CATEGORY OF PAPER					
Specific action required:		**Provides Assurance:**	✓	**For Information:**	✓

Board of Directors' Meeting – 26/09/2019	
Report title:	**Patient Story**
Purpose of report:	The purpose of the report is to provide the Board with a reflection of our service delivery through a patient experience or staff perspective, with a view to use these experiences to continually improve the services delivered.
Key issues: *(key points of the paper, how this supports the achievement of the Trust's corporate objectives, overview of risk implications, main risk details on page 2)*	This patient story was previously presented to the Board in May 2019. This report summarises the story previously presented regarding the experience of the patient and her family following a delay in our Palliative Care transport for an end of life patient to be taken home. This resulted in an action plan being developed to improve the experience of those patients using the service and their families and the report goes on to detail the progress and improvements made. In addition, the author of the paper has had the privilege of being an observer with one of the dedicated Palliative Care crew and has seen firsthand the peace it can give to a patient at being at their preferred place and with their family at the end of life. Also included in the paper are two appreciations, from patient's family, received via the Macmillan service. These appreciations are not directed to the specific end of life service however show the care and compassion shown by ambulance crews from the core service and demonstrates the impact the service provided by the crews has on a patient's family at a very sad and difficult time. The report provides assurances that NEAS has acted on the learning identified from the complaint to improve the service and experience for other patients and their families when accessing our Palliative Care transport. In addition, assurance can be gained from the appreciations shared of the positive impact our core crews have on patients and families at a difficult time for all involved.
Issue previously considered by:	N/A
Recommended actions:	The Board is asked to review this paper and take assurance the Trust acts on learning identified to continuously improve patient experience.
Sponsor / approving director:	Director of Quality and Safety (Executive Nurse)
Report author:	Gillian Summers, Complaints Manager, Patient Experience Team

Governance and assurance

Link to Trust Priorities: *(please tick)*	**Organisational Sustainability**	**Improving Quality & Safety**	**Workforce & Investors in People**	**Clinical Care & Transport**	**NHS 111 & Clinical Assessment Service**	**Comms & Engagement**
		✓		✓		✓

Link to CQC / KLOE: *(please tick)*	**Caring**	**Responsive**	**Effective**	**Well Led**	**Safe**
	✓	✓	✓	✓	✓

<table>
<tr><td rowspan="3">Link to Trust values:
(please tick)

(Please explain how this paper supports the application of the Trust's values in practice)</td><td>Pride</td><td>Strive for excellence</td><td>Respect</td><td>Compassion</td><td>Take responsibility & be accountable</td><td>Make a difference – day in & day out</td></tr>
<tr><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td colspan="6">The actions of staff involved in implementing the action plan demonstrates all the Trust values and in particular making a difference, striving for excellence and take responsibility and be accountable. The appreciations and observations of the author demonstrate the respect and compassion, not only of the dedicated crews but also our core crews when encountering patients at the end of their life.</td></tr>
<tr><td>Any relevant legal / statutory issues?
(Such as relevant acts, regulations, national guidelines or constitutional issues to consider)</td><td colspan="6">N/A</td></tr>
<tr><td rowspan="3">Equality analysis completed

If this is not relevant please explain why:</td><td colspan="2">Yes</td><td colspan="2">No</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2">✓</td></tr>
<tr><td colspan="6">An equality analysis is a review of a policy, function or significant service change which establishes whether there is a positive or negative impact on particular social groups</td></tr>
<tr><td>Key considerations</td><td colspan="6">Details</td></tr>
<tr><td>Confirm whether any risks that have been identified have been recognized on a risk register and provide the reference number:</td><td colspan="6">Not applicable</td></tr>
<tr><td>Please specify any Financial Implications

Please explain whether there are any associated efficiency savings or increased productivity opportunities?</td><td colspan="6">Not applicable</td></tr>
<tr><td>Are any additional resources required e.g. staff capacity?</td><td colspan="6">Not applicable</td></tr>
<tr><td>Is there any current or expected impact on patient outcomes/experience/quality?</td><td colspan="6">Improved patient experience</td></tr>
<tr><td>Specify whether appropriate clinical and/or stakeholder engagement has been undertaken:
(stakeholders could include staff, other Trust departments, providers, CCGs, patients, carers or the general public)</td><td colspan="6">Patient story to be shared via Comms Team for publication in The Summary or PULSE</td></tr>
<tr><td rowspan="4">Are there any aspects of this paper which need to be communicated to our stakeholders (internal or external)?

(Please tick – if 'yes' then please complete all boxes. Please briefly specify the key points for communication and ensure the Comms team are informed via mailto:publicrelations@neas.nhs.uk)</td><td>Yes</td><td>No</td><td colspan="2">Positive</td><td colspan="2">Negative</td></tr>
<tr><td>✓</td><td></td><td colspan="2">✓</td><td colspan="2"></td></tr>
<tr><td>Proactive</td><td>Reactive</td><td colspan="2">Internal</td><td colspan="2">External</td></tr>
<tr><td>✓</td><td></td><td colspan="2">✓</td><td colspan="2"></td></tr>
<tr><td colspan="6"></td></tr>
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Board Meeting
Patient Story
26th September 2019

Summary of complaint presented in May:

A complaint was received from the daughter of a patient who, along with her father, was waiting with her mother for the Palliative Care transport to arrive to take her mother home from hospital. Following a 3 hour wait in a chair the patient was transferred back to a bed and after a further 2 hours the patient's family made the decision to transport the patient home by taxi as the patient was afraid she'd die in hospital and her wish was to be at home surrounded by her family.

Our dedicated transport service for Palliative / End of Life patients operates Monday to Friday; on the day in question the finish times of the three vehicles were 17:30, 18:00 and 19:00. On this occasion, due to the time the request was received it was too late to allocate the journey to the dedicated crews, therefore the patient had to wait for an ambulance from our core resource. This resulted in a delay in assigning an ambulance from our core resource due to the amount of emergency calls and urgent cases outstanding.

Action Plan Update:

A new 3 month trial for the End of Life vehicles has been introduced which started on 5th August 2019. This included new guidance for Health Advisors, Dispatch and the HCP's that make the bookings and addressed the following points from the action plan previously reported:

- Dispatch to link in with NEAS Macmillan Nurse/End of Life Care Facilitator to see how we can improve the service further and prevent any distress for patient and family.
- Formal palliative escalation process – dispatch to escalate to Duty Manager to help explore all options and someone to call the hospital to set expectations and give the hospital, patient and family a chance to decide whether the patient remains at hospital until morning
- Call handlers to reiterate the duty times of the crews on receipt of a request if the case falls into late afternoon
- Stronger communication with the hospitals – possibly from a call handling point reiterating vehicle duty times and setting expectations.

The following guides have been issued and the trial will be reviewed and the policy amended if deemed a success in improving patient experience:

- Guidance for Healthcare Professional booking End of Life Transport
- End of Life vehicle dispatch guidance
- End of Life Ambulances Health Advisor Guidance
- End of Life Ambulance Booking Process

Other updates:

- More communication out to the hospitals regarding the times of the dedicated palliative care vehicles (completed - teams have been communicated to but there will be ongoing refreshers). **Update: Further communications were sent out around the End of Life vehicles to hospitals, hospices and community teams on the 2nd August. In addition, it has already been disseminated by the Northern England Clinical Network.**

- A review of the Palliative Care duty times to see if there's anything NEAS can do to improve out of hours provision. **Update: The End of Life team regularly review the usage of the vehicles and collate this data monthly and look at Out of Hours figures too to see if this is something NEAS need to take back to the commissioners for further funding. This includes a review of the in hours operating times to determine whether the current times suites the demand .This is an ongoing process.**

- Dispatch representation at the Palliative Care Steering group. **Update: Dispatch Managers have been added to the Palliative Care Steering group and are regularly attending meetings.**

- Sharing the Palliative Care mean response times with the dispatch teams to celebrate success and or strive for improvement. **Update: Completed - performance is monitored and is being fed back to Duty Manager – further performance management feedback is given to dispatchers during coaching sessions.**

- Palliative lead and deputy to engage with dispatch team, sharing feedback from families. **Update: In progress the NEAS Macmillan Engagement Officer is in the process of preparing an OLM programme for dispatch to give dispatch staff a full description of what the vehicles are for and will include some good and bad examples of patient experiences**

Observation Experience:
On the day of the Complaints Manager's observation the crew were asked to collect a patient from a hospital in the south of the area and transport the patient to a town approximately 100 mile south of the region. The patient was to be taken to a hospice where his family was waiting. The crew were advised that the patient may not survive the journey and if the patient passed away while on the ambulance to carry on to the hospice.

Due to heavy traffic, the journey took longer approximately ¾ of an hour longer than expected and the patient, who was not able to verbally communicate, became agitated. The crew member travelling with the patient provided continuous attention and reassurance to the patient. On arrival at the hospice the patient was transferred to his room, still in an agitated state. The crew reassured the patient, advising that he was now at his destination and in his room and the only thing left to do was transfer him into his bed so his family could come and be with him. On hearing this, the patient's agitated state subsided and for a few seconds was peaceful, smiled and raised his arms in recognition he had made it to his family. The moment of peace, the smile and the reaction of the patient in knowing he had reached his destination was very moving and gave the Complaints Manager a better understanding of the powerful impact this service can have for all involved. The patient's family were waiting at the hospice and once hospice staff had settled the patient into his bed, would be with him as both the patient and family had wanted.

Appreciations received:
Two appreciations have been received via McMillan staff and demonstrate the difference our core crews can have when someone passes away while in their care:

1. McMillian Nurse called the Patient Experience Team to pass on the thanks of the patient's wife to the two crew members who transported her husband from the hospital to the Palliative Care Unit. Sadly, the patient passed away en route. Although the patient's wife was not with her husband when he passed she was comforted to know he had passed talking about his old army days with the crew who had had some experiences in common. The patient's family were extremely touched to find that although the patient had died en route, they had taken the patient to his waiting bed and made him ready for his family to arrive, turning his bed down in a military way as he would have wanted. The crew also waited for the family so they could explain how it had happened and the family were extremely grateful to the crew for all they had done.

2. Another McMillian Nurse called the Patient Experience Team to pass on comments from the patient's wife. The patient was palliative and an ex charge nurse who had been unwilling to discuss his end of life plans. The patient had gone to bed and taken a turn for the worst during the night, his wife called an ambulance however he unfortunately passed away during the journey. Rather than taking the patient to hospital the crew turned around and took the patient home. The crew helped present the patient in a dignified way in his bed to allow the family to say goodbye. , before calling the GP. The patient's wife had said the crew had shown so much care and compassion, were so respectful, it was outstanding.

Assurances:
The Board can take assurance from the ongoing work being carried out in our operations centre by all staff to improve the service we can offer to end of life patients.

In addition, the actions of all the crews involved in the experiences outlined above demonstrates the impact our service has at what is the most sad and difficult time for patients and their families. All crew members made a difference and showed compassion and care to all involved.

Document Information

Author Name:	Gillian Summers
Author Title:	Complaints Manager, Patient Experience Team

Sponsor Name:	Joanne Baxter
Sponsor Title:	Director of Clinical Care and Patient Safety