Health and Adult Social Care Scrutiny Board

Thursday, 31st March, 2016 at 3.00 pm
in Committee Room 1 at the Sandwell Council House, Oldbury

Agenda

(Open to Public and Press)

1. Apologies for absence.

2. Members to declare:-
   (a) any interest in matters to be discussed at the meeting;
   (b) the existence and nature of any political Party Whip on any matter to be considered at the meeting.

3. To confirm as a correct record the minutes of the meeting held on 7 January, 2016.

4. Update on Transforming Care Together (The partnership between Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Birmingham Community Healthcare NHS Trust)

5. Healthwatch Sandwell Report - Why Do Good People Allow Bad Things to Happen?
   a) Healthwatch presentation.
   b) Sandwell and West Birmingham NHS Hospital's Trust response.

6. Overview and Scrutiny Committee briefing note on people who have a delayed transfer of care.

J Britton
Chief Executive
Sandwell Council House
Freeth Street
Oldbury
West Midlands

Distribution:

Councillor Sandars (Chair);
Councillor Jarvis (Vice-Chair);
Councillor Bob Lloyd (Vice Chair);
Councillors Edis, Giles, Gill, Hartwell, D Hosell, Piper and Phillips.

Agenda prepared by Rebecca Hill
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Sandwell
Metropolitan Borough Council

Agenda Item 3

Minutes of the Health and Adult Social Care Scrutiny Board

7th January 2016 at 3.00pm
at the Sandwell Council House, Oldbury

Present: Councillor Sandars (Chair);
Councillors Hartwell, Jarvis, Lloyd and Piper.

Apologies: Councillors Edis, Giles, Gill and D Hosell.

In Attendance: David Stevens (Director - Adult Social Care, Health and Wellbeing);
Debra Ward (Safeguarding Board Business Manager);
Kay Murphy (Divisional Manager Brokerage, Adult and Community Service);
Eddie Clarke (Lead Director for Adult Safeguarding Board);
Bill Hodgetts (Sandwell Healthwatch).

1/16 **Minutes**

Resolved that the minutes of the meeting held on 15th October, 2015, be confirmed as a correct record.

2/16 **Sandwell Safeguarding Adults Board - Annual Report 2014/15**

The Board received a presentation on the Annual Report for 2014/15 of the Sandwell Safeguarding Adults Board from the Boards Business Manager and the Lead Director for Adult Safeguarding Board.

Due to the implementation of the Care Act 2014 each local authority had a statutory duty to set up a Safeguarding Adults Board; to include representatives from: the Local Authority, the NHS and the police. All partners should meet regularly to develop shared plans for safeguarding. In addition a safeguarding plan and report should be published annually and be publically accessible. Sandwell Safeguarding Adults Board met on a quarterly basis.

Safeguarding was defined as an umbrella term for both 'promoting welfare' and 'protecting from harm'; in that every person had the right to live a life free from harm and abuse. Society needed to work together toward the termination of abusive situations.
Alongside the responsibility to promote the welfare of the people supported, they should also be protected from harm or abuse.
Adults at risk should be given information, advised and supported in a form they can understand; whilst their views remained central to any safeguarding decisions made about them.

"An 'adult at risk' was defined as an adult (a person aged 18 or over) who 'is or may be in need of community care services by reason of mental or other disability, age or illness; and who is, or may be unable to take care of him or herself, or unable to protect him or herself."

The Board heard that people could be made to feel unsafe or threatened in a number of different ways and a variety of different circumstances:

- Physical abuse;
- Emotional/Psychological abuse;
- Sexual abuse;
- Neglect;
- Financial/Material abuse;
- Institutional abuse (in a care home, for example);
- Hate crime/Discrimination;
- Organisational abuse;
- Modern slavery;
- Self-Neglect.

The four identified safeguarding priorities for 2014/2015 included:

- Protect and Prevent;
- Quality & Assurance;
- Learning & Development;
- Making Safeguarding Personal;

The Board questioned and discussed the following points;

- Where referrals in relation to adult safeguarding were generated and what the referral process consisted of. They heard that referrals tended to be received generally from community social care staff or police, with most victims being located within care

homes or their own home which reflected the national trend. The Care Act 2015 had removed the restriction of time scales related to referrals, but safeguarding had continued to complete a high number of enquiries within an impressive timeframe; considering many enquiries needed a wide range of data to be gathered. Current data showed that 63% of enquiries were completed within 20 working days. 98% of cases had been discussed within 5 working days within the last 3 months.

- It was acknowledged by the Sandwell Safeguarding Adults Board that improvements needed to be made to their website, as currently there was no facility to direct members of the public to Sandwell MBC's main website where abuse could reported. In addition minutes of the Boards meetings were also to be added at a future point.

- All parties agreed that the profile of what 'safeguarding' actually was needed to be raised both regionally and nationally. A high percentage of the public would simply not be aware of what was meant by the term. A number of strategies connected to prevention work was to take place in the public domain to raise awareness of safeguarding and the safeguarding Board itself. Representatives of the Sandwell Safeguarding Adults Board were invited to speak at a future meeting of Healthwatch in order to further engage members of the pubic and raise awareness of safeguarding.

- Data sharing was reported to have progressed well, and found to be more than satisfactory by the Safeguarding Board. The Safeguarding Board had an operational protocol which all agencies are required to have signed up to. Relationships between agencies were reported as being positive with no barriers being found as yet. The operational team were located next to the Councils Multi Agency Safeguarding Hub team (MASH), which gave it ready access to police and medical advisers.
  It was highlighted that the Authority does have the power to require an organisation to investigate something on its behalf, though the need to exercise these powers had not yet been necessary.

- Due to changes in legislation and projects such as the community offer less formal routes of care had been instigated, for example, the use of voluntary organisations. Concerns were

raised that this could potentially result in a reduction of abuse being reported as fewer professionals would be involved and hence it may not be recognised, with lack of training being one possible outcome. The Health and Adult Social Care Scrutiny Board were reassured by the Lead Director for Adult Safeguarding Board that informal care providers were able to access training programmes and support through them. However, this was a further area that needed to be promoted.

- Personalised care would be focused upon strongly over the next twelve months. This highlighted the need for professionals to work closely with vulnerable adults to take their thoughts, needs and wishes into account holistically. The service had moved on from simply 'doing things to people': – Possible outcomes, education and professional views were all relayed to the service user to enable them to make an informed decision about their care. This required having real adult conversations between professionals and service users. It was also stressed that institutionalised persons must be given the opportunity to have a regular voice and a chance to be heard.

- The quantity and quality of data was hoped to improve over the coming year. Included in this was that the Safeguarding Board hoped to receive data in relation to near misses and never events related to abuse. It intended to work alongside the Clinical Commissioning Group to gain access to this information; the aim being that the occurrences of these instances was reduced.

- The Lead Director for the Adult Safeguarding Board acknowledged that it was always possible for individuals to slip through the net – the service was unable to support potential service users if they were not aware that they existed. The risk of this, however, would be reduced by the use of the 'neighbourhood services campaign'. This was intended to raise awareness of issues and hoped to assist in prevention.

- The challenges for the Sandwell Safeguarding Adults Board for 2015/2016 focused on the prevention of abuse, the protection of vulnerable adults and increased quality and excellence through the utilisation of data to ensure the Deprivation of Liberty Safeguards (DoLS) was used appropriately.
  The Deprivation of Liberty Safeguards came into force in England and Wales in April 2009 under amendments to the

Mental Capacity Act 2005. Article 5 of the Human Rights Act 1998 required that service user should not be deprived of their liberty except in certain, pre-defined, circumstances; there must also be an appropriate, legally based, procedure in place to protect the individual's rights. This could range from locking doors, physical restraint and to the level and type of advice being given.
These safeguards were intended to protect individuals from being deprived of their liberty unless it was in their best interests to protect them from harm, or to provide treatment, and there was no other less restrictive alternative. The Local Authority was the lead agency involved in these claims and provided twice yearly reports to the Safeguarding Board. Recent changes to legislation had drastically increased the amount of claims made as a much wider scope was able to be viewed. The investigation of claims was described as a rigorous process and included a number of other agencies, mental health clinicians and best interest assessors.

- It was highlighted that different issues were approached in different ways – for example problems, which arose from hoarder behaviour, could be addressed though neighbourhood intervention and/or floating support. This type of service allowed time to be spent with the service user and for physiological help to be received.

The Chair and members of the Health and Adult Social Care Scrutiny Board thanked the representatives of the Sandwell Safeguarding Adults Board for their educational presentation on the work of the Safeguarding Board.

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(Meeting ended at 4.10pm)

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Agenda Item 4

Sandwell Scrutiny Board

31st March 2016

Update on Transforming Care Together (The partnership between Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Birmingham Community Healthcare NHS Trust)

1. Summary Statement

1.1 The purpose of this report is to provide members with an update on the Transforming Care Together partnership between Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Birmingham Community Healthcare NHS Trust.

2. Background information

2.1 **Transforming Care Together** is the name for a new partnership agreement between three NHS Trusts in the Birmingham and Black Country area: Birmingham Community Healthcare NHS Trust (BCHC), Black Country Partnership NHS Foundation Trust (BCPFT), and Dudley and Walsall Mental Health Partnership Trust (DWMH).

2.2 There are significant pressures in the health and care system, and like many healthcare organisations, Black Country Partnership Foundation Trust (BCPFT) was concerned about the future and protecting the services it delivers to patients. The Trust Board and staff spent time considering different options before deciding to talk to other NHS Trusts in the West Midlands about the potential of working together.

2.3 During September 2015, BCPFT asked local NHS Trusts to consider this idea and if interested to submit a proposal for partnership. We shared information between Trusts so we learnt more about each organisation and how we might be able to work together.

2.4 Birmingham Community Healthcare NHS Trust (BCHC) and Dudley and Walsall Mental Health (DWMH) Partnership Trust decided that they would

like to work together on a joint proposal and in November 2016 they shared this with BCPFT who spent time reviewing it. Part of this review involved inviting patients, carers and staff to hear directly from the two Trusts about how they would work in partnership with BCPFT.

2.5 In December 2015, the BCPFT Executive Board made the decision to accept the proposal from BCHC and DWMH, and together the three Trust's made an announcement to confirm partnership working.

3.0 Progress and Moving Forward

3.1 From the beginning of 2016 the senior leaders of the organisations have been developing a shared vision, values, governance and plans.

3.2 The first step was to determine a name for the partnership, **Transforming Care Together,** reflects our **vision** and approach to working together:

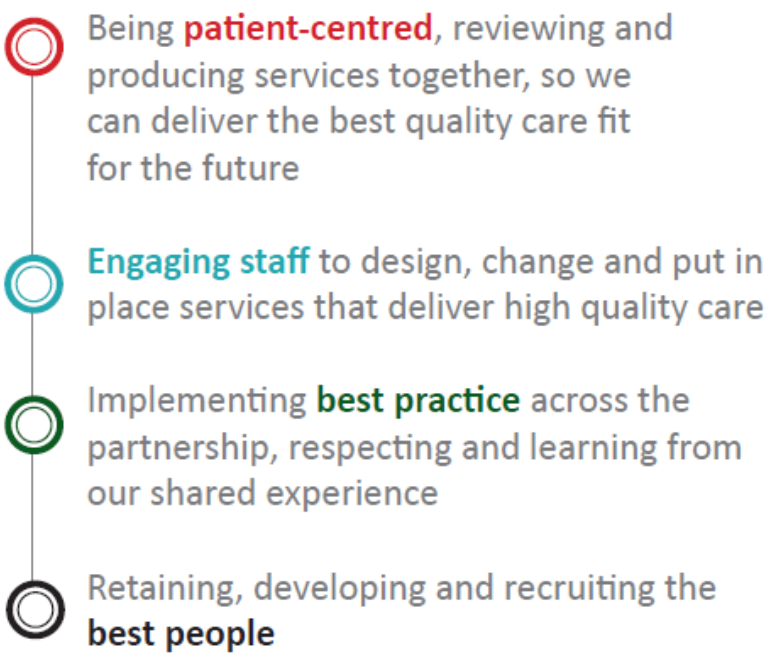
We want to take a creative and innovative approach to **transforming** our services. We want to improve the care we deliver to our communities, and we keep an open mind, listen and learn, being bold where we feel change is needed.

Our vision - to improve the **care** we give - is at the heart of everything we do. We want to increase the range of services we offer, improve choice and access, and make the most efficient use of our resources so we can reinvest in patient care.

Not only are we three Trusts working **together**, but we share a passion for involving patients, carers, families, governors, members, staff, and health and social care professionals in helping us design the services we provide. We want people to be involved, and we value your opinion.

Our decision to work together was based, in large part, on us sharing similar organisational culture and values. Simply put, this means 'how we do things around here' and we believe that a partnership based on sharing similar culture and values is more likely to be successful.

3.3 There are shared **guiding principles** for our partnership, which describe our approach to partnership and will be the basis of the way that plans are developed and implemented:



3.4 Our objectives for Transforming Care Together are simple:

3.5 There is a detailed over-arching plan which is summarised in “Our Journey” on the next page. As work and engagement events progress plans will be continually reviewed and updated to reflect the views of users, carers, families, clinicians and other stakeholders.

January - February 2016

We will set up a Partnership Board to oversee our work and establish how we will govern the work we do, including how we will work together to develop sustainable services for the future. We will also agree a name for the partnership programme, our key objectives, the areas of work we will focus on and our priorities for communicating with and involving people.

March - April 2016

We will agree what resources are needed to manage our partnership work and sign our Memorandum of Understanding. We will develop a plan that sets out how we will work towards partnership and set up workstreams for the different areas of work that we will focus on. These will be launched at a number of engagement events in April. We will also hold an event for our clinical staff to explore areas of partnership working. We will be involving people such as commissioners, staff, patients and local organisations in helping us shape the future of our services.

May - June 2016

Our workstreams will be busy with their areas of work and we will continue to involve people in helping us to shape the future of our services. We will establish priority areas of work, and start to explore and test the potential for joint working in these areas. We will also assess each of our partner organisations to understand our operational and financial position.

July - August 2016

Our workstreams and pilot areas of work will continue to develop and this work will help us to review our partnership strategy. We will evaluate the assessments of our organisations alongside our plan for change, and our Boards will start to define the more detail about our partnership, including potential challenges.

September - October 2016

We will start to explore in detail some of our larger plans for transforming services to ensure our plans contribute positively to improving access, quality and patient experience. We will begin planning the implementation of some of these larger plans and continue to talk to, and involve, a variety of people.

November - December 2016

Looking at the activity of each area of work, our Boards will start to review the potential impact that the partnership may have on the future of local services. They will also consider the impact each workstreams' area of work has on other workstreams and any other partnerships we are involved in.
This will shape the future of our partnership.

January - February 2017

By this time our Boards will have collated a series of plans and information about our potential to transform services and deliver high quality services fit for the future. They will consider a number of options and scenarios, and decide on a preferred option which they will build a formal business case.

March - April 2017

Our Boards will review, challenge and gain opinion on the preferred option. If approval is supported we will begin the process of planning and implementation.

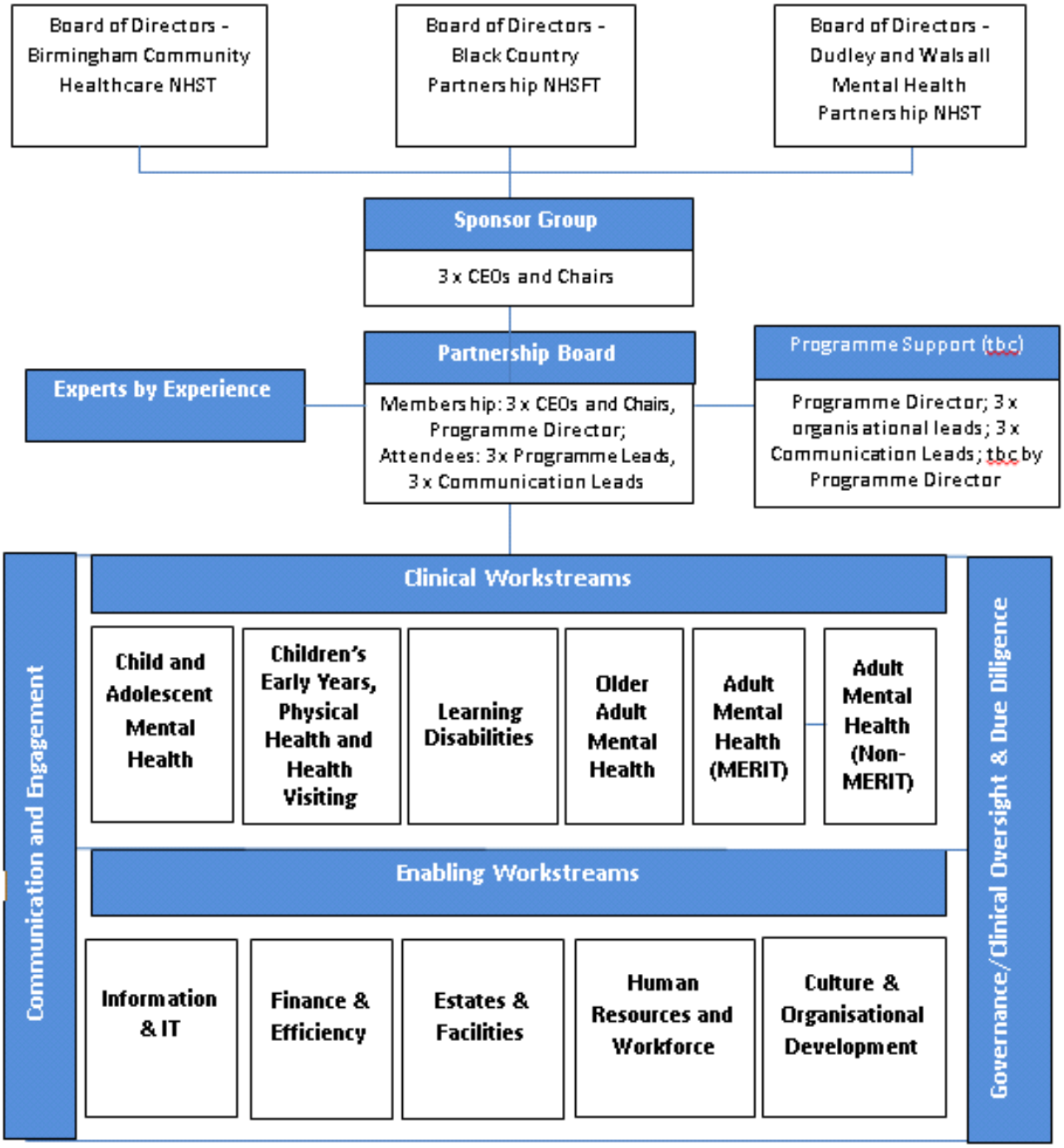
Our journey timeline will be regularly updated to show our progress.

April 2017 onwards

We will begin any formal processes that are necessary such as public consultation or regulatory approvals.

3.6 There is a Memorandum of Understanding, Confidentiality Agreement and Terms of Reference in place for the Partnership Board which are due to be approved by each organisation at their next Board meeting.

3.7 Terms of reference for workstreams are being developed and membership for the groups determined. The programme governance structure is shown below:



3.8 Two of the partners, Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health NHS Trust, are also partners in the Mental Health Alliance for Excellence, Resilience, Innovation and Training

(MERIT) vanguard. Our programmes will be aligned to avoid any duplication of effort on the Adult Mental Health workstream(s).

3.9 Communication briefs tailored to each stakeholder group are currently being developed and will be shared before the planned engagement events in April and May.

3.10 The first clinical engagement event is planned for 15th April, with governor sessions on 19th April and a wider stakeholder event being arranged for the beginning of May.

3.11 Each organisation needs to assure their Boards on the risks and rewards of partnership and therefore due diligence is also currently being planned.

3.12 Medical Directors and Directors of Nursing are developing an analysis of strengths, weaknesses, opportunities and threats to ensure that there is a high level assessment of the current position and opportunities from partnership. This approach will also be used in the clinical workstream to ensure that there is a clear evidence based understanding of the current clinical practice, risks and opportunities.

5.0 Financial Implications

5.1 At this stage there are no implications to consider. The partnership will ensure that we can sustain and improve patient experience for the long term even taking into account the financial pressures within the health and care sector nationally. In partnership we will be able to reduce the proportion of costs incurred on back-office functions to reinvest in patient care.

6.0 Legal Implications

6.1 There are no legal implications to consider at this stage. There may be competition implications to consider if the partnership determines that being one organisation would provide the best solution, however, the Partnership Board has agreed that form will follow function and therefore the plans are focused on delivery of the best solution for the communities we serve. We will work with all of our stakeholders in assessing the preferred option.

6.2 The partnership has always been based on delivering patient and health economy benefits from the outset, therefore the legal implications are likely to be minimal even if competition was considered to be a risk.

7.0 Equalities Implications

7.1 There are no implications to consider at this stage, however, plans should improve equality by ensuring that best practice is shared and implemented across the Black Country. The plans are aimed at improving choice and access to communities and enabling the development of improved specialist services such as Eating Disorders and female services through delivery of services across a geography large enough to sustain such specialist services.

8.0 Environmental Implications

8.1 There are currently no implications to consider.

9.0 Human Resource Implications

9.1 There are currently no implications to consider, however, it is likely that there will be human resource implications in the future so a workstream has been set up to identify opportunities, risks and develop plans.

10.0 Corporate Landlord Implications

10.1 There are currently no implications to consider, however, the partnership will take the opportunity to review the estate portfolio to ensure that we are making the most efficient usage of our combined portfolio. A group has been set up to consider the opportunities, risks and develop plans.

11.0 Schedule of Background Papers

11.1 There are no additional papers.

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Why Do Good People Allow Bad Things To Happen?

Report Into Care At Sandwell General Hospital

February 2016

Contents

DISCLAIMER

This report is based on the views and experiences of respondents. Due to the nature of this approach, we recognise that there may be differences between people's views and provider's intentions. Efforts have been made to ensure information is accurate or where necessary, reflect more than one view, whilst keeping to the brief.

Published by Healthwatch Sandwell, Walker Grange, Central Avenue, Tipton, DY4 9RY.

www.healthwatchsandwell.co.uk

Summary

Healthwatch Sandwell (HWS) carried out an investigation into patients' experience of care at Sandwell General Hospital (SGH), in particular potentially unacceptable incidents, during the latter half of 2015. This report contains findings from this investigation and recommendations for improvement.

The recommendations are:

- The Trust should consider why these issues have arisen, and what can be/has been done to prevent any repetition, even if improvements have already been made.
- The Trust should consider why the culture leading to these failures has existed among staff i.e. Why do good people allow bad things to happen?
- The Trust needs to consider patients' reluctance to complain, which patients sometimes attribute to fears of discrimination (which may be founded or not).
- The complaints process needs to be more explicit, clearly stating the steps involved, what can/will happen, and possible outcomes.

Our investigation found failures to provide appropriate nursing care, communications issues regarding patients and family, including end of life circumstances, and limitations in the complaints system.

This investigation was undertaken as a result of HWS being contacted by a number of patients and relatives, with issues relating to care on SGH wards. This included one particularly detailed case, which we successfully supported through the complaints process, detailing multiple unacceptable incidents.

Having established that unacceptable care incidents were occurring, our aim was to create a picture of the 'lived experience' for patients and their relatives and carers.

Therefore, it has considered the experience of the patient, but only where a description of the incident could also reasonably be considered to raise serious care issues. A two stage approach was taken, firstly to identify potential cases, and then to carry out in-depth interviews.

We have not sought to quantify the frequency of these experiences, and we recognise that the sample interviewed was small. However, we have established that these are not one-off incidents, and as we have focussed on incidents that would possibly be unacceptable at any level, we believe that it is not necessary to accurately determine frequency.

Recommendations

HWS recommend:

The Trust should consider why these issues have arisen, and what can be/has been done to prevent any repetition, even if improvements have already been made. HWS is aware that some improvements have been made recently, which may have improved care. However, we believe that it needs to be established if this has tackled the underlying cause or just a symptom. In either case, understanding how this situation has occurred is the only certain way of being able to take steps to prevent it happening again.

The Trust should consider why the culture leading to these failures has existed among staff i.e. why do good people allow bad things to happen? Where information is available, problems appear to be in particular wards, which suggests a cultural effect on staff's behaviour. We are also aware that there are examples of excellent care at SGH e.g. Children's Services, which was highly commended in a recent CQC report (2015), and which HWS concurred with. These cultural differences need to be understood, and best practices replicated.

The Trust needs to consider patients' reluctance to complain, which patients sometimes attribute to fears of discrimination (which may be founded or not). Complaints are essential to service organisations in order to know if they are getting it right. Complaints need to be welcomed and shown to be acted upon. Any reluctance from service users to complain due to lack of faith in the complaints system, not only deprives the organisation of valuable insight and feedback on how it is doing, it can also give the organisation a false view of the quality of service that it is delivering.

The complaints process needs to be more explicit, clearly stating the steps involved, what can/will happen, and possible outcomes. The SGH website does provide information on making complaints, but does not seem to explain the process following this or potential outcomes. Respondents were unaware of some of this information. Patients who complained were often unhappy with the response. They just wanted proper levels of care, and in some cases to prevent the same problems affecting others and confirmation that something had been done. They presumed this would happen, but it didn't, even when they persisted.

'Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients'

The Governments Mandate to NHS England for 2016-17

The Department of Health (December 2015)

'We need to embrace transparency and learning, unequivocally and everywhere, so as to build trust with the public and knowledge within the NHS. We need to embed compassion in every part of the NHS, placing patients' wellbeing at the centre of every decision we make. And we need to involve patients, their families and carers as much as possible in that process'.

Jane Cummings, Chief Nursing Officer for England and NHS England Chief Nurse

The Francis Report: One Year On (2014)

Comment

Given the findings and methodology used in this report, and our wider experience of SWBHT, we believe a comment is required to set them in context.

Although the issues highlighted are serious and raise concerns, we are aware that it is difficult to consider this information comparatively. i.e. similar research may not be available for other hospitals, so we do not know if the findings for SWBHT are outside of or the norm.

We believe it would be unfair to rate SWBHT on this investigation without similar research to compare to other hospitals. However, there are clearly issues in patient care and these do need to be addressed.

Findings

The following main themes were identified from this investigation:

- Failure to provide appropriate nursing care
- Communication with patients and family
- Communication: End of Life
- Limitations to complaints system

These themes are expanded below.

Failure to provide appropriate nursing care.

The experiences relating to this theme were varied and included, not receiving care, lack of access to medication, not being treated with dignity and a lack of care related to feeding.

Examples of experiences attributed to this theme:

Respondents described how they were left unattended for long periods of time and that requests for help (either practical care or access to medical care) were ignored. Ten respondents described how attention was given only after they had protested and how on one occasion, visitors had to intervene to help an elderly confused man whose family had returned home, as there was no accessible help. Another respondent described how their relative did not have access to water until a relative requested this

'Here we go again'

Issues were raised about access to medication: a respondent described how her father was very confused and she was concerned he wasn't getting his medication at the right time as the staff had suggested, 'that dad could manage his own medication'. He was confused and at times disorientated. The respondent felt that she had to persistently raise the issue of medication. She described the experience as here we go again.

A respondent described how his own drugs (Tramadol (controlled) and Oramorph) were 'lost' on admission and were not replaced. Another respondent described how her relative was receiving antibiotics via a cannula which was removed and not replaced. Her perception was that her relative was not receiving prescribed medication. She was not informed if medication was being given in other forms.

care did not seem to be given automatically

There were instances when patients were treated without dignity and many examples were given, which included, an elderly woman's dentures and glasses not being given to her and the relative later finding the dentures on the floor. Respondents described how their relatives were left in soiled clothes and bandages, causing distress for both. This instance was only addressed when it was brought to the attention of staff by visiting relatives. They described how care did not seem to be given automatically.

A relative described how she asked staff to feed her husband as he was unable to feed himself. The staff refused saying that he may choke, so she had to go into hospital every day to feed him. She was not advised to not do this. She never asked them to help again. She described how food and drink was put out of his reach on the bedside table.

She never asked them to help again

Another respondent, whose father was having chemotherapy and an operation to remove a cancerous tumour, described how he was being tube-fed, but the machine kept sounding an alarm. The staff didn't know why, until the Nutricare nurse came along and pointed out it was a gravity-feed and needed to be raised higher (it was flat). This caused considerable stress to patient and the family.

A daughter described how she would feed her mother, but one day she was prevented from entering the room while staff cleaned. When they left the room, they had left soiled pads and bedding in the room, and she believed it was unhygienic to eat in there. This relative believed that meal times were supposed to be protected and that cleaning should not occur while food is being served. She expressed concern about infection transmission and stated that there was supposed to be barrier nursing* when attending to patients, due to MRSA. Sometimes they would wear gloves, but not at all times.

[he] was left on the floor with staff passing him by for ten minutes

A visiting relative described that they saw a gentleman fall out of bed. They called a nurse, but the gentleman was left on the floor with staff passing him by for ten minutes.

*Barrier nursing is a set of stringent infection control techniques. The aim is to protect patients against infection, especially those with highly infectious diseases.

Communication with patients and family

Examples of experiences attributed to this theme:

Medication was discussed openly without apparent regard for confidentiality: a respondent described an incident involving a health care assistant and nurse openly discussing her medication in front of other patients. The nurse said, 'Oh that's alright, she only wants her morphine.' Patient was unhappy with this as it was said in front of another patient.

Three respondents described the aggressive manner in which they were spoken to:

A relative was questioning why the patient was in so much pain and wanted to complain about this. The relative asked a nurse involved for her name in order to pursue a complaint. The nurse threw her name badge at her saying, 'take it from that.'

'Your mother isn't the only one on the ward'

A physiotherapist was sent to show a patient how to use crutches. The patient described their approach as very aggressive, with the physiotherapist saying that the patient had already been shown how to use crutches at Manor Hospital. However, when the patient then asked the head nurse for his shoes (trainers) so that he could try to walk with the crutches, he was told, 'you have feet don't you?' It transpired that the trainers had been lost.

When a relative asked for help for her mother she was 'aggressively' told, 'Your mother isn't the only one on the ward'.

A patient who had had a severe stroke and was without speech was ignored and isolated. The relative described how no one communicated with her husband and that he was unable to let people know what he needed. The relative had to advocate for him, but could only do this during visiting times. She was very anxious about what happened to him when she wasn't there.

A patient… without speech was ignored and isolated

Two respondents described a lack of information about their relatives' care needs, both whilst in hospital and after discharge. A respondent was distressed that her husband was moved to City Hospital without consultation with her. She had also requested that he not be moved to City Hospital due to travel difficulties for her. Her husband had no verbal communication and was unable to give consent to any transfer. The relative was the key person and was not communicated with about this transfer or in deed the need to move.

A relative described how basic needs were met (washing, dressing and feeding at set times occurred), but no medical intervention. They were left totally unaware about what was happening, questioned why their relative was in hospital, but no one communicated with them. They received no diagnosis or prognosis.

Communication: End of life

A relative of a patient who was dying had to keep asking staff for information. She stated, 'They didn't tell me anything'.

This relative had assumed her husband was coming home, when in fact he was dying. She was never told this. She described how he was always lying on the same side, and when she asked them to move him, she was told they had 'only just done that'.

When he had a temperature, she asked for a fan to help cool him down. The nurse said she 'couldn't put a fan on him because we are not doing anything for him.'

'They didn't tell me anything'

This was the first time that the relative knew that her husband was coming to the end of his life. It does however question the quality of end of life care. This exacerbated a very stressful situation and appears to be very poor communication. One relative felt that she was put under pressure to sign a DNR form (Do Not Resuscitate) even though her mother was able to make that decision herself (capacity to consent). This was very distressing for the daughter, and raises questions about practices.

[She] felt that she was put under pressure to sign a Do Not Resuscitate form

These instances caused considerable distress to patients and their family members. A respondent stated, 'It's 'cause we're old they don't want to know'.

Limitations to complaints system

Examples of experiences attributed to this theme:

A respondent who had talked to a ward manager about issues with her relative's care noticed that afterwards, staff whom she had not met before knew her name. She felt this was due to having made a complaint and led to a feeling of being targeted. The same respondent gave an example of feeling targeted relating to rules regarding numbers allowed around the bed at visiting times. Before the complaint, these were relaxed, but afterwards were rigorously enforced. This experience caused further stress to the respondent, as she feared what might be happening to her relative when she wasn't there as a result of having raised concerns.

Respondents shared their experience of the Patient Advice and Liaison Service (PALS), which offers confidential advice, support and information on health-related matters and is a

point of contact for patients, their families and their carers. Experiences varied. One respondent spoke very highly but described some of the difficulties that PALs itself experienced with ward staff e.g. not returning calls etc.

'It's 'cause we're old they don't want to know'

Two respondents contacted PALS, but did not get a response. This left people feeling frustrated and they gave up pursuing their complaints.

One respondent stated that her mother didn't want her to make a complaint, 'just in case she got the bad end of the stick'

The investigation identified that there was suspicion around the complaints system which hindered people in reporting or pursing concerns. This is not only an issue for patients who can't complain, but also for the hospital as a result of losing this valuable insight.

…didn't want her to make a complaint, 'just in case she got the bad end of the stick'

Compliments

Although this report was addressing experiences of unsatisfactory patient care, examples of good and excellent care were given.

Three respondents described examples of good care that they had received at City Hospital and Queen Elizabeth Hospital: 'City were brilliant when he moved there. We were well informed. My dad had to go into the QE for major surgery and we have seen what good hospital care looks like. It was a marvellous experience way blown out of the window. Care on Ward 42 at City Hospital was good'.

They were fantastic when I had a seizure. They stayed with me, reassured me.

Another respondent stated that certain nurses took an interest in her mother, and even though she had dementia, they talked to her and encouraged her.

Three respondents described good experiences at SGH: 'I had fantastic treatment on AMU from [Named staff]. They were fantastic when I had a seizure. They stayed with me, reassured me. They were comforting, explaining to me what was happening and they gave me pain relief'.

> '[Named staff] on Newton would make me hot drinks and stay with me when I couldn't sleep'.

Finally, one respondent believed that her care improved once her parents rang the hospital after she had rung them at 10pm. Care did seem to get better for a while, including nurses asking her if she needed anything.

Rationale and Aim

As a result of the background to this investigation, our aim was:

To identify if people have recently experienced care at Sandwell General Hospital that could be considered unacceptable, in particular on Lyndon 5 (but not limited to), and to understand and describe the patient experience.

Where instances have occurred, to ask about experiences of making or considering making complaints.

Background

During 2015, HWS was contacted by the relative of a patient who was unhappy with their care at Sandwell General Hospital. The issues they raised also suggested possible cultural issues at the hospital relating to care. The relative wanted to complain, so due to the systemic nature of the issues, HWS agreed to support the complaint. This led HWS to carrying out further research. This involved reviewing previously gathered intelligence, which showed that between May 2015 – August 2015, there were 49 recorded experiences. Our Experience Gatherers were asked to look for any more potential cases during their work. HWS had previously carried out an Enter and View visit at the hospital, which although had found no issues, had been the result of previous concerns raised.

As well as the issues relating to the above, HWS's existing evidence suggested that very few people would complain, or if they did, would not see it through. This was also a view, and of concern to the Healthwatch Sandwell Board.

Notice of this investigation being carried out was provided in our Healthwatch Activity Reports 7 and 8, dated June and September 2015 respectively (Available on our website). http://www.healthwatchsandwell.co.uk/activity-update-0

The CQC inspection report (March 2015) reported that urgent and emergency services, medical care, and surgery required improvement and outpatients and diagnostic imaging was inadequate.

In medical care it was noted that some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet their assessed needs. This investigation confirmed that some staff were not aware of patients' assessed need.

The CQC inspection report (March 2015) summarised that the trust had systems in place, including internal and national audit, to monitor patient safety. However, some practices were creating risk to patient safety. These included doctors not reporting incidents and staff not properly following some procedures, such as for medicines storage and for infection control. The report noted that in surgery, infection control measures were largely ignored by medical staff, and in outpatients and diagnostic imaging the Inspectors saw practices that could compromise the safety, privacy and dignity of patients.

SGH provided us with Family and Friends Test results (see Appendix 1). Recommendation levels appear high (significantly over 90% for most wards, apart from one at 66%). Response rates do vary significantly.

Methodology

Approach

From the background and purpose, the need identified was to understand experiences relating to care that should not be happening. Therefore, an in-depth understanding of experiences was needed. The method chosen was to identify patients who reported experiencing potentially unacceptable care, and to carry out in-depth and predominantly open interviews to capture the full lived-experience of what they had gone through.

Methods used to identify the individual patients (or relatives and carers) are detailed below. Therefore, although this study is not aiming to describe or present a statistical picture of what is happening (as these are events that should not happen), the data is available for the reader to draw their own conclusions regarding the frequency of incidents.

Identification of patients' stories

An analysis of data collated at HWS identified 49 patients who had spoken to HWS about concerns relating to their experience at SGH, either through HWS's experience gathering in the community, or through them directly contacting HWS's office, between May and August 2015. Of these, fifteen had agreed to be contacted for further information. They were contacted to take part and twelve agreed to participate.

Three HWS support officers visited SGH and spent a day on the whole of floor 5 (Lyndon, Priory, Newton) in August 2015 talking to patients and relatives. They used a pre-set questionnaire which collated qualitative and quantitative data. They spoke to 33 people, 21 of whom reported negative experiences in relation to care and agreed to being contacted at a later date.

In total 33 from both of the above sources agreed to be contacted. This was followed up with eleven people agreeing to be interviewed. Five respondents were from the day spent at the hospital and six from other contact with HWS.
Reasons given by those not wanting to take part included, wanting to put the whole experience behind them.

We recognise that this study is based on an approach that would be considered interpretivist within the realm of social sciences. However, the above details, regarding the sourcing of stories, are provided to allow the reader who may be more used to quantitative and positivist based research, to understand the validity of what may appear, to the untrained eye, to be a small sample size. We do, however, feel able to comment that the number of stories identified in relation to the efforts undertaken, specifically with regards to the survey carried out on the hospital ward, does show a worrying level of occurrence. We recognise the limitations of identifying most of these sources from one visit, but we think it is fair to presume that this was not a one-off. We would add further, that this approach is consistent with the Francis report, and Robert Francis' (Inquiry Chairman) comment in his covering letter:

'It should be patients – not numbers - which counted. That remains my view'.

Questions and interviews

A set of semi structured questions were developed and were trialled with one of the respondents. These results were taken into account, and two officers visited the remaining people. The interviewers asked respondents to describe their experiences at SGH, if they had complained and any barriers to complaining. These interviews were recorded and analysed into key themes.

All interviews were recorded and stored in accordance with the Data Protection Act (1998).

Note: Patients were frequently unable to remember the names of wards, or may never have been aware of the name. They simply knew that they were in the hospital and how to get around. We recognise that not providing names of wards where incidents occurred may cause difficulties for those responding to this report. However, we believe that not being able to provide a ward name should not prevent the evidence being used. The patient experience is paramount, and to ignore this on a technicality would be to repeat the lessons of the past.

Acknowledgements

Healthwatch Sandwell would like to thank all respondents for sharing their experiences.

About Healthwatch Sandwell

HWS is an independent consumer champion that gathers and represents the public's views on health and social care services in Sandwell. It ensures that the views of the public and people who use the services are taken into account by those who commission and provide services.

Healthwatch Sandwell's activities include:

Experience Gathering. HWS staff meet with the public at various locations including community events, supermarkets, bingo halls, high street etc. They provide information about Healthwatch and ask if people would, 'describe their last experience of health or social care services'.

Enter and View. These are visits to health and social care premises, involving staff and volunteers to look at the quality of services from the patients' perspective.

Information and Communication. HWS provides information and means for people to contact through various means including: telephone, website, email, public meetings, networking with community groups, Twitter, Facebook.

As part of HWS's statutory functions, it is our responsibility to make:

> '…reports and recommendations about how local care services could or ought to be improved.'
>
> (1 Section 221 (2) of the Local Government and Public Involvement in Health Act - 2007)

References

Care Quality Commission (2015). Sandwell and West Birmingham Hospitals NHS Trust. Sandwell General Hospital Quality Report

Care Quality Commission (2015). Sandwell and West Birmingham Hospitals NHS Trust. Children, Young People and Families Services

Department of Health (2015) The Governments Mandate to NHS England for 2016-17

Francis, R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office

The Francis Report: One Year On (2014), https://www.england.nhs.uk/2014/02/06/the-francis-report/

Appendix 1: Family and Friends Test Results

	Friends and Family Test Results - April 2015 to January 2016 (Quarterly Average)											
	QTR 1			QTR 2			QTR 3			QRT4 (Jan16)		
Wards/Areas	Response Rate	Would Recommend	Would Not Recommend	Response Rate	Would Recommend	Would Not Recommend	Response Rate	Would Recommend	Would Not Recommend	Response Rate	Would Recommend	Would Not Recommend
New ton 4	100%	98%	1%	81%	100%	0%	68%	100%	0%	100%	100%	0%
Priory 5	15%	86%	2%	36%	82%	9%	54%	81%	14%	99%	100%	0%
Priory 4	69%	94%	2%	37%	99%	0%	40%	98%	2%	45%	100%	0%
SAU - Sandw ell	19%	96%	3%	8%	97%	3%	7%	94%	2%	37%	100%	0%
Lyndon 5	49%	94%	3%	43%	96%	2%	0%	0%	0%	1%	100%	0%
AMU B - Sandw ell	59%	94%	2%	39%	97%	1%	8%	94%	4%	0%	100%	0%
New ton 3	32%	94%	3%	11%	98%	2%	47%	94%	0%	83%	98%	0%
AMU A - Sandw ell	11%	81%	1%	5%	89%	0%	29%	97%	2%	23%	98%	1%
New ton 5	31%	96%	4%	15%	93%	7%	13%	100%	0%	67%	96%	3%
Critical Care - Sandw ell	100%	92%	0%	100%	94%	0%	98%	96%	0%	70%	95%	0%
Lyndon Ground	16%	90%	0%	26%	92%	4%	17%	90%	5%	21%	95%	3%
Lyndon 3	48%	98%	0%	44%	96%	0%	40%	99%	0%	41%	93%	4%
Lyndon 1	28%	77%	1%	33%	96%	2%	26%	94%	2%	22%	89%	8%
Priory 2	67%	98%	1%	35%	92%	1%	29%	94%	4%	5%	83%	0%
Lyndon 4	29%	97%	1%	6%	29%	0%	16%	81%	2%	10%	66%	22%
Priory Ground	33%	33%	0%	56%	100%	0%	47%	67%	0%	n/a	n/a	n/a
Lyndon 2	58%	94%	3%	36%	94%	2%	18%	87%	4%	n/a	n/a	n/a
New ton 2	24%	93%	1%	9%	85%	1%	n/a	n/a	n/a	n/a	n/a	n/a

Source: Sandwell and West Birmingham Hospital Trust

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

It was created in 2013 to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS.

NHS England and NHS Choices websites (2016)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Response to Sandwell Healthwatch Report into Care at Sandwell Hospital

Sandwell & West Birmingham Hospitals NHS Trust has reviewed the contents of the report from Sandwell Healthwatch that outlines concerns raised by 11 patients or carers in August 2015. We have also met with Healthwatch leaders to discuss the report in detail.

We are disappointed to hear about the concerns that have been raised and would like to apologise to the 11 individuals who have received or observed care that is below the standards that all our patients should expect and deserve. We would welcome the opportunity to meet these individuals to further understand their experiences and learn from them.

We regularly seek feedback from patients and their relatives to ensure that we consistently provide good standards of care and that we continue to learn and improve based on what patients tell us. This includes our regular patient surveys, the friends and family test, our Patient Advice and Liaison Service, complaints and comments posted on patient websites. The report from Healthwatch Sandwell highlights the great work that is usually carried out by staff as reflected in the positive patient feedback that we have received. Our aim is to make sure that every patient receives high quality care from us at all times.

	Patient Experience Survey results- April 2015 to January 2016 (Quarterly Average)								
	QTR 1 (710 responses)			QTR 2 (277 responses)			QTR 3(150 responses)		
	Do you feel that Patient Safety Standards are given a high priority at our hospital:								
	Yes always	**Yes, sometimes**	**No**	**Yes always**	**Yes, sometimes**	**No**	**Yes always**	**Yes, sometimes**	**No**
Sandwell Hospital	84%	15%	1%	89%	10%	1%	88%	11%	1%
	Overall, how would you rate the care you received on this ward/unit:								
	QTR 1 (511 responses)			QTR 2 (294 responses)			QTR 3 (156 responses)		
	Excellent /Good	**Fair**	**Poor**	**Excellent /Good**	**Fair**	**Poor**	**Excellent /Good**	**Fair**	**Poor**
Sandwell Hospital	98%	2%	1%	96%	2%	0%	96%	2%	2%

Sandwell & West Birmingham Hospitals NHS Trust has a number of ways to monitor the care provided in our patient services, including care that patients receive on our wards. We use this information to alert us to any potential safety or quality issues so that steps can be taken to rectify any problems. There are no safety concerns that arise from this report.

In September 2015 our own monitoring systems identified concerns about care in one particular ward at Sandwell. That ward was closed because we felt we were no longer able to staff that ward to the standard we pride ourselves on. In the last six months we have seen improvements in our substantive staffing levels including reductions in the numbers of nurse vacancies across the wards at Sandwell Hospital. That provides a basis for confidence in care, alongside the data that we evaluate about what we do.

We do remain concerned by the large number of extra beds open at Sandwell this winter, which place additional pressure on all clinicians, and increase our reliance on temporary staff. The health and social care system must explore why projects to prevent admissions have failed over the last 12 months and why, in spite of the Better Care Fund, demand on the hospital is rising.

Agenda Item 6

Health and Adult Social Care Scrutiny Board

31 March 2016

Overview and Scrutiny Committee briefing note on people who have a delayed transfer of care

Looking backwards:

1. Sandwell MBC and SWBH have worked jointly to try and address issues of patients who are delayed in hospital because they are waiting care elsewhere. Although every hospital has a volume of patients who are medically fit, only a proportion of those patients are awaiting community packages of care, either funded by the NHS, or Local Authorities, or part paid for by families themselves.

2. In 2014-15 we reorganised services for the year ahead to try and achieve two aims, which reflected both clinicians, social work, and family feedback:

    - To ensure that we could rapidly move patients from a hospital phase into a more social care based phase, by creating the Rowley Regis based 'Seva-care' project
    - To begin to address discharge issues very rapidly on admission, by applying a model we called the ADAPT pathway.

3. There remains much to be done to improve further. However, the Health Service Journal recently analysed national data and concluded that Sandwell residents had seen the second largest fall in bed days lost to delayed transfers of care anywhere in England, as a result of the efforts of the team.

4. In outlining what had worked we explained that there had been a combination of innovation (the ideas above) and disciplined implementation of some basic good practice. The latter, for some media outlets, led to a focus on the process of alerting patients to their need to move, and their rights and responsibilities. Like every hospital and LA we have a series of letters which are given to families to set this position out. The file of such letters is appended for the OSC. In practice, only one

person in the last 12 months has received the final stage letter, and we did need to proceed to the conclusion outlined therein.

5. Health-watch have raised with us their opinion about language in these issues, and creating a climate of conflict which none of us wish to do. However, in supporting staff and in balancing needs of current and future patients, it is sometimes important to be explicit with families about the legal basis for remaining in hospital beyond the clinically necessary period.

6. Our overall aim is to begin conversations with patients and families at the very outset of their stay with us. Typically it is apparent at that point what the final discharge destination may be. Using the elapsed time of the hospital stay can be helpful in ensuring people have time to make decisions about next steps and are focused on those decisions ready for discharge.

Looking forwards:

7. There remain some foreseeable major challenges in our system, which we seek to manage as a senior officers group each Thursday morning. Community bed availability is a challenge, and the Living Wage will place further pressure on the local supply market, and may reduce supply. Current occupancy levels means that even small changes in supply will have big effects on discharge volume and pace.

8. Uncertainty over funding flows around emergency care and the better care fund mean that models of service are operating on short term contracts. This can mean that improvements in delivery are not achieved because there is no stability from which to work.

9. We have not yet succeeded in establishing first 48 hour involvement for every patient in discharge planning. This is despite excellent moves to create 7-day working by social care. The Trust continues to strive to deliver on this, and has a full time clinician leading on this priority project.

10. Demand continues to rise. We need to ensure that we have a shared view of future demand to 2020 and have put in place resources to meet need.

11. The Trust has to reduce its bed base. In winter 2016 we had 60 beds open (largely at Sandwell) for which funding was not available, and which BCF plans said would not be needed. Moreover, in 2016-17 we expect to try and reduce our acute bed base further. This means that we have to tackle length of stay, re-admissions and DTOC bed days. Our current focus is on the “pending list” of patients who become delayed.

Conclusions suggested to the OSC:

12. To recognise the successful joint work being done in SMBC/SWBH to address delayed transfer of care.

13. To note the fairly daunting risk profile presented for the next two years, and request that it is tracked closely, perhaps via either the Better Care Fund programme or HWB, or both.

14. To ask for a data set on performance in 2016-17 Q1 and Q2 to be shared with the OSC for its mid-year / pre-winter meeting.

Toby Lewis
Chief Executive, SWBH.

Accompanying Documents;-

Letter One
Letter Two
Letter Three and Check List accompanying letter three.

Letter One

Dear

Your Discharge From Hospital: Future Plans

We hope that you are starting to feel better. We are writing to you now to tell you what may be happening to you from this point on. Our aim is to help you to recover as fully as possible and to minimise any loss of independence.

A busy hospital ward is not the best place to fully assess what you need to manage or to give you the time and support you might need to recover. We may need to arrange a period of care in a residential or nursing home to give you more time to regain your strength and confidence to consider any future needs you may have.

If it is decided that you would benefit from a short period of time in a care home, we will help you to find a suitable placement. The team will give you all the information you need to help you make the right decision. Your social care professional will continue to work with you whilst you are in your placement to review your progress and ongoing care needs.

If it is decided you need a longer term placement in a care home, we know that it can take time to find the right place and make the necessary arrangements. Your social care professional will work with you and help identify suitable placements. Remaining in hospital for long periods of time while you wait for a bed to become available at your first choice home is not an option. You may therefore, be asked to select another care home on a temporary basis. This can be until a place becomes available at your first choice of home.

We hope you will understand that it is not be appropriate for you to stay in hospital any longer than you need for your medical treatment.

We will do our best to help you to move as quickly as possible and take full account of your personal circumstances. We will also consider any follow-up care and support in the place where you will live.

Should you have any concerns about this letter or anything else during your stay, please discuss them with our staff who will be happy to help you. You can also ask to speak to our Patient Advice and Liaison Service (PALS) who are here to support patients or relatives with any concerns or queries. You can contact PALS on 0121 507 5836.

We would like to take this opportunity to thank you and your family for your co-operation.

Yours sincerely,

Rachel Barlow
Chief Operating Officer
Sandwell &West Birmingham
Hospitals NHS Trust

David Stevens
Executive Director
Adult Services and Health
Sandwell MBC

Letter One

Date:

Dear

YOUR DISCHARGE FROM HOSPITAL

We hope that you are starting to feel better. We are writing to you now, to tell you what may be happening to you in future. We shall allocate you a social worker and/or a discharge nurse, if we have not done this yet.

We need to see if you can return home once your medical treatment is completed. If you cannot return home, even with help, you may need a period of care in either a care home or a care home with nursing. The process we use to decide what care you will need is called a community care assessment. Your discharge nurse or social worker will help to complete this assessment with you.

If it is decided that you will require a period in a care home, we shall help to find a home with a vacancy. You will find that our team will give you all the information to help you make the right decision.

We know that it can take time to find the right place for you. It can also take time to make the necessary arrangements. At the same time, patients cannot stay in hospital for long periods of time while they wait for a place at their first choice of care home. Consequently, you may need to move into another care home on a temporary basis. This Interim Home will be until a place comes up in your first choice home.

It will not be appropriate for you to stay in hospital any longer than you need for your medical treatment.

We can give a copy of this letter to your carer, or the main person helping with your arrangements, if you want us to.

Please do not hesitate to ask your nurse or social worker any questions you want about these arrangements.

Yours sincerely

Rachel Barlow
Chief Operating Officer
Sandwell & West Birmingham Hospitals NHS Trust

Adults & Communities
Birmingham City Council

Letter Two 26.03.14

Dear William Allbutt / Next of kin

Your Discharge From Hospital – Next Steps

Our goal is to help you return home. We are pleased that the team caring for you feels that you are now well enough to leave the acute hospital bed that you are in.

As a result of your recent discussions with health and social care professionals, it has been agreed that your needs would be best met by your moving to a residential care home / a care home with nursing support / home with some carer support. We shall make every effort to help you obtain your placement of choice. If however, you are not able to move to this straight away you may need to choose an interim placement while waiting for your preferred option to become available.

We do not wish to cause you or your family undue anxiety or distress but you will be aware that there are many people needing acute hospital care and we need to be able to offer treatment to them as soon as is possible. Remaining in an acute hospital bed is not an option.

Should you have any questions about these arrangements you can discuss them with the ward manager / discharge liaison team / senior trust manager. You can also ask to speak to our Patient Advice and Liaison Service (PALS) who are here to support patients or relatives with any concerns or queries. You can contact PALS on 0121 507 5836.

Yours sincerely,

Rachel Barlow
Chief Operating Officer
Sandwell &West Birmingham
Hospitals NHS Trust

David Stevens
Executive Director
Adult Services and Health
Sandwell MBC

Letter Two

Dear

YOUR DISCHARGE FROM HOSPITAL

We are pleased that you are now well enough to leave hospital.

As a result of your recent discussions with key nurses, doctors and social workers, it has been agreed that your needs would be best met by your moving to a care home/care home with nursing.

It is very important for your future health and well-being that you are given help to move out of hospital as soon as possible to a place that can offer you the right level of care and support.

One of our team of social workers and complex discharge nurses should have provided you with information to help you choose an appropriate care home or care home with nursing and make arrangements within the next few days. If this has not happened please ask one of the nurses to contact them.

We shall make every effort to assist you in finding a home of your choice. However, if you have not chosen a home in the next week, or the home you prefer has no vacancies, we shall help by giving you a list of suitable homes where there are current vacancies. As you will not be able to remain in hospital you will need to choose one of these to move into – until a place in your home of choice becomes available.

Please do not hesitate to ask your social worker, nurse or consultant if you have any questions about these arrangements or the decision that you no longer require care in hospital.

If you wish, we can give a copy of this letter to your carer, or the main person helping with your arrangements.

Yours sincerely

Rachel Barlow
Chief Operating Officer
Sandwell & West Birmingham Hospitals NHS Trust

Adults & Communities
Birmingham City Council

APPENDIX 5

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Letter Three

Ref: DCC3

Date:

Dear

Your Discharge from Hospital – Immediate Action Required

You were admitted to XXX Hospital on the date due to XXX.

Since that time, you have received treatment for your condition and are now on XXX Ward. As you are aware, you were deemed fit for discharge on [INSERT DATE] and you have failed to leave the hospital despite our reasonable request for you to do so and arrangements being made by the Local Authority to assist you with your return home.

You are no longer in need of medical care and, as such, you have no right to occupy an NHS bed or remain within the hospital. We need to make your bed available to patients with acute medical needs. We repeat our request that you leave the hospital immediately. Should you need assistance with transport, please speak to the nurse in charge.

Should you fail to leave the hospital by TIME and DATE, we will begin the process of formally removing you. We may, without further notice, seek a court injunction for trespass and/or use reasonable force to remove you from the premises. We believe that your refusal to leave is a criminal offence under section 119 of the Criminal Justice and Immigration Act 2008 and that your forcible removal under section 120 of the same Act would be justified.

We hope that we will not have to have recourse to legal means to remove you and hope to work with you to enable you to return home. However, should you continue to refuse to leave, we will act in order to protect other patients who are in need of the bed that you are occupying unreasonably.

As your treatment has concluded, should you continue to remain within the hospital we shall levy a charge for the provision of accommodation to you. We would also like to inform you that being an in-patient within a hospital is likely to have a negative effect on your entitlement to certain benefits such as disability living allowance and housing benefit.

Please note that should legal action be required, the Trust will seek to recover the legal costs incurred in respect of removing you from hospital, including the costs of formal legal proceedings, should they be necessary. It is likely that these costs will be substantial.

Yours sincerely

Rachel Barlow
Chief Operating Officer
Sandwell & West Birmingham
Hospitals NHS Trust

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

CHECK LIST ACCOMPANYING ISSUE OF LETTER THREE

For Office Use Only (not issued) CHECK LIST TO BE COMPLETED PRIOR TO ISSUE OF LETTER THREE		
PATIENT NAME:		**WARD:**
	YES / NO	**DATE**
Date of Section 2		
Funding in Place		
Interim/Transitional, Long/Short Term Placement / Home Care Package Available		
Date of Section 5		
Offer of interim/transitional placement **DECLINED** by patient/family (pls note reason as well)		
Name(s) of staff aware when offer made and declined)		
SW confirmed in med notes or on Look Forward regarding offer and decline.		
Choice Letter one issued		
Choice Letter two issued		
Choice Letter three triggered		
Consultant agreement to issue Letter 3 (insert name)		
Social Work Team Manager agreement to issue Letter 3 (insert name)		
(Deputy) Head of Nursing/Matron agreement to issue Letter 3 (insert name)		
Head of Capacity agreement to issue CL3		
Choice Letter three issued for Chief Operating Officer signature		
Name of person completing this checklist.		
Additional Comments:ie. declined four placements		