Agenda Item No.3

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Libby McManus, Chief Nurse	Decision		High	Med	Low
	Discussion	X		X	
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Edmund Tabay, Deputy Chief Nurse	Strategic				
	Operational	X			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
Denise Smith, Chief Operating Officer					
CQC Domain: (safe, caring, effective, responsive, well-led)	Effective Responsive Safe Caring				

Meeting Date: 4th February 2020
Report Title: Update on the actions taken following the patient story at the Trust board

PURPOSE:

To update the Board on actions taken following the patient story at the board on 26th November 2019

SUMMARY:

Mr Ian Semmons shared his experience of care following a surgical procedure at the QEH in October 2019. There were no concerns with regard to the procedure itself including post-operative care, however, the Trust failed to communicate with him the outpatient follow-up.

FINANCIAL IMPLICATIONS / EFFICIENCY SAVINGS / QUALITY IMPROVEMENT:

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
			X		X

RECOMMENDATIONS:

The Trust Board is requested to note the actions taken following the patient story.

REPORT TO THE TRUST BOARD ON PATIENT EXPERIENCE

1. INTRODUCTION

Mr Ian Semmons shared his experience of care following a surgical procedure at the Trust board on 26th November 2020. There were no concerns with the procedure itself including post-operative care, however, the Trust failed to communicate with Mr Semmons with regard to his outpatient follow-up.

2. EXPERIENCE OF CARE WHILST AT THE QEHKL

- The Trust failed to communicate with Mr Semmons the follow-up clinic appointment following his discharge from the hospital.
- There was an unacceptable delay in his clinic appointment which was booked eight months after discharge. The original plan was for Mr Semmons to have a clinic review three months after the surgical procedure.
- Mr Semmon's son had an unsatisfactory experience in our oral surgery department.

3. UPDATE OF ACTIONS FOLLOWING THE PATIENT STORY

- Failure to communicate with Mr Semmons his outpatient follow –up was an oversight and this has been discussed with the relevant team to learn lessons and reiterate compliance with current processes.
- The unacceptable delay in Mr Semmons' clinic appointment was due a current backlog for urology follow up clinic appointments. To alleviate this in the short term, additional sessions are being provided. Longer term, capacity and demand work is being undertaken within the Urology service to understand the needs of the service.
- Dr Frankie Swords, Medical Director, met with the relevant clinician in the oral surgery department to provide feedback on the unsatisfactory experience of Mr Semmons' son when he visited the unit.

Edmund Tabay, Deputy Chief Nurse
29 January 2020