EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS – 22 MAY 2014**
SUBJECT:	**PATIENT STORY**
REPORT FROM:	**CHIEF NURSE AND DIRECTOR OF QUALITY & OPERATIONS**
PURPOSE:	**FOR INFORMATION AND DISCUSSION**

CONTEXT/REVIEW HISTORY
The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services.

Patient stories are a key feature of our ambition to revolutionise patient and customer experience. Capturing and triangulating intelligence pertaining to patient and carer experience from a variety of different sources will enable us to better understand the experiences of those who use our services.

Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

SUMMARY:
This story describes the experience of a young person with mental health difficulties who attended our A&E. The story reveals a number of lapses in the pathway of care for young people who require mental health assessments out of hours and specialised care. It highlights the distress caused for the family when they do not have confidence in the services offered due to their previous experiences when their daughter has become unwell. The story describes the disjointed communications between different agencies across the health economy. The family resorted to contacting the press which revealed a number of communication and misunderstandings.

A number of actions have resulted from this story which involves continued collaborative working between the Trust and our external partners. These actions include making improvements in the referral processes; escalating concerns about out of hours mental health services by the CCGs and NHS England; working together to provide skills training for Trust staff whilst they await a mental health expert to attend; considering a way of risk rating concerns and complaints received by the Patient Experience Team so that the correct escalation and actions can be mobilised in a timely manner.

It is important to report that the patient is currently attending a day placement in Staplehurst and is getting on well.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Improving patient experience and satisfaction with the outcomes of care are essential elements of our strategic objectives.

FINANCIAL IMPLICATIONS:
None

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
None

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES:
None

BOARD ACTION REQUIRED:

(a) to note the report
(b) to discuss and determine actions as appropriate

CONSEQUENCES OF NOT TAKING ACTION:

If we do not learn from events such as these there is an increased risk of further occurrences which may adversely affect both patient experience and outcomes.

Board of Directors
Patient Experience Story
May 2014

Introduction

This month's story describes the experience of a young person with mental health difficulties who attended our A&E. The story reveals a number of lapses in the pathway of care for young people who require mental health assessments out of hours. It highlights the distress caused for the family when their previous experiences do not give them confidence in the services offered when their daughter becomes unwell. The story also describes the disjointed communications between different agencies across the health economy.

A number of lessons learned have been identified and actions put in place to address the issues raised by the family.

The Patient Story

A 17 year old teenager suffering from psychosis attended the A&E at Queen Elizabeth Queen Mother Hospital Margate (QEQM) during March 2014. She presented having cut her arms and legs. She was also experiencing hallucinations and suicidal thoughts. She was accompanied by her mother, Mrs P and her stepfather Mr R. Both were very concerned for her welfare.

<u>The Story from the Perspective of the Family</u>

Mr R said that their daughter was not assessed for 45 minutes after arriving in A&E. He said that he had to find the Doctor himself. It was then that their daughter was given a sedative to help her. The staff caring for the teenager, were not mental health trained practitioners. There was no mental health assessment undertaken during this time by the Child and Adolescent Mental Health Services (CAMHS). The family were told that this was because the CAMHS team only work during the day. However, Mr R did speak to the CAMHS Home Treatment Team 24 hour helpline.

The patient's mother described the treatment her daughter received in the A&E as disgusting. She said that it seemed to her that none of the staff appeared to be trained or equipped to care for her daughter. She said that she had to ask four times before her daughter's wounds were dressed. She said that her daughter was hearing a voice in her head that was telling her to kill everybody and was frightened that someone was going to kill her; such was the severity of her psychosis at that time. Mr R felt it was unsafe for his stepdaughter to be in the main A&E open area, so she was cared for in a treatment room. Mrs P said that she felt that her daughter should have been given her own room. The family were told that she would have to stay in the treatment room as there were no mental health beds available. There was a delay in transferring her to Rainbow ward which resulted in the teenager remaining on the floor for around three and a half hours. Her transfer to the ward took place at midnight. The family said that the staff on Rainbow ward were fantastic.

It was after this experience that Mrs P went to the press where the story was published along with a photograph of her daughter in the A&E treatment room on the floor. On the 28th March 2014 the story was printed in Kent Messenger's 'KentOnline' news page.

Other Communications

On the 19th March Mr R contacted Kent & Medway NHS and Social Care Partnership Trust (KMPT). He complained of being passed from 'pillar to post' by the QEQM who had given him their number. It transpired that the patient was not known to KMPT, therefore this member of staff in KMPT contacted the Trust, raising the concern, and she also emailed CAMHS at Sussex, just in case the teenager was on their caseload and would be able to offer advice and a medical history. In the meantime the Patient Experience Team contacted Matron Jenny Ray in A&E at QEQM to respond to Mr R.

In addition Mrs P contacted South Kent Coast CCG saying that she had left a voicemail with the Patient Experience Team and that they had not responded. In fact she had left her message with another organisation, but did not realise. This added delays in responding to the family and increased their anxiety and also that of the CCG who were concerned with the potential seriousness of the case. In the meantime Matron Jenny Ray was able to speak with the mother.

The Concerns made Visible

Matron Jenny Ray's conversation with Mrs P revealed the extent of the family's fears and concerns. The issues in A&E had been upsetting to Mrs P. Concerns were expressed regarding the attitude of certain members of A&E staff which Matron Ray promised to address making clear to Mrs P that she expected the staff in the Department to treat all patients with respect and dignity at all times. However Mrs P was full of praise for Sister Anne and Sister Strickland who the family found very caring.

The bed originally offered to her daughter in A&E was in the observation bay but because her daughter was expressing intent to harm other people, her mother felt it was inappropriate to nurse her with other people for the safety of those other patients. She agreed that the treatment room was better for her daughter as it was quieter. She also agreed that the staff had indeed offered a bed or a trolley but that she had preferred to stay where they were with her daughter on the floor as she felt it was safer. However the staff should have probably considered providing a bed or trolley mattress on the floor for her to sleep on. The issue for Mrs P was that the A&E staff should have been better trained to manage patients with mental health issues and had this been the case they would have had greater understanding about how her daughter's psychosis might have put other patients at risk in an open bay.

Matron Ray discussed with Mrs P the newspaper article. Mrs P said she was passionate about raising awareness over what she perceives to be the lack of mental health services out of hours for young people. Her intention was to 'call' for improved mental health services throughout Kent as she felt that her daughter has never received the level of care she feels she requires. She said there are no support groups that she is aware of and she is only aware of one residential mental health unit for adolescents in the whole country. As a result of her article these concerns have been escalated to local MPs and local support groups. Families with similar issues have also contacted Mrs P.

Summary

This story describes the experience of a young person with mental health difficulties who attended our A&E. The story reveals a number of lapses in the pathway of care for young people who require mental health assessments out of hours and specialised care. It also highlights the distress caused for the family when they do not have confidence in the services offered due to their previous experiences when

their daughter has become unwell. The story highlighted the disjointed communications between different agencies. Communication and misunderstandings were evident as shown in the press article and during the family's time in our care in A&E. Matron Ray was able to build an empathetic relationship with Mrs P and was able to allay her fears and distress by spending time listening to her experiences and hearing how she was feeling at the time. This enabled a clearer picture to be revealed and support and explanations offered to Mrs P that reassured her.
The story also highlights the challenge for A/E staff and paediatric staff working to support the patient and family in difficult circumstances.

Learning and Actions
The story was a catalyst for communication and collaboration with our CCG colleagues. They too were briefed and have taken responsibility for working with our mental health partners in addressing some of these issues.

CCG Actions
At present there is a Parliamentary Inquiry into the lack of mental health beds being undertaken. The CCGs and NHS England are also influencing where they can to ensure a resolution to this problem. One vehicle for this is the Health Safeguarding Group (Kent and Medway Safeguarding Team) who are working closely with relevant agencies to ensure plans are being developed and that the problem is being addressed and escalated as appropriate. Locally work is in progress by the CCGs that involves examining the current pathway and where both the Trust and CAMHS can make improvements. This work includes:

- Developing clarity over the referral criteria for mental health patients;
- Ensuring that a referral is made earlier in the pathway for the patient;
- Ensuring that CAMHS log all referrals effectively so that they can plan their staffing appropriately to meet the demand in a more timely fashion;
- CAMHS are increasing their home treatment pathways to prevent patients needing to attend the A&E and be more effectively managed at home;
- CAMHS are working with us to set up skills training for staff in the Trust so that they are better equipped to care for patients such as Mrs P's daughter.

The CCGs are also working with Surrey and Sussex Partnership NHS Foundation Trust around this issue. They have informed us that children's commissioning is an agenda item at the next Clinical Forum and they recognise that the Early Intervention Teams are under resourced. The team 'Young Healthy Minds' is spot purchasing additional support.

Trust Actions
Another area that this story raised was recognition of the seriousness or potential risk a concern raised to the Patient Experience Team may have for the Trust. To explore this area, the Complaints Management Steering Group have undertaken to look at whether complaints and concerns need to be risk rated in order to ensure the correct escalation to the correct people. This may be the risk to the patient/client, or a reputation risk to the Trust, such as a press enquiry. This work has just commenced as a result of this story.

As described earlier in the story, Matron Ray is working with her teams to minimise a recurrence of the care issues that Mrs P discussed with her. In the meantime it is important to report that Mrs P's daughter is currently attending a day placement in Staplehurst and is getting on well.

The broader questions for the CCG's and the Trust are:

- Where is the best place of safety for adolescents whilst awaiting specialist assessment and access to specialist services.
- The need to develop standard operating procedure and guidelines to support staff in caring for this patient group.