PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS
Sandwell and West Birmingham
NHS Trust

Annex 1 Response to Patient / Staff / Service Stories shared with the public Trust Board in 2022/23

Story synopsis	Key themes/ learning points	Actions taken and planned
APRIL 2022 – Patient /Family Story		
Paul Turner, a GP attended to tell us the story of father, William Turner, who died at Sandwell hospital from metastatic angiosarcoma having been admitted urgently via A&E with a pneumothorax caused by lung metastases in November 2020. The story talked about the issues with his journey and the lack of communication.	• Lack of communication of End of Life to families • Challenge the reliance on the cancer multidisciplinary team for aggressive cancers. • Advocate for a much more appropriate level of individual leadership • Lack of responsibility from doctors for people during their last days • No one seemed prepared to recognise what was going on with Bill or take the leadership.	a) End of Life dashboard now in place b) Fast track process in place and being communicated with staff c) service improvement project ongoing re improving care at end of life d) This story was shared with the End-of-life team to use as support to educate staff e) Paul has been part of a video to educate staff regarding good care at end of life
MAY 2022 Service Story		
The Neonatal Community Outreach Team are responsible for working alongside the MDT to ensure timely and co-ordinated discharges. The team have a duty to follow up any referrals and undertake home visits where required. The service provides support to parents and carers of sick and preterm babies on discharge from the neonatal unit and transitional care allowing a seamless transition in to the community.	• Reducing length of stay of babies, and mothers when on TCU • Reduce cot capacity, enabling a smoother flow of patient care within NNU, whilst allowing staff to delivery care safely and effectively to their patients. • Protect family's mental health and well-being. • Supports breastfeeding. • Introduction of the STORK programme	a) Continuing to develop the service to ensure babies return home earlier b) Neonatal review being undertaken May 2023 which will review the whole pathway

JUNE 2022 Community Third Sector Story		
Newbigin Community Trust is an embedded, community-based organisation which aims to provide a place of welcome, inclusion and social cohesion for neighbours in Winson Green and Handsworth area. The first site is The Lodge Road Church Centre where we provide a drop in crisis service and a social support cafe. Local residents and their families drop in for help and assistance and any advocacy and support needs. There is support accessing such things as housing, benefits and council tax etc A safe place for people to come together. The second site is Benson Community School where we run a Parent Hub that facilitates family and children's work, drop-in advocacy appointments, mum's groups and after school kids' clubs. The third site is Newbigin House where we hold community meals, monthly community events, such as funfairs and festivals, as well as kids' clubs and a weekly youth group.	• Many people who struggle to access health care and statutory organisations will say they are seldom heard but we need to meet them where they are in our communities like at Newbigin. • Healthcare professionals do not always make best use of trusted voluntary sector colleagues who are willing to transport folks to appointments and attend alongside patients to help get better outcomes. • Healthcare professionals often fail to explain treatment options and have proper discussions about risks and benefits of each and then make a joint decision. • The Trust GP Practices teams should be outward facing and have links to the voluntary organisations with in the catchment area. • Services should be developed for some segmented for some people based on specific needs • Newbigin and other local community organisations are best placed to help local communities and statutory organisations should make best use of the relationships they have within their communities.	a) Integration committee will lead the community response b) Further work planned with Newbigin to work together in partnership. c) Community Takeovers in place – Integration Committee is now taking place in community venues and voluntary and community organisations are attending to present and discuss with us how we work in partnerships

JULY 2023 Patient/Family Story		
Helen is Bill's daughter. Bill was involved in an accident in January 2022 in which he sustained 4 fractures to his skull. He was admitted to the Queen Elizabeth Hospital Birmingham and was later transferred to Sandwell Hospital to be closer to home. Helen describes difficulties in communicating with ward and medical staff when trying to discuss the incidents above and other issues such as support to positioning and feeding, Bill's dignity and one to one supervision.	• Barriers to communication • Lack of compassionate care • Lack of open and transparent communication • Lack of fundamentals of care	a) Several meetings with Helen to discuss and listen to concerns. b) Fundamentals of Care Trust Year one Priority of Communication – Plan in place trust wide plus several projects c) Story shared at Patient Experience Group d) Visiting policy reviewed and improved to a better position to Pre Covid ensuring families are able to help and support their loved one 24/7 if requested
SEPTEMBER 2022 Fundamentals of Care Improvement Story		
Following a paper in February 2021 which highlighted concerns regarding Trust wide MUST compliance, complaints, patient stories, care planning, SJR's, incidents and PLACE assessments, the Nutrition Steering Group was restarted. The Nutrition and Hydration steering group focuses on ensuring that there is an embedded process of improved quality of care and patient outcomes through policy, quality improvement programmes of work are resulting in sustained high quality and safe patient care.	Malnutrition Universal Screening Tool (MUST) score compliance • Positive patient experience • - Reduce length of stay of acute beds • - Reduction in readmissions • - Food chart compliance and data quality • - Fluid balancing chart compliance and data quality • - Improved mouth care • - Improved dentistry Approach to date	a) Mouth care Matter now been rolled out across the organisation. b) Patient Panels in place c) Patients are members on the Nutrition & Hydration Steering group and sub groups d) Hydration Project at Rowley Hospital to monitor patients' fluid intake
OCTOBER 2022 D" A Service Story through presented through a patient story		
The D2A model means that rather than a person's needs being assessed in the hospital environment, once their acute medical treatment is completed, the person is taken home and assessments are completed in their own environment. Within SWB this is co-ordinated through our Integrated Discharge Hub. This is the story of Elma	• The environment of an acute hospital does not always facilitate a realistic assessment of a person's ability or needs. • Standardised assessment of confusion is required before assumptions are made – this is now happening on a consistent basis via our Frailty SDEC • The need for us all to understand communication barriers and avoid	a)We now have a dedicated transport service – Driving Miss Daisy – which provides 1-hour slots from 10am to 6pm, Mon-Fri - dedicated to D2A services b)Further communication is ongoing across all professional groups to ensure clear understanding and role of D2A

which was used to demonstrate the work of the discharge Hub in improving our patients discharge	assumptions Subjective nature of cleanliness in the home and the need to understand the detail behind reports of 'unsafe environments' • The benefits of taking a 'home first' and person-centred approach – reversing our culture of defaulting to bed-based solutions instead understanding community options available • The value of speaking first to the person – son spoken to first, rather than the Elma herself • Links to the "Last 1000 days" campaign – Enabling people to spend more time at home in the last weeks/months/years of life • Co-ordination of discharges where support is required is key and a dedicated and responsive transport service is key to delivering this. Elma's discharge was arranged as part of a trial	
December 2022 Staff Story		
SHC attended board development day to present his story of how he has been treated through a disciplinary investigation of which the outcome was he was cleared of any wrong doing	• Communication • Staff Support/wellbeing • Are our disciplinary processes correct in respect of above?	a) Launch of the People Plan b) New Trust Values Introduced c) Pilot of Leadership programme completed. d) Review of Disciplinary Process ongoing

JANUARY 2023 Service Story		
The stroke Team had received multiple complaints around communication, lack of opportunity to practice rehab skills outside of Therapy sessions, and increased number of falls on the ward and poor documentation of essential care.	• Getting the fundamentals of care right for our patients is essential, the co-production of care and the clinical assessments need an integrated co-produced approach. • Integrated teamwork encourages compassionate care; improved morale of the team, better care provision for our patients and joint learning from patient experiences/incidents and complaints allows change to happen at the right time, by the whole team and is responsive to the needs of the patients. • Reduction of risk. • Co-design is imperative. • Use of the third sector and communication with and about the people and services available, is key to preventing our patients feeling like they have been abandoned when their treatment journey has ended.	a) Integrated care/therapy assistant roles to be explored; cross skills to facilitate 24-hour rehabilitation and ensure this is done in a meaningful way. Get up, get dressed, get moving would benefit from this joint role. Potential for reduction in LOS and avoidable falls. b) Continued development of the integrated approach to care to ensure consistency of care. c) Continued and ongoing review of the patient journey and how each MDT member is adding to the quality of care. d) Mealtimes Matters launched. e) Patient panels set up for feedback
MARCH 2023 Patient/Family Story		
Peter McKernan was a 76-year-old man admitted to City hospital via his GP in July 2020. Peter had dementia and an aortic aneurism; he was diabetic with high calcium and was in remission following kidney cancer. He was able to walk with assistance. Peter was a proud man able use a commode only rarely using a pad as a precaution. He was able to carry out small tasks, such as making tea. The purpose of the 24-hour admission was only to rule out a stroke. The agreement with family was Peter would stay no longer than 24 hours. Peter's stay extended to four days, after which he did not get out of bed once home and Peter died one month later.	• Lack of communication • Lack of fundamentals of care • No patient voice	a) Dementia lead nurse commenced February 2023/ John's campaign being relaunched. b) About me documentation being reviewed c) Fundamentals of Care Trust Year one Priority of Communication – Plan in place d) Carers partnership agreement being scoped. e) Visiting policy reviewed and improved f) Partnership work with Black country Healthcare to improve our care pathways. g) Two meetings with the family to listen to their story and share the work that is ongoing. h) Further meeting with the family May 2023