Independent Healthcare Providers Network

IHPN Share & Learn Community of Practice Quarterly Roundup

Issue: March 2025

Welcome!
As the eighth Round Up for IHPN Share and Learn we hope you find this update useful, please feel free to share with your Patient Safety, Clinical Governance and Heads of Department colleagues!

New Share & Learn updates this quarter
Find enclosed recent learnings identified at the meeting held in March 2025.

Dates for your diary
2025 dates for the Share & Learn CoP have been shared with CoP members.

Extending invite across all sectors
If you would like to be invited to the CoP please contact Linda.Jones@ihpn.org.uk.

Medical Colleagues
The CoP would welcome hearing from any medical colleagues that would be interested in joining or presenting a case study during the meetings. For more information, please contact Linda.Jones@ihpn.org.uk.

Feedback to IHPN
IHPN would be very keen to hear about any changes you have made to practice since receiving these share and learn updates. We would be delighted to be able to demonstrate that the group is contributing to turning the dial on patient safety. Please get in touch with Linda.Jones@ihpn.org.uk if you would like to share any changes you have made following any outcomes of the Share & Learn Community of Practice.

To learn more about the Share & Learn CoP please email info@ihpn.org.uk.

Welcome

Welcome to the eighth IHPN Share & Learn Community of Practice Round Up which intends to keep you up to date with learning outcomes following the IHPN Share & Learn meetings.

IHPN Share & Learn CoP

The IHPN Share & Learn Community of practice consists of a small number of representatives from the Independent Sector who come together to discuss an incident in a safe environment, sharing ideas, best practice and learnings right across the sector. The meetings are scheduled to take place every quarter and aims to improve patient safety by sharing learnings widely.

IHPN S&L Webpage

IHPN have developed a webpage for the S&L CoP. Here you will find copies of this Round Up and other valuable resources that are shared within the meetings. Please use this link to access the webpage.

Share & Learn Report

To read the '12 months on' report click here.

Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.

Etienne and Beverly Wenger-Trayner 2015

Case Study background

Service provider operates an Integrated Urgent Care Clinical Assessment and 111 first services and provides telephone assessment to patients when their initial 111 assessment determines that they require further clinical telephone support. This service runs 24 hours a day, 7 days per week (Mainly evenings and weekends).

Day 1:

Patient called 111 service due to experiencing lower back pain.

A message was sent electronically to GP practice to call patient.

Patient chased call with GP, but no call back received.

Day 2:

Patient called 111 service provider and placed in queue.

Patient Safety Call System called patient to check wellbeing – worsening symptoms so escalated to next clinician.

Triaged by Doctor – prescribed NSAIDs.

Day 3:

Patient found deceased by husband.

The first call made from provider to patient's family:

1st call with patient`s husband

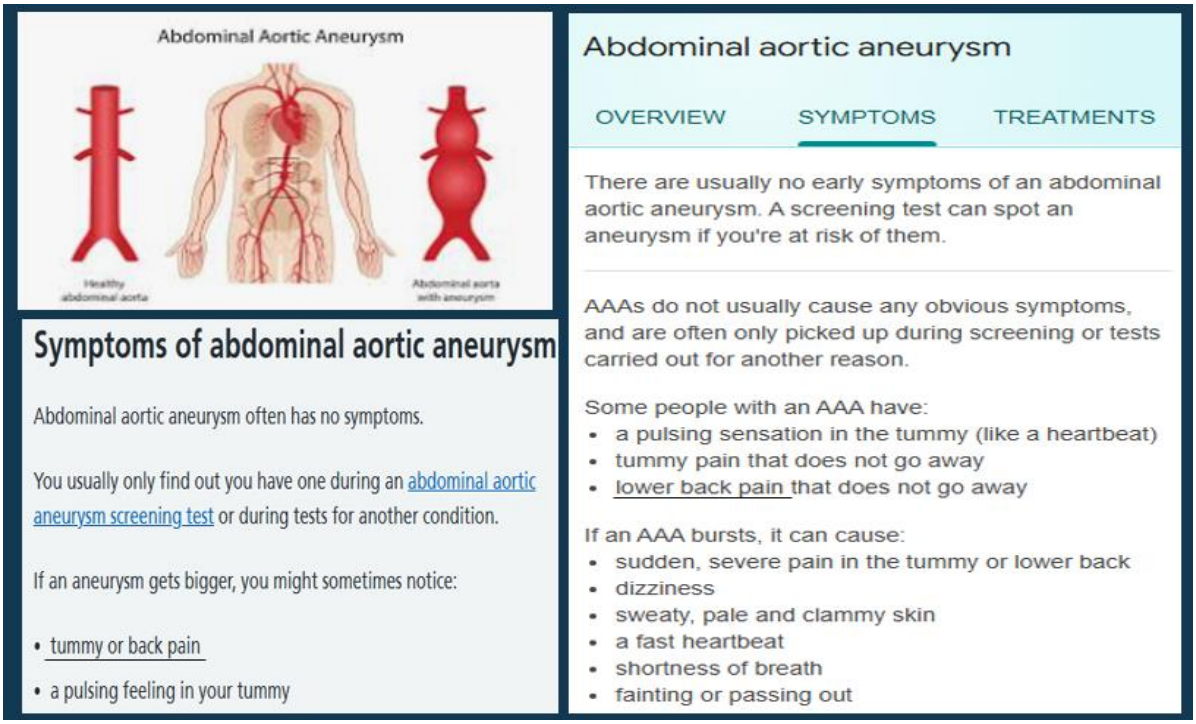
- Shared condolences.
- Outlined the investigation that will be completed.
- Provided contact details.
- Followed up via email.
- Polite conversation held.
- Further call arranged for the following week.

Currently awaiting a Postmortem to be performed.

Ahead of next meeting, patients husband contacted service via email to provide further timeline of calls made to GP – start of rapport building.

Shared Learning Points

- Families may have already researched possible causes before you call them. You will need to be prepared for this.
- The first phone call is always difficult, you are talking with grieving relatives who may present different emotions.
- Families and staff members may make presumption of probable cause.



The second call from provider to patients family:

Patients husband asked why GP did not action the referral sent from 111 services - Service provider agreed to follow up with GP to find out why they did not action the 111 referral or the patients chasing call on the following day.

Service provider sent a Health Care Professional Feedback (HCPF) to GP advising them it was a safety investigation, and their support with the investigation was required due to a question being asked from the family.

General update provided on how the investigation was progressing.

Husband started to open up in conversation – possible outlet for him.

The third call from provider to patient's family:

Duty of Candour letter sent - at this stage it was felt appropriate as had no direct evidence not to send one.

Concerned there were no provisional postmortem results so unable to confirm cause of death.

Recorded as a PSII on STEIS.

Patients husband started to share memories about his wife and family network.

Provisional Postmortem Results (Awaiting Report):

1a Heart Failure.

1b Ischemic and Valvular Heart Disease.

2 Myocardial Fibrosis.

1a is caused by 1b.

Post PM decision making and action taken:

Based on the provisional postmortem results – had the option to close the investigation but chose not to.

Had developed a strong rapport with husband – invited into his family.

Downgraded investigation from PSII.

Final report was 80% completed and family were expecting report.

Family still had unanswered questions from GP – had chased on two occasions.

Husband met with GP practice; no explanation provided. GP informed husband they would investigate.

Service user sent report to husband; incident closed.

Approx 3 weeks later:

Minor clarification questions raised by family from incident report.

Family requests:

- A Subject Access Request for call recordings from 111 service provider.
- Wished for transcripts of calls to be sent.
- Details of how to raise a complaint about the GP practice.

These were all actioned as required and service provider notify solicitors.

Family responds and thanks provider and state they have decided to wait for the postmortem report.

The end – or was it?

The family received the postmortem report a week earlier than expected.

Not only traumatic to read for the family – they also didn't understand the wording.

Blaming themselves that if she had attended hospital sooner for heart issues, would the outcome have been any different.

Service provider offered to read and interpret this to the husband so he could make sense of the report.

Finally:

*Thank you so much for your explanation of the coroner's report. This really has helped myself and ***** daughters fully understand the causes of her passing.*

*It has also helped to resolve the "what if" question, which has been on our minds since ***** passing.*

***** would not have wanted a long stay in hospital, and as you say may well have had the same outcome.*

*Hopefully ***** passed peacefully in her sleep.*

Thank you for all your help through what has been a difficult time for myself and the family, now we can look back on our fond memories of her and the love she gave us all.

Reflections & Shared Learning

Family engagement can be challenging as you represent the organisation that may have contributed to that safety event.

Families do need answers and don't be afraid to be honest and transparent with them.

When you build that rapport, it's a privilege to be working alongside them in a considered traumatic period of their lives.

Be bold and get patients and families involved with investigations.