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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

2.00 pm	Tuesday 14 April 2015	Waltham Forest Town Hall

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Sanchia Alasia
Councillor Eileen Keller
Councillor Danielle Lawrence

LONDON BOROUGH OF WALTHAM FOREST

Councillor Stuart Emmerson
Councillor Sheree Rackham
Councillor Richard Sweden (Chairman)

LONDON BOROUGH OF HAVERING

Councillor Nic Dodin
Councillor Gillian Ford
Councillor Dilip Patel

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Mark Santos
Councillor Tom Sharpe

CO-OPTED MEMBERS:

Alli Anthony, Healthwatch Waltham Forest
Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Richard Vann, Healthwatch Barking & Dagenham

For information about the meeting please contact:
Anthony Clements, anthony.clements@oneSource.co.uk, Tel: 01708 433065

Essex County Council

London Borough of Redbridge

Waltham Forest

Havering LONDON BOROUGH

The London Borough of Barking & Dagenham

Protocol for members of the public wishing to report on meetings of the Outer North East London Joint Health Overview and Scrutiny Committee

Members of the public are entitled to report on meetings except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise London Borough of Havering Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

3 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to declare any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 1 - 10)

To agree as a correct record the minutes of the meeting held on 13 January 2015 and to authorise the Chairman to sign them (attached).

5 BARTS HEALTH - RESPONSE TO WHIPPS CROSS HOSPITAL CQC INSPECTION

To scrutinise the plans of Barts Health NHS Trust in light of the recent inspection of Whipps Cross Hospital by the Care Quality Commission (CQC).

6 CARE QUALITY COMMISSION HOSPITAL INSPECTION PROCESS

Discussion with Lucy Hamer, Involvement Team Leader, Care Quality Commission, of the hospital inspection process used by the organisation.

7 CCG/NHS ENGLAND CO-COMMISSIONING

Scrutiny of the new co-commissioning landscape operated by NHS England and Clinical Commissioning Groups.

8 URGENT CARE REPROCUREMENT

Update on the position with the urgent care reprocurement process from a representative of local Clinical Commissioning Groups.

9 HEALTHWATCH BARKING AND DAGENHAM - REPORT OF ENTER AND VIEW VISIT (Pages 11 - 28)

To receive a report from Healthwatch Barking and Dagenham on a recent enter & view visit to Fern ward, King George Hospital. Healthwatch report and action plan from Barking, Havering and Redbridge University Hospitals' NHS Trust attached.

10 URGENT BUSINESS

To consider any other item of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item should be considered at the meeting as a matter of urgency.

Anthony Clements
Clerk to the Joint Committee

Venue Information

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3 hours: £3.80
4 hours: £5.10
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Induction loop facilities are available in most Meeting Rooms.

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MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Redbridge Town Hall
13 January 2015 (2.00 - 5.05 pm)

Present:

COUNCILLORS

Essex	Chris Pond
Havering	Nic Dodin and Gillian Ford
Redbridge	Stuart Bellwood, Mark Santos (Chairman) and Tom Sharpe
Waltham Forest	Richard Sweden

Healthwatch representatives present:

Ian Buckmaster (Havering)
Mike New (Redbridge)

Officers present

Nilesh Mistry, Community Pharmacist
Rob Burns, Director of Planning and Information, Great Ormond Street Hospital for Children NHS Foundation Trust
Wendy Matthews, Director of Midwifery, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Denise McInnerny, Head of Midwifery, Whipps Cross Hospital
Jacqui Niner, Partnership of East London Cooperatives (PELC)
John Light , PELC
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Ilse Mogensen, Commissioning Support Unit

Scrutiny officers present

Masuma Ahmed, Barking & Dagenham
Anthony Clements, Havering (clerk to the Committee)
Jilly Szymanski, Redbridge

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

25 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of the action to be taken in case of fire or other event requiring the evacuation of the meeting room.

26 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillors Sanchia Alasia and Eileen Keller (Barking & Dagenham) and Dilip Patel (Havering). Apologies were also received from Alli Anthony (Healthwatch Waltham Forest) and Richard Vann (Healthwatch Barking & Dagenham).

27 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

28 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 14 October 2014 were agreed as a correct record and signed by the Chairman.

29 PHARMACY ARRANGEMENTS

The Committee was addressed by a community pharmacist from the Loughton area. The pharmacist had created a template to allow more effective communication between pharmacists and GPs. It was felt that advice given by pharmacists was not currently communicated directly to GPs. Equally, pharmacists were not currently able to access GP patient records. The template had therefore been created to show on patient records what interventions a pharmacist had undertaken with patients.

The pharmacist stated that 95% of patients he had assisted would otherwise have gone to the GP and his pharmacy alone had therefore produced a £62,000 saving to the NHS. He felt however that the template project needed funding in order to maximise the benefits of interventions by pharmacists.

The project had been discussed with the pharmacist's local Clinical Commissioning Group – West Essex CCG, NHS England and the Royal Pharmaceutical Society. While most pharmacies currently operated a paper-based system, the form that had been developed could be completed on a Tablet device. Patients using the pharmacy system had to consent to their information being transmitted to their GP. The pharmacy form had been

developed in cooperation with stakeholders over a three year period. It was hoped to also develop an I-phone based system with different levels of security.

It was noted that a co-director of Healthwatch Havering was the secretary of the North East London Local Pharmaceutical Committee.

It was emphasised that the template could be used by any pharmacies, whether independent or part of a large chain.

The Committee felt that any initiative that reduces pressure on A&E and GPs should be supported and it was **AGREED** that the local CCGs should be asked to support the project.

30 **GREAT ORMOND STREET HOSPITAL**

The Director of Planning and Information at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) explained that GOSH was a specialist children's hospital, founded in 1885. The hospital had a small number of beds (350) but high staff numbers (approximately 4,000) and turnover. Nearly half of the hospital's beds dealt with complex care and there had been an 80% increase in the number of patients seen over the last 8 years. The hospital also ran the second largest private hospital service in the UK.

GOSH offered all children's services except burns treatment. GOSH dealt with 25% of children's heart surgery in the UK as well as 33% of bone marrow transplants and 75% of children's epilepsy surgery. There were a total of 19 specialist children's services offered by the hospital and these were not commissioned by CCGs but by NHS England in most cases. Forty-eight per cent of GOSH patients were from London with a further 24% from Hertfordshire, Essex and Bedfordshire. 11.5% of admissions were from Essex with the ONEL boroughs each accounting for 1.6 – 3.2%. Redbridge for example had seen 1,210 admissions in the last year. One per cent were overseas patients funded by the NHS under reciprocal agreements.

There was no A & E department at GOSH and the hospital did not generally take referrals from GPs. Referrals were usually made by consultants in other hospitals. The Trust's vision was for GOSH to be the leading children's hospital in the world for patient experience, outcomes and research.

A major challenge for GOSH was the planned change in NHS commissioning arrangements for specialist services which could have an impact of £20 million on the Trust's finances, The ability to recruit and retain key staff was also a challenge. The Trust also wished to make patient records digital and transferrable.

Opportunities for the Trust included the hospital's strong brand name which allowed it to diversify its income base. The hospital's new clinical building was due to open in 2017. GOSH was also at the forefront of genomic medicine such as the development of a non-invasive pregnancy testing service.

The greatest clinical pressures at GOSH related to end of life care. GOSH was often the hospital of last resort and families were often reluctant to agree to the ceasing of intervention. Some patients incurred extremely high treatment costs with the 125 most complex cases seeing £12.5 million more being spent on treatment than GOSH had received from commissioners for these patients.

The private patient wing at GOSH was operated separately from the rest of the hospital and funds from this were being used to support NHS services and research.

The Liverpool Care Pathway had never been used at GOSH and the UK's only dedicated paediatric palliative care team was based at GOSH. Digital records were in the process of being rolled out to different departments at GOSH. It was hoped to also develop a portal system to be used by other hospitals around the UK.

GOSH did make use of premiums for groups of staff that were difficult to recruit to although the Trust had not moved outside of national pay scales. Staff recruitment and retention at GOSH had improved in the last year and a lot of nurses had been recruited from countries including Ireland, Portugal and Spain.

A service level agreement was in place to allow the GOSH palliative care team to visit hospices. This team also administered care in people's homes.

Lobbying and risk assessment work was in progress in relation to the impact of specialised commissioning changes. GOSH was also seeking to increase efficiencies and derive more income from private patients. The GOSH officer accepted however that the planned changes in commissioning arrangements were likely to lead to fewer NHS beds and theatre sessions at GOSH.

The Committee **NOTED** the update and thanked the GOSH officer for his attendance and input to the meeting.

The Committee **AGREED** that GOSH should not be penalised by any forthcoming changes in the arrangements for specialised NHS commissioning and that a letter communicating the Committee's view should be sent to NHS England.

31 MATERNITY SERVICES

A. Whipps Cross

The head of midwifery for Whipps Cross advised that 4,800 babies had been born at the hospital in 2013/14. Services available through Barts Health included community midwives for home births and other specialist services including bereavement services. There were also specialist teams available for e.g. pregnant women with mental health needs.

Whipps Cross offered the full range of maternity services. Specialist scans could now be done at the Royal London Hospital meaning it was no longer necessary to travel to Great Ormond Street for these. There were a total of 158 midwives at Whipps Cross. There were not any vacancies for midwives at the hospital currently but this situation did vary. A consultant midwife had been appointed to give clinical leadership and a clinical education lead was in the process of being recruited. An infant feeding coordinator was also now in post.

Women's experiences of maternity were very important and the Trust was working with its Maternity Services Liaison Committee. The friends and family test was used and the Trust sought to learn from complaints received. Clinical skills of midwives had been assessed and feedback from local women was also sought via the Trust's 'Mum to Mum' programme.

Improvements implemented at Whipps Cross over the last 18 months included opening a new theatre suite in HDU, standardising maternity services and developing a home birth team across Barts Health. A new programme of labour induction had reduced the number of caesarean section required and 1:1 care for maternity was now at 97% - a good safety indicator.

The report from the latest CQC inspection of Whipps Cross had not yet been shared but warning notices issued from the previous inspection had since been lifted.

B. BHRUT

While all hospital births at BHRUT now took place at Queen's Hospital, maternity outpatient appointments were still provided at King George. Community midwifery and home birth teams were also available.

There were a total of around 350 midwives at BHRUT including 70 community midwives. A total of 15 midwives including two senior midwives were present on each shift. Electronic patient records were used in maternity and all birthing rooms were en suite, There were approximately 20 births per day at Queen's, making it one of the busiest maternity units in the UK. Consultants were present on the wards from 8 am to midnight and the Trust's current rate of caesarean sections was 24.8%.

BHRUT now had low rates of use of epidurals and of labour induction, both of which were positive indicators. There were also now very low admissions of mothers to ITU and a very low level of brain damaged babies. There had not been any intra partum still births at BHRUT in the last two years.

Maternity HDU was staffed by midwives and trained nurses. This meant there had only been one admission needed to the hospital's main intensive care unit so far this year. There had also been fewer post partum hysterectomies needed so far this year.

Maternity triage was open 24 hours a day for pregnant women. The antenatal ward had 16 beds and there were two post-natal wards for high risk and low risk cases. The obstetrics assessment unit was midwifery-led and open 7 days per week, 8 am to 6 pm.

Maternity clinics were held at Queen's and King George as well as at the Fanshawe Community Clinic in Barking. The life study project had been set up to conduct research on babies over a 20 year pathway. The project was centred at King George and was currently recruiting women.

Other services provided included parenting sessions, clinics for women who had previously undergone caesarean sections and birth reflection sessions. The Queen's birthing centre had opened in January 2013 and only 25% of deliveries had required any transfer to the main labour ward. Neo-natal services were available at Queen's up to level two.

BHRUT was commissioned for an annual total of 8,000 births and was projecting 7,957 deliveries for 2014/15. When the Care Quality Commission had last visited in October 2013 it had found significant improvements in maternity services at Queen's. The Trust had been compliant with all maternity standards inspected.

Service user feedback was collected and there had been a fall in the number of formal complaints received. There were also around 240 compliments received by the service each month which scored 96-98% on the Friends and Family Test. A lot of service user surveys were also collected.

The workforce was funded at a 1:29 midwife to birth ratio and there were approximately 10% of posts vacant at present. There was a recruitment and retention plan and the Trust was also looking at training maternity care assistants as midwives. Staff were rotated through the different maternity services in order to build up their skills. The Trust was proud of the 1:1 care it could offer in labour and that its maternity services had been transformed. Moving forward, the Trust wished to increase rates of home births and to lower rates of caesarean sections and of still births.

C. Comments from Healthwatch Havering

Healthwatch Havering had undertaken an enter and view visit to maternity at Queen's in April 2014. The visit had been undertaken by Healthwatch representatives including a senior commissioning manager from another area. This had found that a number of improvements had been made and were being built into the system. BHRUT did respond to the recommendations made by Healthwatch and included these within the Trust's action plan. It was planned that Healthwatch would revisit maternity in order to check on progress.

Officers could provide figures for the number of births commissioned at Whipps Cross split by each borough. Around 1,400 women in the Whipps Cross catchment area also gave birth elsewhere. Work was in progress to investigate where these women gave birth. A representative of Healthwatch Redbridge added that 30-50% of Redbridge mothers delivered at Whipps Cross and that the new facilities at the hospital were very good. It was noted that the business plan for the next phase of work at Whipps Cross was awaiting approval.

D. Further Discussion

It was confirmed that BHRUT had a consultant midwife in public health who focussed on issues relating to female genital mutilation and could refer women to appropriate agencies if necessary.

BHRUT was aiming to achieve baby friendly accreditation over the next 4-5 years and needed the boroughs to work together to give breast feeding advice to new mothers. Funding was needed to support mothers in the community with breast feeding. The Committee **AGREED** that better joint working should be encouraged to develop breast feeding.

BHRUT officers accepted that services needed to be strengthened at the Barking Birthing Centre. The service would continue for the present but needed to be reviewed.

A Member congratulated BHRUT on how the closure of in-patient maternity services at King George had been dealt with. Figures on where maternity service users came from would also be useful as there was a lot of mobility in choice of where to give birth. Officers had not seen any change in the ratio of male: female terminations carried out at the Trusts but it was noted that terminations could also be carried out in the private sector.

Consultant cover at Whipps Cross was available for 74 hours per week but this was not sufficient in the delivery suite. It was hoped to increase consultant numbers but this would cost Barts Health in the region of £1.4 million per year. It was **AGREED** that a letter should be sent on behalf of the Committee to Barts Health supporting Whipps Cross maternity in their bid for funding to increase consultant cover.

HIV screening was offered to all women giving birth at both Trusts. A specialist HIV midwife was available at Whipps Cross to develop appropriate care plans etc.

There was also a consultant psychiatrist and psychiatric nurse available at Whipps Cross who worked with the midwives. Mothers thought to be suffering from e.g. depression would be referred back to their GP; those who were e.g. bipolar would be treated by the specialist service team.

It was confirmed that a maternity dashboard of 50 indicators was used at BHRUT and that a pan-London dashboard was also being developed. Figures from the BHRUT dashboard could be supplied to the Committee.

Home births currently accounted for 0.7% of BHRUT births with figures for home births across London being slightly higher at 1-2%. It was emphasised however that many women were not suitable for home births. Women's choice of where to give birth was accommodated where this was possible and safe to do so. Home births at Barts Health were approximately 2% of the total deliveries at the Trust and it was hoped to expand this. Patient experience questions used by Barts Health were nationally available on the internet.

Whipps Cross would also offer, at the point of GP referral, a choice of place of birth and antenatal care, within the Trust provision. Barts Health was funded to a midwife: birth ratio of 1:32 but the current figures were in fact 1:30.4. As regards still births, audits and process reviews were undertaken for all such cases at Whipps Cross.

It was confirmed that both Trusts were happy for Members to visit their maternity services if they wished. The Committee **NOTED** the update and thanked the officers and Healthwatch representatives for their input.

32 **NHS 111**

It was explained that the service provider for NHS 111 as well as of the out of hours GP service for ONEL and Essex was PELC – the Partnership of East London Cooperatives. PELC also operated GP walk-in centres at King George and Whipps Cross Hospitals.

The NHS 111 service allowed easier access to urgent care and access to on-site advisers for complex care issues. Ambulances could be dispatched if the telephone assessment deemed this to be necessary and the NHS 111 software had an automated link to the NHS 111 service. NHS 111 would otherwise give a time frame and clinical outcomes to e.g. see a patient's GP within three working days.

NHS 111 used the NHS Pathways system that had been developed by GPs and other clinicians. Around 30% of calls received were transferred to clinical advisers such as nurses or paramedics if they were thought to be sufficiently complex. Nationally, there were around 500,000 calls to NHS 111 each month.

The service used a directory of services that listed all NHS services within England. NHS 111 was also able to send patient details electronically. Training for health advisers on the services lasted for five weeks including a two weeks initial course that was required to be passed. Ongoing training and support was also available. Updates were added to the system for new issues such as the Ebola outbreak.

As regards clinical governance, NHS 111 met on a monthly basis with commissioners and also with patient representatives. Feedback was received via surveys and end to end audits with patients. All complaints and incidents were also logged. There had been approximately 21,000 calls to NHS 111 from the ONEL area in December 2014. Around 62% of calls were referred to primary care though it was accepted that access for patients to GPs remained a problem.

The directory of services used by NHS 111 allowed the identification for commissioners of gaps in services and it was felt that NHS 111 had made the NHS as a whole more cost effective. NHS 111 had its own dashboard that it used for performance indicators.

If calls were referred incorrectly, this was fed back to NHS 111 by the services concerned on occasions but did not always happen. The profile of a service could also be changed on the directory of services if necessary. NHS 111 was keen to receive more feedback on calls that had been misdirected. Feedback could be given via the PELC website and PELC officers would supply the links to this. There were also mechanisms via the PELC website for health professionals to give feedback. PELC also worked with the local Healthwatch organisations for example in planning resilience. NHS 111 also conducted their own patient surveys.

The response time target for the service was to answer 95% of calls within 60 seconds. This indicator had reached 97% over the Christmas period. Targets to limit the number of abandoned calls were also being met. It was noted that around 40% of calls to the ONEL NHS 111 service originated from other geographical areas.

There had not as yet been much national publicity for NHS 111 due to provider problems in other regions. It was clarified that NHS 111 staff had the same ability to assess calls as did operators on the 999 emergency service. The recent establishment of GP Federation Hubs in two of the ONEL boroughs would be reflected in the NHS 111 directory of services. The local ‘Not Just A&E’ campaign also promoted NHS 111.

Officers indicated they were happy for the Committee to visit the NHS 111 offices in order to learn more about the service and the work it undertook.

The Committee **NOTED** the update.

33 URGENT CARE PROCUREMENT

The chief operating officer of Havering CCG explained that the four local CCGs were working together to reprocure urgent care. This covered non - A & E services such as NHS 111, walk-in centres (other than at Barking Hospital) and urgent care centres. The CCGs were keen to engage with patients and the public on this process and had identified key elements for the public such as quick assessments by doctors and good transfer of patient records.

The reprocurement process was currently at the stage of 'competitive dialogue' and it was planned to award the contract for urgent care services at the end of June 2015. The new service was hoped to start in September 2015.

Outline solutions from bidders were currently being evaluated and further engagement sessions with patients and the public were being planned. Officers were happy to give an update on the position at the next meeting of the Committee.

Sessions were planned whereby each of the bidders could hold discussions with patient and public engagement representatives. These would not be open sessions due to the confidential nature of the procurement process.

The Committee **NOTED** the update.

34 URGENT BUSINESS

There was no urgent business raised.

Chairman

Enter & View Visit
Fern Ward
Medicine and Elderly Care Ward
King George Hospital

For further copies of this report, please contact

Info@healthwatchbarkinganddagenham.co.uk or
Telephone: 020 8526 8200

www.healthwatchbarkinganddagenham.co.uk

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Introduction

Healthwatch Barking and Dagenham is the local independent consumer champion for health and social care. We aim to give our citizens and communities a stronger voice to influence and challenge how health and social care services are provided for people in the borough.

Enter & View is carried out under the Health & Social Care Act 2012. It imposes duties on certain health and social care providers to allow authorised representatives of local Healthwatch organisations to enter premises and carry out observations for the purposes of Healthwatch activity.

Authorised representatives observe and gather information through the experiences of service users, their relatives/friends and staff to collect evidence of the quality and standard of the services being provided.

To do this we:

- Enable people to share their views and experiences and to understand that their contribution will help build a picture of where services are doing well and where they can be improved.

- Give authoritative, evidenced based feedback to organisations responsible for delivering and commissioning services.

- Are able to alert Healthwatch England or the Care Quality Commission, where appropriate, to concerns about specific service providers of health or social care.

Summary

Healthwatch Barking and Dagenham authorised representatives undertook the visit to speak with patients about three areas of care during their hospital stay: nutrition, personal hygiene and interaction between staff and patients. We spoke to 10 patients on the day of the visit.

Overall patients were satisfied with the meals provided and felt that they were given a choice of what they would like to eat. In terms of drinks, all patients were not aware that soup or a milk drink was available. There were concerns raised about catering staff asking if people want a drink only from the entrance of the bay. This was a problem for those who had hearing impairments and also for those who were in the bathroom or asleep at the time.

Patients highlighted that staff had a lot to do but do try their best to provide the care they can.

Although patients were satisfied with their bedding being changed and staff helping them with bathing, issues were raised by relatives about incontinence items not being changed overnight.

All patients have an information board placed behind the bed. Relatives indicated that these are not always updated to reflect the correct information.

Details of the Visit:

Date:

8th October 2014

Premises Visited:

Fern Ward, King George Hospital

Enter & View Authorised Representatives:

Barbara Sawyer
Val Shaw
Manisha Modhvadia (Healthwatch Officer)

Specific Areas Identified for Observation:

- Nutrition
- Personal Hygiene
- Interaction between Staff and Patients

Reasons for the Visit:

To visit wards that provide in-patient hospital services for older people - to gather the views and experiences of patients about the services being provided to them. This Enter & View visit is part of a wider programme being undertaken by Healthwatch Barking and Dagenham around issues concerning health and social care services for older people and is as a consequence of findings from the Francis Report. Healthwatch have undertaken a visit previously to Queens Hospital as part of this work programme and wanted to determine parity of care across the Trust.

Purpose of the Visit:

To ascertain patients' views on the choice and quality of the food and drink they receive; to ask patients and their visitors about the staff interaction with them and to get views and comments about the quality of personal hygiene support that patients receive.

Healthwatch authorised representatives spoke to 10 patients on the day of the visit.

The Wards' Services:

The ward has 30 beds: split into 4 units with 6 bays each, set up as single sex units. There are 4 side rooms.

It is a medicine ward for elderly care.

Visiting times start at 10.30am till 7.30pm and patients are provided with 2 cooked meals a day.

Staffing arrangements:

Morning: 6 Qualified Nurses and 3 Health Care Assistants

Afternoon: 4 Qualified Nurses and 3 Health Care Assistants

Evening/Overnight: 3 Qualified Nurses and 3 Health Care Assistants

During the weekend the staff numbers drop by 1, in all categories.

During the visit, the staff from the ward were very helpful and assisted by providing all information that was requested.

Healthwatch Barking and Dagenham would like to thank the staff for their assistance and co-operation during our visit.

On entering the wards, each one has a sink near the entrance to encourage visitors to wash their hands as well as use the alcohol hand rubs.

Information boards were observed on the wards' reception areas.

We saw a system of red trays and water jugs with red lids being used to identify patients that required help with feeding and drinking.

Patients' Experiences:

Nutrition:

Healthwatch representatives were not looking at nutrition on the wards from a Dietician's perspective, but from the point of view of the patients.

The questions asked centred on the help patients get to eat and drink, whether they can choose the food they eat and if they feel it is of good quality.

On the day of the visit Healthwatch representatives spoke to ten patients.

Generally, patients found the quality of food to be satisfactory. Healthwatch Representatives observed a red tray and lid system being used. Every patient had a red tray and lid. A staff member told Healthwatch Representatives that all the patients in the ward had them as it's an elderly ward.

Patients were asked if they are helped with food and drink, four patients told Healthwatch representatives that they did not need any help but were sure a member of staff would help them if they did. Five patients out of the ten said they received help.

Eight patients said they were happy with the size of food portions provided and two said they were not.

Patients' opinions varied on the choices of food.

Comments included:

"I was given what the patient before ordered; there was no other alternative choice for me".

"I am given a menu to choose from and the choices are good"

"Yes I am given choices by the menu".

"I have had sandwiches the bread is too thick, Its needs to be thin bread"

In discussion with patients and relatives it came to light that some patients are not being helped with the menu options, the menu is left on their table to complete by themselves.

Comments included:

"Don't always get what you want, not much help to fill out the menu option, there are a lot of the elderly people in here who are confused and are left to fill in the options."

" I cannot read very well, as my sight is very poor, the staff do not always do the menu with me."

Relatives highlighted that patients were not aware that they can ask for a milk drink or a cup of soup. It's only when a patient or a relative ask staff that they become aware of this.

Healthwatch representatives spoke to patients about drinks. Out of the ten patients 5 mentioned that catering staff only came to the doorway and ask patients if they wanted a drink. One patient on the ward, who was hard of hearing, told us that she has missed out on drinks due to this.

Patients also told us that catering staff do come back to ask if they would like a drink. Patients who are asleep or in the bathroom miss out on having a drink.

One relative spoke about his mother's care on the ward. His mother, he explained, his mother is a stroke victim and unable to use one side of her body. No staff member had helped her to have a drink and her jug was left on the side of the table where she was unable to reach it. No beaker was provided to the stroke patient until a relative asked for one.

Comments from patients

"You have a menu that you can choose from. I am happy with the choices, sometimes if I don't like something, the staff will give me something else but it depends on if there is anything left"

"Not aware that soup is an option, unless you ask, you would not know that's its available, it's only a packet of soup, but people still need to know it's an option"

"Yes food is hot enough for me"

"Two hot meals a day, but when I have had sandwiches the bread is too thick, it needs to be thin bread"

"Plenty of water in the jug"

"Always enough water and drinks"

Personal Hygiene:

Patients were asked for their views and experiences of personal care support: was it meeting their needs and was it being carried out in a way that preserved their dignity?.

Overall, patients were satisfied with the way they were being cared for and said that they were treated with dignity and respect. All patients that were asked said that their bed linen was changed every day.

Patients and relatives commented on the call button: highlighting that it took a while for staff to attend to patients once they had buzzed.

One relative spoke to Healthwatch Representatives about his mother's experience within the ward. He felt that the staff seem to be very busy but try their best. His concern was over the call buttons "I told the nurse that the call button does not work: the nurse told me that the button would be fixed the following day. I felt uncomfortable leaving my elderly mother without having a way to call for help overnight. The nurse then got some sellotape as a temporary measure. My mother has been here over two weeks and the problem has not been dealt with."

Relatives were concerned that patients were not being asked about changing incontinence pads overnight. A relative commented, "One morning I came in my mother was drenched, although the nurses changed her and gave her a bed bath, this would not have happened if someone asked if she needed a change."

Two patients told us that when they use a bedpan, they are left with the bedpan and the nurse goes to deal with something else and then they are left waiting until she comes back. The patients said the position is uncomfortable.

Comments from patients

"I wash everyday"

"I can use the toilets, wash every day, I do wear continence items."

"Would help if asked, but can wash myself"

"Overnight no one asks if you need a change."

"I had to wait a while before anyone came to take the bedpan"

"After using the buzzer there was no response and therefore her daughter had to go to the desk"

"It does take staff a while to come I know they have a lot to do"

Staff interaction

Healthwatch representatives wanted to explore the experiences that patients and relatives had when interacting with hospital staff.

We spoke with patients; we wanted to know if they had been treated with respect and dignity during their stay: that the staff responded to requests for assistance in a timely way and whether patients understood why they were in hospital and the treatments they were being given.

Overall patients were generally happy with their experience of the staff.

Patients felt that sometimes staff had a lot to do but tried their best. Feedback from some patients showed that staff treat them with respect and are approachable.

Comments from patients included
"Staff do treat me well",
"Very pleasant"
"Yes staff are very nice".
"Patients are put at the end of the queue".

Comments from other patients and relatives however, were less favourable:

"I had to wait one and a half hours for them to set up a commode".

Two relatives who were spoken to on the day felt that if they were not there, their relative would be left alone all day, they felt a befriending service of some sort would be of great help.

Some patients said they are given an explanation about their treatment and medication, whilst others said they were not told what was going on.

Relatives who were present on the day said doctors had explained what medication their relative was taking. One relative said "I am glad I know what is going on, as a carer I need to know what is happening with my mother or it will make things a lot worse when she comes home and I have no idea."

Additional information

Representatives observed information boards above each bed, they consisted of patient information, including the patients name, the date, the nurse and consultant who were treating the patient.

Three relatives indicated issues with incorrect information being displayed on the boards.

One relative told Healthwatch Representatives that staff had swapped their relative and other patient between bays. However once this was done the information on the boards were left with incorrect details of the patient. Another relative said that although the boards are a good idea, at times the details of the nurse who is treating the patient are incorrect.

The third relative told us that there is vital information that nurses keep missing out such as their mother only being able to drink with a beaker. The relative felt this information should be on the board so that all staff are aware and catering staff know that the patient needs her water in the beaker.

Incorrect or incomplete information on these boards is inconvenient at the best, and could possibly be dangerous. This is particularly the case if the wrong name and details are mistakenly left over a bed when patients are moved.

Conclusion and Recommendations:

Overall feedback indicates that majority of patients were happy with the portions of food they receive. However issues were raised about catering staff and the communication with the patient when distributing drinks and the food menu.

Information boards were an issue raised by relatives in particular. Their feedback indicated that incorrect information was being displayed. Healthwatch Representatives felt that incorrect information could have serious implications, especially in terms of the wrong medication being given to the patient.

Patients did not have issues with bathing. However feedback that was received about the management of incontinence items show that improvements need to be made.

Taking into consideration the views of patients and relatives Healthwatch recommend:

- Catering staff distributing tea and coffee need to each individual patient and ask if they would like a drink. This is essential on an elderly ward, where patients could be confused and for those with hearing impairments.
- Before leaving the ward, catering staff should ask those who may have been having a wash/gone to the toilet if they would like a drink.
- All patients should be asked if they need help filling in the menus.
- Staff need to double check that patient information boards display the correct information at the beginning of their shift.
- Where patients are using a bedpan, staff need to wait for the individual to finish using the bedpan so they are not left waiting in a uncomfortable position longer then they need to.
- All call buttons on the ward need to be checked to ensure they are in working order. If a call button is not working an alternative method needs to be provided to ensure the patient has a way of calling staff when they need to.

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Enter & View Visit by Healthwatch Barking & Dagenham

Action Plan

Healthwatch Barking & Dagenham carried out an Enter & View Visit on Fern Ward at King George Hospital on the 8th October 2014. The action plan below includes the recommendations that were made following the visit.

Recommendation	Lead	Timescale	Actions Taken
Catering staff distributing tea and coffee need to go to each individual patient and ask if they would like a drink. This is essential on an elderly ward, where patients could be confused and for those with hearing impairments.	Mary Etchells, Senior Sister	With immediate effect	Recommendation discussed with Karen Burroughs from Sodexo. Ward Sisters to oversee that this is carried out for each patient in each bay daily. Sodexo Supervisors to monitor that the housekeeper is going into the bays and offering drinks to every patient, using the correct cup, beaker. Escalation to Matron Hughes in the event this is not being maintained.
Before leaving the ward, catering staff should ask those who may have been having a wash/gone to the toilet if they would like a drink.	Mary Etchells, Senior Sister	With immediate effect	Recommendation discussed with Karen Burroughs from Sodexo. Ward staff to ensure all patients receive appropriate drinks daily and escalation to Matron Hughes if housekeepers fail to deliver this action.
All patients should be asked if they need help filling in the menus.	Mary Etchells, Senior Sister	With immediate effect	Volunteers currently assist patients when on the wards with the support and guidance from the nursing and care staff on the ward.

Recommendation	Lead	Timescale	Actions Taken
			Health Care Workers need to ensure patients are supported to complete their menus daily and to ensure they are collected and given to the kitchen staff daily. To be monitored by Registered Nurses.
Staff need to double check that patient information boards display the correct information at the beginning of their shift.	Mary Etchells, Senior Sister	With immediate effect	Daily checks of patient boards to be undertaken by the Nurse in Charge. Matron to check compliance daily.
Where patients are using a bedpan, staff need to wait for the individual to finish using the bedpan so they are not left waiting in a uncomfortable position longer then they need to.	Mary Etchells, Senior Sister	With immediate effect	All staff are aware of the issues and have been instructed to remain by the patients when they are using bedpans, but far enough to ensure privacy. Call buzzers to be in easy reach of all patients.
All call buttons on the ward need to be checked to ensure they are in working order. If a call button is not working an alternative method needs to be provided to ensure the patient has a way of calling staff when they need to.	Mary Etchells, Senior sister	With immediate effect	The patient's Named Nurse to ensure that they have call buzzers in easy reach. Matron to check on ward rounds Faulty equipment to be reported to the works department on 5702 and checked daily for completion. Concerns of continued faulty equipment to be escalated to Matron Hughes.

Action Plan developed by: Matron Connie Hughes, January 2015

Action Plan to be reviewed monthly