

## Board of Directors

<b>Date:</b>	Wednesday 26 September 2018	<b>Attachment Number:</b>	A																
<b>Title of Report:</b>	<b>2018 Review of Patient Stories</b>																		
<b>Purpose of the report and the key issues for consideration/decision:</b>	<p>To inform the Board members of progress for each of the stories presented over the last 10 months.</p> <p>Considerations include:</p> <ul style="list-style-type: none"> <li>- How we continue to embed support for carers and patients with learning disabilities or who lack capacity with a family centred approach to care</li> <li>- Continue to explore innovative approaches to enhance patient wellbeing in community settings</li> <li>- Work with partner providers to build robust IT systems to bridge the gaps between services and reduce duplication.</li> </ul>																		
<b>Prepared by:</b>	Lynsey Nicholson, Patient Experience Officer																		
<b>Presented by:</b>	Jill Asbury, Director of Nursing																		
<b>Strategic Objective(s) supported by this paper:</b>	<table border="1"> <tr> <td><b>Financial Sustainability</b></td> <td></td> <td><b>Empower &amp; Engage Staff</b></td> <td>x</td> </tr> <tr> <td><b>Quality of Care</b></td> <td>x</td> <td></td> <td></td> </tr> </table>			<b>Financial Sustainability</b>		<b>Empower &amp; Engage Staff</b>	x	<b>Quality of Care</b>	x										
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<b>Which CQC Standards apply to this report:</b>	-Person Centred Care -Dignity and Respect -Safety -Consent -Complaints																		
<b>Have all implications related to this report been considered: (please X)</b>	<table border="1"> <tr> <td><b>Finance Revenue &amp; Capital</b></td> <td></td> <td><b>Equality &amp; Diversity</b></td> <td>x</td> </tr> <tr> <td><b>National Policy/Legislation</b></td> <td></td> <td><b>Patient Experience</b></td> <td>x</td> </tr> <tr> <td><b>Human Resources</b></td> <td></td> <td><b>Terms of Authorisation</b></td> <td></td> </tr> <tr> <td><b>Governance &amp; Risk Management (BAF)</b></td> <td></td> <td><b>Other:</b></td> <td></td> </tr> </table>			<b>Finance Revenue &amp; Capital</b>		<b>Equality &amp; Diversity</b>	x	<b>National Policy/Legislation</b>		<b>Patient Experience</b>	x	<b>Human Resources</b>		<b>Terms of Authorisation</b>		<b>Governance &amp; Risk Management (BAF)</b>		<b>Other:</b>	
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**Recommendations:**

The Board is asked to note the learning that has taken place to either build on the good practice described by patients and families or to prevent a recurrence of poor patient and family experience.

# 2018 Review of Patient Stories

## Wednesday 26 September 2018

### 1. Context / Background

This paper overviews the patient stories presented to board from June 2017 until March 2018. At the request of the Board members, a follow up for each of the stories has been conducted with staff to understand how learning continues to embed and how progress is being made.

Staff from the relevant departments across the organisation have been approached to comment on the relevant story and summarise their actions since.

Each report heading describes the initial story presented to the Board. The report goes into further detail about work that has been undertaken to address any elements of care that were of concern to the patient or their carer. Where the experience was positive, the report overviews the steps taken to roll out and embed the actions / approach.

In addition to staff feedback, patients and carers have also been invited to comment.

### 2. Executive Summary

Hearing directly from patients and their family members at the Board meetings provides unique insights for the members into a range of services across the organisation. The stories allow opportunity for healthy discussion, debate and challenge and set the scene for the rest of the meeting agenda.

### 3. Report Headings

#### 2.0 Month: June 2017

**Title: Phillip's Story**

**Patient/ Staff member presenting: Video**

**In attendance: Fran Edwards, Matron and Sasha Stoney, Senior Sister Ward 14**

Phillip is a 27 year old man with Downs Syndrome. Following a very positive experience at the hospital, Phillip's Mum wrote a letter to PALS. She and Phillip met with the patient experience officer and agreed for their experience to be audio recorded and presented to Board.

Over the Christmas period in 2016, Phillip had been quite unwell. He had been vomiting after eating his meals and had diarrhoea. In January, the GP undertook a series of tests and found that Phillip had high cholesterol. He was referred to Airedale for an Ultrasound. The staff were incredibly kind and were able to help Phillip feel settled. The radiographer informed Phillip and his Mum that he had Gallstones. An appointment was made for surgery however Phillip became acutely unwell in the meantime and was urgently admitted. His Mum reported feeling very anxious about leaving him in hospital, on the children's ward she was always allowed to stay with him but now he was an adult she feared she would be told to leave- however the staff on ward 14 were very understanding and encouraged her to stay. Two of the nurses provided her a mattress, pillows and blankets- so she could get some sleep and stay with Phillip and this meant a great deal to her. Phillip underwent surgery and was cared for by a range of staff that helped to clearly explain the procedure so he could understand what was happening and why. One staff member provided an iPad for Phillip to help distract him from the unfamiliar environment.

The entire stay in hospital was wonderful. All of the staff, including the cleaners, porters and catering staff as well as the nurses and doctors involved in Phillip's care were amazing – Phillip's Mum was very keen to express her gratitude to all those involved.

## 2.1 How are we progressing?

The trust is re-establishing links with community teams for learning disabilities, most recently hosting a joint event on the top landing to promote LD week. Colleagues are working together to establish a robust process for informing community teams (BDCFT) when a patient with a learning disability has an unplanned admission to hospital.

The patient information officer in collaboration with Speech and Language Therapy colleagues has produced and is piloting a communication support tool. The tool is a visual aid designed to support conversations between staff and patients that may have a communication need. The tool is being tested on two ward areas and feedback has been sought from local groups. Once a final version has been developed it is hoped that charitable funding will finance printing costs to resource each ward with two copies.

Phillip, his Mum Sue and his Dad Frank came to the hospital to meet with the patient experience officer to talk about how they've all been since Phillip's operation. Unfortunately, Sue has experienced a bout of ill health and has been admitted to Airedale on three occasions since May 2018. During her most recent stay, Sue spoke with the Director of Nursing to express her gratitude about the excellent care she was receiving on ward 7. She describes this ward as 'an extended family' who made her very welcome, including Phillip and Frank. Phillip was allowed to lay on the bed to be close to his Mum, rather than having to sit in a chair.

Sue reported that on one of her admissions, the housekeeper on ward 7 recognised her and specially ordered her a meal of Curry from the menu– Sue described her stay that evening as *"like a night out, as Frank doesn't like Curry so I can't have one at home!"*

Phillip continues to enjoy his activities in the community. The family recently moved to Ilkley and Sue is looking in to a local company 'Outside the Box' which employs people with learning disabilities in its café. Phillip has some experience of this, helping his mum in her volunteering role with Age UK – he described his favourite cake as 'Batman Cake'.

Sue and her family view Airedale as part of their community and are incredibly grateful for the care they've received here.

## 3.0 Month: July 2017

**Title: Advanced Clinical Practitioner – my role**

**Patient/ Staff member presenting: Ian Segovia, ACP**

Ian Segovia attended to discuss his role as an Advanced Clinical Practitioner. Ian explained his journey from when he qualified as a nurse in 2003 to his current role in orthopaedics. Ian explained he comes from a clinical nurse specialist background and said spending time on the Acute Medical Unit as part of his ACP training had made him realise the difference between specialities across the hospital.

He was the first ACP to move from medicine onto the wards, which he said had proved challenging at first however progress had been made and the potential his role could offer was now more recognised. Ian said the general feeling was that more ACPs would be of benefit in the team and the intention going forward was for him to be included the on-call rota to help support the service. In response to questions about supervision and how clinical practice boundaries could be expanded, Ian explained two clinical supervisors were supporting him. He said there was scope to move the role forward and discussions were in place around how this could be achieved. Mr Mainprize highlighted the importance of supporting clinical practitioners to develop their roles going forward and said this was also about developing a skilled workforce for the future. This was one area that would be debated at the Trust's Workforce Summit on 2 October.

### 3.1 How are we progressing?

Advanced Practice is delivered by experienced registered health care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a Masters level award or equivalent that encompasses the four pillars of clinical practice, leadership, education and research, with demonstration of core capabilities and area specific competence. Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes'

At Airedale, ACP's work in the medical model supporting the medical rota to offer high quality evidence based practice to patients.

The ACP role is always developing at Airedale. The role includes developing the following clinical skills; Lumbar puncture, paracentesis, Pleural aspirations to ensure timely treatment our patients. There are now 7.6 WTE qualified ACPs in the Acute Assessment Unit, plus eleven trainees. There is one elderly care based ACP covering the medical rota on ward 4 and six newly appointed trainee ACPs in the Emergency Department to support the medical workforce.

The role is constantly evolving to learn and acquire new skills to support patients' needs.

It is anticipated in the future that the trust will consider more ward based ACPs and more specialised roles.

(Julia Nixon –ACP Lead/ Lead for Clinical Transformation AAU)

### 4.0 Month: September 2017

**Title: Nutrition Training in Care Homes**

**Patient/ Staff member presenting: Carolyn Wagstaff, Care Home Manager, Louise Nash, Frail Elderly Pathway Team Dietitian and Laura Rowe, Nutrition and Dietetics Lead**

Carolyn talked to the Board about a training package for nutrition and hydration aimed at care home staff facilitated by the Dietetics team. Staff learned how to fortify food and drinks, make them palatable and improve the nutritional value of food. This had significantly improved the general wellbeing of residents. Also noted was the importance of ensuring residents had nutritious and varied diets. Staff had been invited to sample food and had been provided with food and diet charts.

The Board asked if there was any evidence that training sessions like this one had reduced admissions into hospital. Louise confirmed thirty care homes had signed up for the training and work was taking place to measure data around admissions and benchmark the impact of this training.

The Trust had received one year's funding (£7000) from the CCG for the sessions as well as additional training via telemedicine. Additional training sessions had also been developed for the wards. There was also a future meeting to discuss rolling out the training to community staff.

### 4.1 How are we progressing?

A thorough evaluation report was produced for this work, which demonstrates impact in terms of both patient safety, in particular fewer falls, pressure ulcers and UTIs, and cost savings.

Unfortunately there was no further funding available to continue the project once it finished. The key highlights from the report are as follows:

1. Regarding admissions – data from fifteen care homes:
  - Admissions increased (see table), – the results were skewed by one care home which had just one admission pre training (Dec 2017) and then seven during March 2018, the follow-up period, including several chest infections which the manager attributed to “a prolonged winter.”
  - Comparing the “pre training” data, mostly collected during Summer/Autumn, with the “post training” data collected over Autumn/Winter does not give an accurate representation as hospital admissions in this patient group are typically higher in the winter.
  - Note that the overall reductions in falls, pressure ulcers and UTIs (see below) may have led to fewer admissions than there would have been otherwise.

	Baseline	3 month follow-up
Number of residents admitted to hospital in last month	16	19
Number of falls in last month	98	82
Number of residents with a pressure ulcer of Grade 3 or higher	3	2
Number of urinary tract infection (UTI)s in last month	45	39

2. Telemedicine: Analysis in report. In summary: the team struggled to get homes to have the training via Telemedicine – just four in the end and only two of these provided evaluation forms. It was difficult to determine whether either Telemedicine or Face to Face delivery led to greater impact as conclusions could not be drawn with only two evaluations. There were some difficulties using the technology which have been shared with the Telemedicine leads.
3. There was a meeting with the CCG about providing a dietitian community home visit service (community wide, not just care homes), but this did not lead to anything. It was hoped that there would be further funding to continue but this did not happen.
4. Generally: the programme was very well received by care home staff and managers and led to improvements in staff knowledge and confidence to deliver good nutrition and hydration. The project may have played a role in reductions in incidence of malnutrition, falls, pressure ulcers and UTIs, with potential cost savings. This ties in with NHS Outcomes Framework Domain 5. It was delivered in a cost efficient manner.

## 5.0 Month: October 2017

### Title: Bethan’s Story

Patient/ Staff member presenting: Bethan Paley and Dr Liz Allison

Bethan is an active member of the Trust’s Youth Forum who wanted to speak to the Board about her experiences around her treatment for anorexia. Bethan had been a patient on four occasions during 2015 on ward 17. At the time Bethan had anorexia and said the staff had been sympathetic towards her however their understanding of her illness had not been as good as it would have been if she had a physical illness. Bethan said some of the doctors on the ward did not understand why she needed to be there and she felt they didn’t want her to be on the ward however Dr Allison had been very understanding and had supported Bethan through her treatment.

Dr Allison said she had previous experience of working with anorexia patients and said Bethan had contributed to her understanding around how alterations for anorexia patient’s treatment could be

put in place. Guidelines and an eating disorder protocol have developed and Dr Allison paid tribute to the contribution Bethan had made. She said staff on the ward had appreciated how open Bethan had been with everyone.

The Trust receives a referral approximately once a month and an admission criteria is in place. An outpatient service is provided by Hillbrook Child and Adolescent Services in Keighley.

Miss Fletcher thanked Bethan for sharing her story and asked what she felt were the main points in the protocol that had made a difference. Bethan said considering the mental health aspect of the illness was very important and patients should not be placed in bays alongside someone else with an eating disorder given the fact this could encourage competitive behaviour.

Members of the Board agreed that Bethan had been instrumental in providing support to Dr Allison in changing the treatment pathway which had proved difficult around challenging behaviours in clinical colleagues.

## **5.1 How are we progressing?**

The guidelines for managing patients with an Eating Disorder are embedded and staff use these to determine plans of care. There are some challenges for staff in relation to ways of working between organisations. This is mitigated with bi-monthly meetings with the CAMHs team to discuss any issues that may arise to ensure a joined up approach continues.

In April 2018 the trust hosted a member's event aimed at raising awareness about support services in the local community for adults and children with an Eating Disorder. The event heard from other provider colleagues from Leeds and York Partnership Trust (adult service provider) and Bradford District Care Foundation Trust (Children and Young People's provider) as well as a marketplace of stalls with literature to take away. It was evaluated very well and the presentations were shared with attendees by email afterwards.

## **6.0 November 2017**

**Title: Penny's Story**

**Patient/ Staff member presenting: Penny Clark**

**In attendance: Annie McCluskey, Head of Nursing Integrated Care**

Penny, a retired Nurse came to speak to Board about her mother's experience on ward 10. She explained her mother was 94 years old and had suffered a fall at home. Prior to the fall she had been very independent although she did have some mobility issues. Whilst an inpatient on ward 10 there had been errors in her mother's care that the family felt were inexcusable. The Board were informed the biggest issue related to the assessment of Penny's mother and in her view the nursing team saw her as an elderly lady who fell frequently and had poor cognitive skills.

During the 10 days in hospital Penny's mother was not seen by a physiotherapist and got weaker during her time in hospital. She was generally frailer and more confused during her time in hospital. The fall had damaged her muscles in her back and although she was prescribed painkillers in ED she did not receive any pain relief on the ward. When Penny challenged this, the response from the nurses was that she hadn't asked for any pain relief.

Penny described other areas of concern regarding her mum's care and said there had been a number of discrepancies in the notes which led to the family feeling they needed to take their own notes about her care. The patient's needs were not discussed with the family and Penny said the overall communication with the family had been poor. She said they were ignored when they approached the nursing station and when a member of staff did communicate with the family they were not made to feel welcome.

At the point of discharge, arranged for 4pm, the family were contacted at 2pm to ask whether anyone was coming. The discharge letter contained incorrect information and the request for a referral to physiotherapy, continence service and the audiology service has not been included. The Board were informed that the healthcare support staff on the ward were very kind and friendly but the family felt they had not had received appropriate leadership. Penny said she was deeply disappointed by the care her mum had received particularly as the points she had raised do not have cost implications to rectify.

A formal apology was issued to Penny, her mother and family for their experiences. Annie McCluskey, Head of Nursing and the nursing team met with Penny to discuss this case and said work was taking place to make improvements. Annie confirmed that ward 10 has good systems in place for delivering patient centred care however they do need to work alongside families to better understand the patient's background.

## **6.1 How are we progressing?**

The Intermediate Care Unit (formally ward 10) has a new Team Leader who is a physiotherapist by background. Martin Welton provides line management to the nursing staff and clinical support therapists. The Intermediate Care Unit is now under the Community Services umbrella within Airedale NHS Foundation Trust. The unit uses the community services experience to help focus on discharging people with support (when needed) from the appropriate community services as soon as possible.

The ward has developed a KPI which will demonstrate whether relatives or carers have been included in developing/updating therapy goals. This is monitored monthly through the KPI tracker and the ward development plan. Ward staff will complete the KPIs (2 out of every 3 months) - this will help them to understand where areas can be improved and emphasises a peer led learning culture rather than top down decisions.

The unit has developed a new integrated Multidisciplinary Team (MDT) meeting and is in the process of developing a daily multi-disciplinary handover process to provide truly holistic care. Discharge letters are completed by a Community Advanced Practitioner (based on IMCU) with support from the meeting - a new MDT record form has been developed to ensure all information/progress reports is collected from the meeting.

Community advanced practitioners and Collaborative Care Teams are providing in reaching support to the unit to keep the focus on community care and patient flow from acute care to community care. The unit has also developed a "Passport to IMCU" to help identify the right people to come to the Unit. This is helping to keep the focus on rehabilitation, rather than acute medical care.

Message from Penny Clark – Sep 18

*"Thank you for the opportunity to give some feedback to The Board at the September meeting.*

*The most important issue for us as a family is that our reportage of the less than professional care of our Mother, was firstly valued, and shared in the spirit in which it was given, that of a positive and constructive way to all heads of the relevant departments involved.*

*We felt supported throughout the whole process to give full honest and in-depth descriptions of the trajectory of events in the care episode that had left my Sister and I, both senior nurse practitioners feeling frustrated and professionally disappointed. We were listened to and taken seriously and this meant a great deal to us.*

*Whilst this opportunity to give further feedback is very much appreciated, what we would have welcomed is some formal feedback as to the outcome of the internal investigations with regard to any changes to professional practice and any lessons learned.”*

## **7.0 January 2018**

**Title: Head and Neck Cancer Pathway Experience**

**Patient/ Staff member presenting: The patient**

**In attendance: Claire Fernyhough, Head and Neck Cancer Speech and Language Therapist, Mary Dickinson, Therapy Manager and Angela Penny, Senior Nurse Specialist Speech and Language Therapy**

The patient attended to talk about his experience of the head and neck cancer pathway following a diagnosis of tongue cancer in December 2016. The treatment pathway is a joint service between Leeds Teaching Hospitals NHS Trust, Bradford Teaching Hospital NHS Foundation Trust and Airedale NHS Foundation Trust.

The patient was diagnosed in Bradford, treated via chemotherapy and radiotherapy in Leeds, and then came to the head and neck clinic at Airedale. He was very positive about his care at Airedale, praising in particular the continuity of care between the different disciplines: Speech and Language Therapy, dieticians, and his cancer specialist nurse.

He felt the emotional support and communication was excellent despite some staff coming from different organisations. However he did feel that there was a bit of disconnect between leaving his treatment at Leeds and starting at the clinic at Airedale. He said more structure and continuity, especially for someone who is generally in good health and not used to accessing health services was important. Also noted was the fact the clinics at Airedale tended to move between rooms from one week to the next which was confusing and a lounge area would have been beneficial to provide some comfort.

Throughout the recuperation process there had been difficulties and he talked about the emotional aspects of this however staff at all levels had been very supportive.

## **7.1 How are we progressing?**

The Head and Neck Cancer pathway is complex involving large teams and organisations (Bradford/ Leeds/ Airedale) but the transfer of information is now more timely and efficient. Caroline Salt, Lead Head and Neck Cancer CNS BRI has been leading on this and patients are seen where possible the week following completion of their Chemo/Radiotherapy in Leeds at the AGH MDT clinic.

The team endeavours to see all Head and Neck cancer patients pre-treatment so they know their AGH support team in advance of surgery or oncological treatment in Leeds = better continuity of care.

The team is offering more intensive support immediately post treatment and this is resulting in better outcomes for patients (i.e. quicker removal of feeding tubes and safe resumption of oral intake, patients feeling well supported).

Challenges:

- Head and Neck Cancer is on the rise. Patient Follow up is often long term and this requires skilled staff, adequate staffing levels.
- Specific Speech and Language Therapy follow up is currently limited due to reduced capacity. A business case is being written in the hope that these issues can be

resolved and the clinical need met with equity of service provision with Bradford/Leeds.

- All cancer patients are on PPM (Leeds) and this system does not (at present) link up with SystmOne. Consequently, there is a lot of duplication of administration.

In regards to accommodation, the same consulting room in Clinic 12 is used on a Thursday morning but often a move to another room is required for the afternoon session. Rooms are often too small to comfortably accommodate the team and family members.

Following each consultation (if there is a change in plan) the patient will be given a handwritten summary. In addition, written copies of the personalised care plan are posted out to patients. Every effort is made to ensure the information is presented in the most suitable format and that time is given to process the information.

## **8.0 March 2018**

### **Title: Roy's Story**

**Patient/ Staff member presenting: Roy Puckey, Jeremy Gee, Trainee Community Advanced Practitioner, Fiona Throp, Community Advanced Nurse Practitioner**

Roy Puckey who was in attendance to talk about the care he had received via the new Bronchiectasis pathway in the community. Roy explained his symptoms started with a lung infection and that he had been hospitalised over Christmas. Following discharge he started to receive IV infusions and physiotherapy at home delivered by the community team. He said the nurses had spent quality time with him and he commended their attention to detail. He explained receiving treatment at home had a very positive impact on both his and his wife's wellbeing. Other benefits included being able to sleep, having his family close to him and not being at risk of hospital infections.

He explained this type of care would be very beneficial patients if it could be expanded into the wider community. He informed the Board the community services team had been very professional and demonstrated very high standards of care and said it was important they had support in place to maintain this given the pressures on these members of staff. Initially he had felt guilty about the cost of his care but it had become apparent this was not as much as being admitted to hospital and he invited the Board to consider whether community care was more cost effective and more beneficial than treatment in hospital.

Fiona Throp informed that the team were working on other pathways to deliver care to patients in their own homes. Roy was invited to be a patient ambassador for community delivered care.

## **8.1 How are we progressing?**

The Bronchiectasis pathway is now firmly embedded in the team. The team received training initially on the pathway and now manages patients autonomously. A new patient information booklet has been completed for patients.

A community IV diuretic pathway has been developed, targeting patients with heart failure that otherwise would require admission to hospital. The team has revised and streamlined the COPD exacerbation pathway with a view to improving quality and safety, whilst increasing number of referrals, reducing length of stay and targeting a reduction in future admissions with early intervention.

A patient currently on the caseload under the bronchiectasis pathway declined admission to the hospital for IV antibiotics leading to the consultant requesting input from the team at the patient's home. The patient remains on the pathway currently and is very grateful to have the

support from the team at a particularly difficult time as they reported that the home environment has a positive effect on their health.

The team is currently distributing IV pathway specific feedback forms with an aspect focussing on patient preference of treatment environment. Early feedback (7 patients) has been very positive with 100% of patients stating they would "prefer to receive this treatment in their own home, rather than in hospital" and 100% stating they "could carry out their normal activities whilst receiving treatment at home."

As well as the above the team has created an IV database which is now live (from the 1st September). This will allow the ability to collate more detailed information about the pathway, conditions and interventions with the overall goal of improving patient safety and experience.

Referrals have been increasing since May 2017 for IV therapy within the community. This however brings its own challenges with managing capacity and demand. Staff within the collaborative care teams continue to up-skill and improve scope of practice allowing for increased capacity secondary to greater efficiency.

In order to create capacity we are scoping the use of elastomeric pumps to deliver antibiotics with the aim of creating a steady state throughout the 24 hours, thus improving quality, whilst reducing the need for multiple visits throughout the day, thus creating capacity for other pathways. The team is also having an antibiotic reviewed. This antibiotic works over a long period of time with only a single dose. This would help people with issues with cannulation and concordance e.g. IV drug users and people with learning difficulties where the hospital environment is not the best place and where multiple administrations could be distressing.

Mr Puckey, the patient who attended Board to talk about his experience. He informed me that he struggled with the cold weather towards the end of winter/spring particularly when going out. Since then he stated he is "doing very good," with continued support from Mrs Puckey and completion of self-management exercises. Mr Puckey reports for the first time in many years he feels his lungs are clear. He remains very keen to support the pathway and wishes to continue to be an ambassador in the future when required.

#### **4. Conclusions**

The Board will continue to hear from a range of patients, carers, community groups and staff members about their experiences. Patient stories are sought from PALS and complaints feedback, SPI walk rounds and via the patient experience officer.

#### **5. Recommendations**

The Board is asked to receive the report and note the work that has been undertaken as a result of the patients' sharing their experiences with us and continued service improvements.