well-planned and coordinated transition project, communication throughout the Trust, daily training and support sessions being made available and the assistance of InPhase themselves.

The importance of incident reporting continues to be highlighted through team brief, the daily safety huddle, senior leads and manager meetings, and within the Divisional Governance meetings.

The graphs below show the rolling average since April 2019, along with the continued monthly average using InPhase data (April 2023 - September 2023).



### **Top five reported incidents**

In total, there were 1037 reported incidents in Q1-Q2 2023/24 (1039 reported in Q3 – Q4 2022/23). The top five reporting themes for the four quarters are shown below.

Theme	Q1	Q2	Total	Summary
Administration Processes	72	78	150	This category includes administrative, clinical record keeping, and communication incidents throughout the Trust, including clinical teams.
Medications	57	60	117	These include dose omitted, drug given by wrong route, wrong dose administered, wrong dose dispensed, wrong dose prescribed, wrong drug administered, wrongly prescribed and administered, prescribed duplicate, and pharmacy dispensing errors.
Communication	32	46	78	This category includes communication between teams, handover between teams, communication with patients, communication with other healthcare providers (such as the ambulance service for outpatients' bookings, and referral information not being completed correctly.
Patient slips, trips and falls	33	28	61	This category includes all records of patient slips trips and falls. Slips, trips and falls happen predominately in the ward areas and can happen at any time of day or night. Delirium and sedation are contributory factors to patients falling
Documentation	25	28	53	This category includes all documentation communication throughout the Trust, including all forms used i.e. electronically/written.

## Learning and actions from Incidents

The learning and actions from incidents are provided below.

Theme	Summary of learning and actions
<b>Administration</b>	<p>The following actions are being undertaken to support process improvement and incident reduction:</p> <p>Clinician Engagement</p> <ul style="list-style-type: none"><li>• Support &amp; ownership for the safer waiting list work</li><li>• Minimum Referral Data Set to be agreed for all service lines</li><li>• Service Line leads need to agree escalations and triggers for pathway management</li></ul> <p>Referral Management</p> <ul style="list-style-type: none"><li>• System interface leads to be confirmed from other Providers</li><li>• Agree correspondence to empower patients when outstanding information is required from other providers</li></ul> <p>Sustainability</p> <ul style="list-style-type: none"><li>• Support a priority investment decision to Admin through annual planning-</li><li>• Commitment to a Single PTL and a move to standardising processes within the Trust</li><li>• Agree to the proposed Governance Structure</li><li>• Digital Excellence Strategy – supporting process automation (robotic process automation, Patient Portal, Digital Communications, innovation, and technology for administrative processes to reduce human error</li><li>• Validation of data quality reports, outpatient waiting list and follow up outpatient waiting list processes</li><li>• Weekly performance operational meetings between admin and divisional leads, supporting closer working and a more aligned approach with clinical divisions</li></ul>
<b>Medications</b>	<ul style="list-style-type: none"><li>• On induction, prescribers receive a presentation on medications management from pharmacy, which includes highlighting key prescribing areas to ensure patient safety. Prescribers are also given direction to key prescribing policies that also include high risk drugs e.g., insulin, intravenous antibiotics, and anticoagulation. Prescribers also work through an electronic prescribing and medicine administration workbook and are assessed on completion. They also access a pharmacy session at medical teaching to go through key medicines management issues, and sharing from incidents including trends are shared with prescribers during these sessions, and feedback obtained to make improvements in process and the EPR system.</li><li>• A medications management training suite has been developed, in conjunction with learning and development, which is available on ESR for nurses. This now forms part of mandatory training for all nurses. This includes a range of training such as policy reading, 1:1 assessment on administration, videos, and a drug calculation test. Newly qualified and overseas nurses also attend preceptorship medicines management training lead by the pharmacy education lead, with medicines safety aspects such as never events and incident trends forming part of the workshop.</li><li>• A mini MDT meets weekly that includes the managers of incidents, where a review takes place of all medication incidents. The meeting quality assesses each incident, to ensure correct classification and scoring of harm/potential harm. Any actions required or lessons learned are discussed and escalated as required. The incidents are often finally approved, which then auto populate the medication incidents dashboard.</li><li>• The Safe Medication Practice Committee meet monthly to review and discuss any significant medication incidents raised at the mini MDT. The medication incidents dashboard enables the committee to focus on trends, harm/potential harm, learning and cascade. Any medicines related patient</li></ul>

Theme	Summary of learning and actions
	<p>safety alerts, e.g. from the MHRA are also discussed and actions agreed during these meetings.</p> <ul style="list-style-type: none"> <li>• The medication dashboard is now the focus for the executive weekly harm report (with respect to medicines) and the monthly divisional governance meetings. A monthly incident summary report is discussed at all three divisional governance committee meetings.</li> <li>• A new QSEC dashboard is now available which summarises incidents year to date, focusing on incident trends, pharmacy near miss data, and KBMA closed loop compliance. Actions and lessons learned are also summarised. This is presented to QSEC each quarter.</li> <li>• Key medication safety themes are communicated to the Trust via the monthly safe medication bulletin and ad hoc corporate communications as required. These themes and noteworthy incidents are also cascaded through prescriber teaching sessions, ward safety huddles, pharmacy meetings and are emailed directly to the relevant teams as needed.</li> <li>• The medicines safety strategy also forms part of the Trusts Quality and Safety strategy.</li> </ul>
<b>Communication</b>	<p>Many of these incidents appear to be during handover between teams, both verbally and written i.e. bed numbers/patient names, bedside handovers, the use of "SBAR" to structure the handover. It is encouraging to see these incidents are reported, even though corrective action is taken at the time using PSIRF methodology we used an MDT review approach to look at themes and to create a safe forum for discussion for improvement.</p> <p>Communication incident themes that arose were gathered and collated by the Patient Safety and Quality Improvement teams. Areas within communication were discussed at a workshop held with various members of the MDT, who came together to discuss improvements they thought they could make and share ideas. These will be shown and presented further at the next Sharing and Learning meeting and fed back locally across the areas, to share awareness.</p>
<b>Documentation</b>	<p>A theme of incorrect patient records being stored within their electronic patient record due to mislabelling of ID, or where the checking process of patient ID has not been sufficiently carried out. Many of these incidents were near misses and the error was highlighted promptly to prevent any further risk to the patient. Even as near misses, it is positive to see these incidents reported. Learnings and incident highlights, from all incidents. will be fed back within the Trust going forward, through the weekly patient safety learning meetings, in monthly learning bulletins.</p>
<b>Patient slips, trips and falls</b>	<p>The Falls Steering group meets monthly, a 72 hr review of all falls are completed and any learnings are discussed and shared at this group. The group has been strengthened by the addition of a Pharmacist and members of the Quality Improvement team. The falls lead is part of a North West Falls Forum that meets up bimonthly to share ideas/ innovations and bench mark.</p> <p>Falls prevention products are in place Trust wide including the Karebag and Karekit. Ramblegard Bond system was installed on Cedar, Birch ward and ACU in July 23. Existing Ramblegard equipment will be shared between all other inpatient wards. This will enable all inpatient wards to have access to falls prevention equipment.</p> <p>Patients and families are encouraged to get involved in falls prevention, by including them in any post falls debriefs, avoiding medications for insomnia and ensuring patients use the call bells. Decluttering of the patients bedspace is encouraged to reduce trip hazards and keeping items in reach.</p> <p>There has been targeted Falls training for the staff on the surgical wards and the Falls Lead teaches on Preceptorship, Care Certificate, Safe From Harm module,</p>

Theme	Summary of learning and actions
	<p>HCA Pathway and also Volunteer induction.</p> <p>There has been a decrease in falls where new delirium has been a causative or contributory factor. The Falls lead is part of the Delirium Steering group, the enhanced observational care policy has been updated and Activity/distraction and reminiscence work is being encouraged on the wards. A new Delirium assessment tool has been trialled on Cedar ward and has been rolled out Trust wide.</p> <p>Further plans for 23/24 include amending EPR documents in line with new National Audit of Inpatient Falls PSIRF guidance, amending the bed rails assessment and focusing on prescribing of medications for insomnia. Vision Assessments have been introduced on admission for all patients at risk of falls and work is planned to improve the recording of Lying and Standing Blood Pressures and increasing education on postural hypotension.</p>

### Severity of Incidents

No harm/low harm continues to be the main category reported within the incident reporting systems. A breakdown of incidents by severity are presented below.

	No/low harm	Moderate (short term harm)	Severe (permanent or long-term harm)	Fatal
Q3 2022/23	471	10	1	1
Q4 2022/23	511	18	5	2
Q1 2023/24	515	21	4	2
Q2 2023/24	413	9	3	0

The detail for the Fatal incidents in Q1 are set out below.

	<p>Q1</p> <p>Patient underwent an AV Node ablation, rare internal bleed complication occurred. Discussions were undertaken with the relevant surgical teams, and surgery was deemed not of benefit. Patient unfortunately passed away. There has been shared learning cross divisionally within our new weekly patient safety learning meeting.</p> <p>Patient delay to CABG operation, due to cross referrals and delay in obtaining images from investigations already carried out.</p> <p>This incident was investigated and the learnings are part of the Executive led Safer Waiting List improvement workstream.</p>
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### 4. Serious Incidents (SIs)

There have been 3 Incidents reported via STEIS in Q1 and Q2

Q3	Nil reported
Q4	<p><b>Unreported renal mass - concluded</b></p> <ul style="list-style-type: none"> <li>Reporting radiologists to check every slice of the CT scan of the chest, looking outside the lung parenchyma before finalising a report.</li> <li>Reporting radiologists to follow RCR guidelines and standards when reporting on images. A local Standard Operating Procedure is to be developed to ensure the reporting radiologist reviews previous scans and attached reports. This will be audited. A review of the capacity for the Aortic clinic is to be undertaken.</li> </ul> <p><b>CT not reported for 8 months - concluded</b> – the findings were that</p> <ul style="list-style-type: none"> <li>Scans from Liverpool Women's Hospital to be reported were not correctly processed.</li> </ul>

	<ul style="list-style-type: none"> <li>• Outpatient clinic follow-up appointment not correctly rescheduled (Other Trust).</li> <li>• Standard Operating Procedure and admin processes have been strengthened (LHCH). The final report has been shared with Clatterbridge Hospital for their own learning.</li> <li>• Reviewed by the Knowsley Place SI panel.</li> </ul>
<b>Q1</b>	<b>One reported that was then found not to meet the SI criteria and de escalated</b>
<b>Q2</b>	<b>Paralysis following spinal block</b> – incident reported due to media interest under investigation.  <b>PE following omission of anti-coagulation after procedure</b> – SI under investigation

A separate SI report is provided to the Board.

## 5. RIDDOR Reportable Incidents

There has been 1 RIDDOR reported in Q2 2023/24 (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)

Q1 – No RIDDORS reported

Q2 – 1 RIDDOR reported – Manual Handling

### 2022/23

Q3 – 1 RIDDOR reported involving lifting and handling

1 RIDDOR reported following a delirious patient grabbing staffs arm

Q4 - 1 RIDDOR involving a Slip, trip or fall

## 6. Complaints

Complaints and concerns are managed in line with Department of Health guidance, which advises that all complaints are dealt with using the same process. The Patient & Family Support Manager produces a monthly complaints report that is presented to each Divisional Governance Meeting, detailing the numbers of concerns and complaints received, and the key issues and action taken. Any action plans and learning from complaints are presented by the relevant lead at the relevant Governance Committees.

### Formal Complaint Themes for Q1 and Q2

Division	Q1	Q1 23/24 Total= 12	Q2	Q2 23/24 Total = 11
<b>Surgery</b>	<b>3</b>	Clinical care and treatment: 3 Discharge: 2 Communication: 2 Private issues: Costs: 2 awaiting results 1 Patient experience: 3 (all related to consultations)	<b>3*</b>	Clinical care and treatment: 2 Cancelled Surgery/rescheduled- 1 Clinical priority of radiology tests- 1 Patient experience- 4 Transfer of care- 1 Discharge- 1 Private care costs- 1 *Cross divisional complaints
<b>Medicine</b>	<b>9</b>		<b>7</b>	
<b>Clinical Services</b>	<b>0</b>		<b>0</b>	
<b>Corporate</b>	<b>0</b>		<b>1*</b>	

At the end of year 22/23 we had received 26 formal complaints which was a decrease to the previous year. In the first 2 quarters of 23/24 we have received 23 formal complaints. The

early intervention from all the divisions is key to acting quickly and resolving concerns before they progress to a formal complaint.

Complainants are contacted at the earliest opportunity to resolve their concerns as soon as possible.

### **Learning from complaints**

All complaints are discussed in the respective governance committees. All the complaints were answered in the given timeframe in Q1 and in Q2 there are 5 still under investigation.

During Q1 and Q2 there are 7 complaints that were not upheld and 11 partly upheld- all actions were taken forward by the divisions.

Summary of learning:

- Advice around driving post procedure
- Careful communication of a lung cancer diagnosis
- Waiting time for test results
- Clear communication of private care costs
- Patient experience especially during consultations
- Change in processes around ordering radiology tests- making the priority clearer

All complaint responses either verbal or written were honest and open in line with the statutory Duty of Candour

## **7. Patient and Family support contacts**

There were 197 contacts in Q1 and Q2 of 2023/24, 125 of which were informal concerns, 72 contacts for advice/information.

Top themes include:

- Waiting times for cardiac surgery- previous multiple cancellations impacting patients- including cardiac surgery and TAVI procedures
- Communication of the cancellations
- Chasing referrals into the trust and waiting times for appointments.
- Appointments being cancelled due to IA and awaiting scheduling
- Administration issues- unable to get through to the access/bookings teams and secretarial teams, not receiving calls back, messages not actioned
- Private patient- expectations of cost

Summary of Learning:

- Quick escalation of any themes on a weekly basis at senior nurse meetings and to departments.
- Administration- issues highlighted to the division leads.
- Divisions are aware of the pathways for patients and trying to plan surgery around strike actions and reduce rescheduling of patients.

## **8. Claims and Coroners Update**

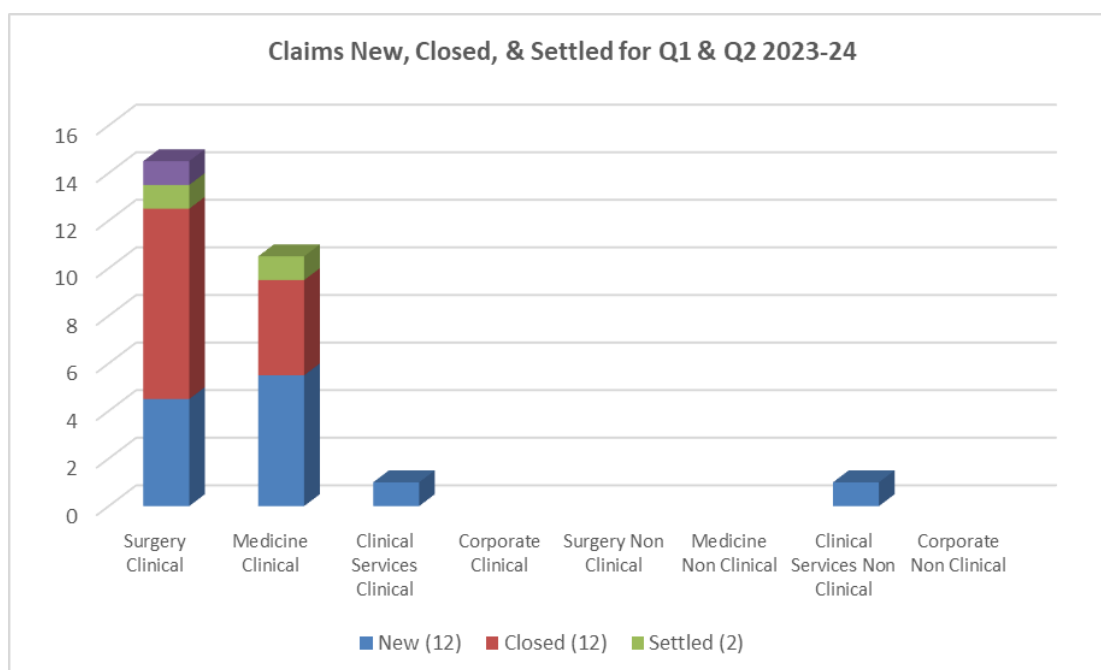
New Requests	Inquests Concluded (see below)	Inquests Scheduled
6	3	3



Inquests concluded					
Trust ref	Date of Inquest	Clinician(s) attended	Cause of death	Conclusion	Concerns/ Actions
880001 (JT)	09/05/2023	Mr Mediratta	1a) Myocardial Failure 1b) Aortic Valve Stenosis (Operated) 1c) Aortic Valve Disease (Operated) 2) Renal Failure	<b>Narrative Conclusion:</b> <i>On the 1st December 2021, JT died of heart failure at the conclusion of surgery to replace a severely stenosed bio-prosthetic valve which had originally been implanted in 2016.</i>	None
976915 (JEJ)	12/06/2023	Mr Kuduvalli	1a) Multi organ failure 1b) Renal and bowel ischemia 1c) Aortic dissection 2) Left ventricular hypertrophy	<b>Natural Causes</b>	None
Cor23/ Misc/ Grundy	01/08/2023	Dr Palmer	1a) Myocardial Infarction 1b) Pulmonary Oedema 1c) Severe Coronary Artery Disease 2) Idiopathic Pulmonary Fibrosis	<b>Narrative Conclusion:</b> <i>Consequence of a combination of naturally occurring disease and a recognised complication following a necessary attempted angioplasty procedure.</i>	No concerns. Not a trust patient. NP assisted on a procedure at another trust.

There were no concerns/ actions from the closed coroners inquests.

### **Claims Data for Quarters 1 & 2 2023-24 (this reporting period)**






## LTPS (Non-Clinical) Claims Data

### Liverpool Heart and Chest Hospital NHS Foundation Trust

Selection Criteria: LTPS claims received with an Incident Date between 01/04/2013 and 31/03/2023

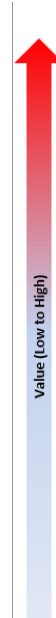
Total number of claims for this Trust: 33. Total value of claims for this Trust £832,361

Data correct at: 30/06/2023

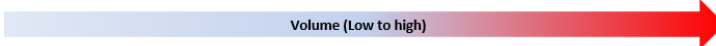


Nr			Value	Nr			Value
Assault	1	£	670,000	(blank)	0	£	-
Grand Total	1	£	670,000	Grand Total	0	£	-
Nr			Value	Nr			Value
Breach of DPA	1	£	5,703	Slip or Trip	9	£	59,987
Electric Shock	1	£	-	Hit by Object	4	£	39,442
Assault	1	£	-	Sharps Injury	5	£	17,688
Manual Handling Regulative	2	£	-	Defective Tools/Equip	4	£	14,000
Manual Handling	1	£	11,000	Workplace (Health, Safety and W	3	£	7,143
Provision and Use of Work	1	£	7,397	Grand Total	25	£	138,261
Grand Total	7	£	24,100				

### Key:



Scorecard Explained	
High Value = £1m and over, Low Volume < 3 claims	High Value = £1m and over, High Volume = 3 claims and over
These are high value, low volume claims where learning on an individual basis could be undertaken.	These are high value, high volume claims. We suggest that this area is a priority area of focus. Not all trusts will have claims in this area and will therefore move their focus to the amber and blue quadrants
Low Value < £1m, Low Volume < 3	Low Value < £1m, High Volume = 3 claims and over
These are low value, low volume claims and you may wish to keep a watching brief on these claims.	These are low value, high volume claims grouped by specialty. You may consider reviewing any themes that arise.



With the focus on learning and improvement under PSIRF, from a litigation perspective claims and coroners' updates and key learning opportunities will be shared through Trust solicitor and Litigation Administrator updates at the joint Medical and Surgical Audit Days. Any immediate learning will be taken at the time of claim, and shared accordingly. This is also aligns with GIRFT Litigation best practice.

## 9. Freedom to Speak Up

Freedom to Speak Up (FTSU) continues to be integrated at Liverpool Heart and Chest Hospital, alongside the Trusts other forms of Speak out Safely channels. The FTSU network comprises of:

- FTSU Executive Lead
- FTSU Non-Executive Director
- Two FTSU Guardians
- Deputy FTSU Guardian
- 18 multi-disciplinary champions

### Trend of themes of concerns raised – in Q1 and Q2 2023/24

In Quarters 1 and 2 there have been 16 concerns raised. All concerns were escalated, addressed and followed-up appropriately as per the FTSU policy.

Themes of concerns raised are documented in the table below.

#### Comparative view of concerns raised in Quarters 1 and 2 of 2023/24 compared with 3 and 4 2022/23

Themes of concerns as categorised by the NGO	Q2 2023/24	Q1 2023/24	Q4 2022/23	Q3 2022/23
Element of Patient Safety or Quality	2	3	0	1
Element of Worker safety, policy or Wellbeing	0	8	5	0
Element of Bullying or Harassment	2	0	0	3
Number of cases where disadvantageous or demeaning treatment (detriment) from speaking up is indicated	0	0	0	0
Other:	1	0	0	0
<b>Total</b>	<b>5</b>	<b>11</b>	<b>5</b>	<b>4</b>
<b>Number of cases raised anonymously</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>

Overall, the issues coming through the FTSU Guardians relate to systems and processes, health-and-wellbeing, working practices and staff values and behaviors.

## 10. Organisational Learning

The Trust has an approved Organisational Learning Policy, which sets out the structure by which the organisation identifies and applies learning. The Trust has also developed an organisational learning database which has been rolled out to Divisions and continues to be developed for wider roll out.

To increase the spread of learning, there is now an organisational learning section on the monthly team brief. Team brief is open to all members of staff. Topics covered include incident reporting and coroners application of regulation 28 (preventing future deaths), management of stroke, learning from serious incident (root cause analysis concerning retained secretions), what a mental health section means and communication between teams regarding a patient who underwent an amputation following thoracic surgery.

The Learning and Sharing session, which is chaired by the Director of Nursing, Quality and Safety takes place bi-monthly. The group's remit has now expanded to include learning from each of the Divisions and discussions on human factors elements of learning.

Through the introduction of PSIRF, there has been a weekly patient safety learning meeting set up in October 2023. This will support cross divisional learning, where departmental leads and matrons will present moderate harm or above incidents as well as any severity of incident, but with good examples of learning that will benefit others. PSIRF has taught us that any severity of incident or concern that arises may have a great deal of learning, that may be pivotal in the prevention of a more serious incident in the future. A forum such as this will also support the open incident reporting culture and encourage team leaders to exercise the new tools and templates in relation to incidents, promoting the no blame Just Culture throughout the Trust.

A network of Patient Safety Champions has been set up throughout the Trust, these individuals have a keen interest in patient safety, and attend quarterly champion meetings where key learning can be shared and taken back to their respective areas to disseminate. To date we have approximately 25 champions from a variety of departments. It is a safe and open forum for people to air patient safety concerns themselves or their colleagues have, seek guidance from their peers, share ideas, and utilise the network along with the leads to advocate for patient safety.

Soon to be rolled out is the Organisational Learning Sharepoint, which will hold a variety of shared learning information. This is soon to "go live" Trust wide, with the Learning from Mortalities section initially available, including Mortality Review Group summaries and Audit Day presentations.

Our quarterly Safety Surveillance Meeting triangulates themes from incidents, claims, complaints and safety huddle to help focus on specific areas which require learning dissemination.

## **11. Patient Experience**

### **NHS Adult Inpatient Survey 2022**

Once again LHCH has been rated one of the best hospitals in the country to receive care in this year's NHS Adult Inpatient Survey 2022 results. The results showed LHCH was rated one of the top two trusts in the country for 'overall patient experience, and best in the North West once again.

LHCH recognises that a positive experience during care leads to positive clinical outcomes. Engaging with patients, families, and carers, enables an understanding of their experiences and learning from them in order to improve service delivery.

Our Patient and Family Centred Model of Care sets out expectations for patients and families at each step of their journey, commencing prior to admission and until after discharge, every decision made is based on what is best for patients and their families.

### **Follow Up calls**

The Trust uses many ways of capturing patient experience, one of which is to contact patients who have had an overnight stay following their discharge home.

The results are very positive -

- 100% of our patients said staff were polite and friendly.
- 99% of our patients were happy with the hospital facilities and cleanliness.
- 99% of our patients said we kept their belongings safe.
- 99% of our patients said they felt included in their care.
- 97% of our patients said they received written information on what to do/not to do post discharge.

Areas identified for improvement are-

- Including patients in plans for their discharge.
- Helping patients to understand how they are asked their views on the quality of care they have received as an in-patient.
- Provision of bedside televisions.
- Car parking and hospital signage.

Themes from the calls have provided action plans for improvement, led by each Division. The action plans and learning from the calls are presented by the relevant lead at the divisional governance meetings. Any areas for concern are raised with the departmental managers who receive feedback from the calls on a weekly basis. This can assist in reducing complaints and local resolution as issues are dealt with immediately by the ward manager/matron.

Information gathered has indicated that the vast majority patients are extremely happy with the care they received. The response to the calls has been overwhelmingly positive and patients have expressed their gratitude for the call. Key themes for compliments have been that patients have received a high standard of safe care, delivered by a kind, caring and responsive team. Patient engagement event the recent patient engagement was held in September and engaged with

### **Patient engagement event**

The recent Patient Engagement event was held September 2023 which engaged with patients, families, staff, volunteers, Health Watch and governors. The patient and family feedback was overwhelmingly positive.

Themes for improvement included-

- The need for post discharge psychological support, especially for patients who live alone.
- Psychological support for patients following a traumatic event, such as a cardiac arrest in the community and also for their family who witnessed the arrest via a 24-hour dedicated help line.

## **Patient Shadows**

Patient shadowing has been overwhelmingly positive with praise for the teams in their communication, teamwork, compassion, and professionalism. None of the shadows recorded any HALTS or concerns for patient or staff safety.

We are continue to encourage shadowing for 2023/24 and hoping to increase the number of shadows undertaken. Patient shadowing aids their professional development as they gain a greater understanding of not only the patient journey, but the role of their colleagues across other departments and as such have found it a rewarding experience.

All comments raised are shared with the team to ensure we learn from every patient experience.

## **12. Conclusion**

Incident reporting, learning from incidents, complaints and claims remain a focus for the Trust. Incident reporting remains relatively consistent and continues to be emphasised in team brief, at safety huddle and in the Divisional Governance Committees. Training for incident reporting is continuing across all areas.

Receipt of formal complaints and claims has remained consistent, when compared to the previous quarters.

The Trust has a strong learning culture. Monthly learning and sharing meetings take place and the organisational learning session has been incorporated into the monthly team brief. All staff are invited to present learning from incidents complaints, claims and patient experience events.

As PSIRF becomes embedded within LHCH, shared learning will increase further, with learning and improvement at the forefront of investigating incidents, complaints, and litigation.

## **13. Recommendations**

The Board of Directors is asked to receive assurance that mitigation to prevent harm to patients and staff, by the reporting of and learning from reported incidents, complaints, claims and patient experience events continue to be monitored through the governance structures within the organisation.