Public Document Pack

Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Tuesday 19 February 2019	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative Group (3)	Residents' Group (1)	Independents Residents' Group (1)
Nisha Patel (Chairman) Christine Vickery Ciaran White (Vice-Chair)	Nic Dodin	Jan Sargent

North Havering Residents' Group (1)

Darren Wise

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

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, 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 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.

What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny sub-committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

The sub-committees have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns to the public.

The sub-committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations. These are considered by the Overview and Scrutiny Board and if approved, submitted for a response to Council, Cabinet and other relevant bodies.

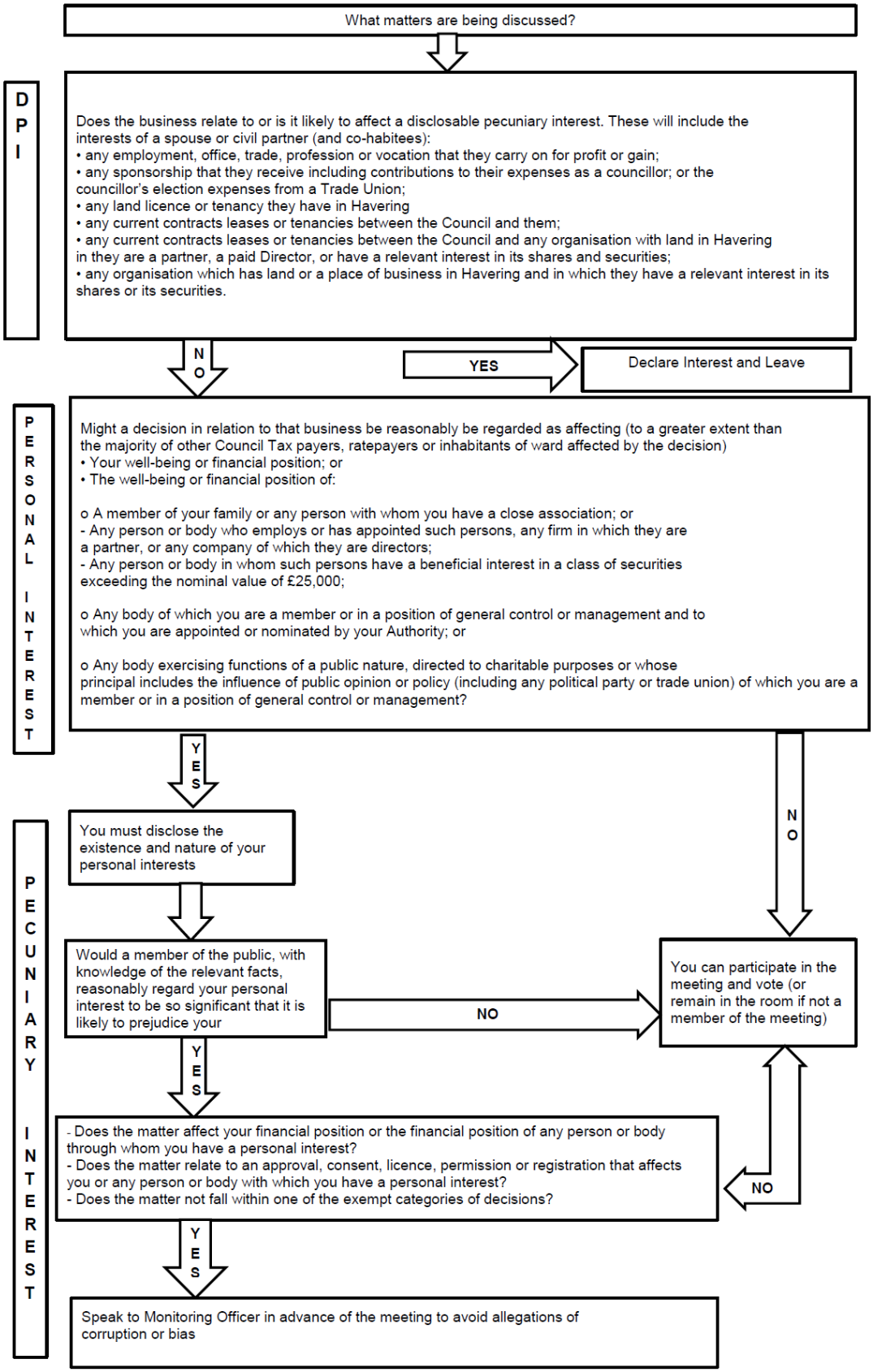
Sub-Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for anything from a few weeks to a year or more to allow the Members to comprehensively

examine an issue through interviewing expert witnesses, conducting research or undertaking site visits. Once the topic group has finished its work it will send a report to the Sub-Committee that created it and will often suggest recommendations for the Overview and Scrutiny Board to pass to the Council's Executive.

Terms of Reference:

Scrutiny of NHS Bodies under the Council's Health Scrutiny function

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF



AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DISCLOSURE OF INTERESTS

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

4 MINUTES

To agree the minutes of the meeting of the Sub-Committee held on 4 December 2018 (attached) and to authorise the Chairman to sign them as a correct record.

5 ST GEORGE'S HOSPITAL SITE UPDATE (Pages 1 - 10)

Report and presentation attached.

6 Q3 PERFORMANCE INFORMATION (Pages 11 - 26)

Report attached.

7 HEALTHWATCH REPORTS - MATERNITY (Pages 27 - 44)

Report attached.

8 HEALTHWATCH REPORTS - IN-PATIENT MEALS (Pages 45 - 68)

Report attached.

9 HEALTHWATCH REPORTS - A & E SERVICES (Pages 69 - 94)

Report attached.

10 WORK PROGRAMME

Members are invited to suggest any items for scrutiny at future meetings of the Sub-Committee.

Andrew Beesley
Head of Democratic Services

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 19 FEBRUARY 2019

Subject Heading:	St George's Hospital Site Update
CMT Lead:	Mark Ansell, Director of Public Health
Report Author:	Dr Gurdev Saini, Chair, St George's Hospital Redevelopment Delivery Board
Policy context:	**The information presented updates the position as regards the development of the former St George's Hospital site.**
Financial summary:	**No financial implications of the covering report itself.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

Details are given in the attached presentation of the current position with the proposed redevelopment of the St George's Hospital site in Hornchurch.

RECOMMENDATIONS

1. That the Sub-Committee considers the information presented and takes any action it considers appropriate.

REPORT DETAIL

Following the recent decision by central Government to not to award any additional capital funding for NHS projects in the North East London area, local health bodies are considering options for the use and redevelopment of the former St George's Hospital site in Hornchurch. An update on the current position is given in the attached presentation and officers will give further details at the meeting.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

St George's Hospital site update

A new health and wellbeing centre in Hornchurch

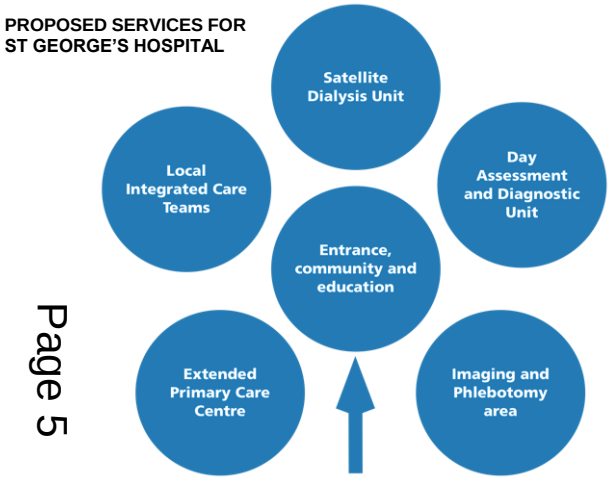
Presentation by Jane Milligan, Accountable Officer, BHR CCGs
Dr Gurdev Saini, Chair, St George's Hospital Redevelopment Delivery Board

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Background

- St George's Hospital (SGH) site not owned by Havering CCG or the local NHS
- Site sold last year by owners, NHS Property Services, for £43m
- Planned new health centre on part of site to cost local NHS £17m
- CCGs, BHRUT, NELFT, plus LB Havering, joint working to deliver centre
- NHS funding routes have changed multiple times in last 5 years
- Regular updates from Dr Saini to all stakeholders
- Capital bids not the only identified funding option.

Why is St George's no.1 priority for the STP?



To support and enable a re-configuration, St George's will provide not only primary care services, it will have space for services that are currently delivered from Queen's. These services are more appropriate for community, non-acute settings and free-up space in the acute hospital for more suitable clinical uses.

- The St George's redevelopment has ranked at the top of the projects in the STP prioritisation process. This shows its importance in creating a community hub for outpatient services to facilitate the shift from Queen's. This also means less reconfiguration work and no extension on a PFI site – a more cost-effective solution for the system.

- The release of 85% of the site for housing will create up to 452 units of housing and generated a capital receipt of £43m to NHS Property Services. However none of this capital is available to be invested in the local system.

- BHR CCGs, LB of Havering, BHRUT and NELFT (BHR Integrated Care Partnership) have been jointly planning the vision for the new locality health and social care hub which will include:

- Primary care at scale for over 30,000 patients
- Relocation of community dialysis unit from Queen's to more appropriate setting (freeing up space for A&E expansion)
- Relocation of outpatient services from Queen's to a more appropriate setting (freeing space for growth and reconfiguration)
- Integrated health and social care team base
- New model for urgent care/out of hours

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

What's happened recently?

- New health centre on SGH site project identified as top estates priority by north east London (NEL) STP – aka the East London Health & Care Partnership
- Key to unlocking other projects (Queen's Hospital reconfiguration, NELFT community teams, new GP practice for Hornchurch, community use)
- Wave 4 capital bid for £17m submitted along with other STP bids for BHRUT and Barts Health projects
- £963m awarded by government nationally in December 2018
- Not a single NEL project awarded any funding in this round.

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

STP Wave 4 Capital bids

- STP submitted eight bids totalling £472m
- No indications of significant issues with process
- Confident we submitted a robust, well-evidenced and realistic set of bids
- Significantly progress plans to meet health/care needs of local people
- Partners proactively seeking alternative funding solutions to address inevitable and significant issues caused by decision
- Limited options available to fund these crucial capital projects.

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

What next?

- Need to understand why NEL bids were unsuccessful - could we have done anything differently?

- Impact on our Estates and Clinical Strategies and longer term plans

- Next round of funding – spring 2020

- Other options - Community Health Partnerships, local LIFT Co. - Estates and Technology Transformation Fund, LB Havering joint venture, third party developers

- Other challenges remain: identify services which can and should go into new heath centre to meet local need and make it affordable in current financial climate.

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Questions?

This page is intentionally left blank

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 19 FEBRUARY 2019

Subject Heading:	Quarter 3 2018/19 performance information
SLT Lead:	Jane West, Chief Operating Officer
Report Author and contact details:	Lucy Goodfellow, Policy and Performance Business Partner (Children, Adults and Health) (x4492)
Policy context:	The report sets out Quarter 3 performance against indicators relevant to the Health Overview and Scrutiny Sub-Committee.
Financial summary:	There are no direct financial implications arising from this report which is for information only. However adverse performance against some performance indicators may have financial implications for the Council.

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[X]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

This report supplements the presentation attached as **Appendix 1**, which sets out the Council's performance against indicators within the remit of the Health Overview and Scrutiny Sub-Committee for Quarter 3 (October – December 2018).

RECOMMENDATION

That the Health Overview and Scrutiny Sub-Committee notes the contents of the report and presentation and makes any recommendations as appropriate.

REPORT DETAIL

1. The report and attached presentation provide an overview of the Council's performance against the performance indicators selected for monitoring by the Health Overview and Scrutiny Sub-Committee. The presentation highlights areas of strong performance and potential areas for improvement.

2. Tolerances around targets (and therefore the amber RAG rating) were reinstated for 2018/19 performance reporting. Performance against each performance indicator has therefore been classified as follows:

    - **Red** = outside of the quarterly target and outside of the agreed target tolerance, or 'off track'
    - **Amber** = outside of the quarterly target, but within the agreed target tolerance
    - **Green** = on or better than the quarterly target, or 'on track'

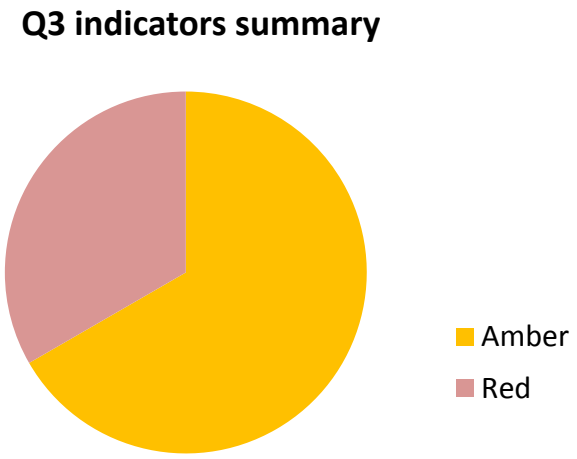
3. Where performance is rated as '**Red**', '**Corrective Action**' is included in the report. This highlights what action the Council and/or its partner organisations will take to improve performance.

4. Also included in the presentation are Direction of Travel (DoT) columns, which compare:

    - Short-term performance – with the previous quarter (Quarter 2, 2018/19)
    - Long-term performance – with the same time the previous year (Quarter 3, 2017/18)

5. A green arrow (↑) means performance is better and a red arrow (↓) means performance is worse. An amber arrow (→) means that performance has remained the same.

6. In total, three performance indicators have been selected for the sub-committee to monitor. Performance data is available for all three indicators this quarter, and these have all been given a RAG status.



In summary, of the 3 indicators:

2 (67%) have a status of **Amber**
1 (33%) has a status of **Red**

This is an improvement on the position at the end of Quarter 2, when two indicators were rated red.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no financial implications arising directly from this report, which is for information only. However adverse performance against some performance indicators may have financial implications for the Council.

All service directorates are required to achieve their performance targets within approved budgets. The Senior Leadership Team (SLT) is actively monitoring and managing resources to remain within budgets, although several service areas continue to experience significant financial pressures in relation to a number of demand led

services, such as Adults' Social Care. SLT officers are focused upon controlling expenditure within approved directorate budgets and within the total General Fund budget through delivery of savings plans and mitigation plans to address new pressures that are arising within the year.

Legal implications and risks:

Whilst reporting on performance is not a statutory requirement, it is considered best practice to regularly review the Council's progress.

Human Resources implications and risks:

There are no HR implications or risks arising directly from this report.

Equalities implications and risks:

Equality and social cohesion implications could potentially arise if performance against the following indicator currently rated as Red does not improve:

- Obese Children (4-5 years)

The attached presentation provides further detail on steps that will be taken to improve performance and mitigate these potential inequalities.

BACKGROUND PAPERS

Appendix 1: Quarter 3 Health OSSC Performance Presentation 2018/19

Havering

LONDON BOROUGH

Quarter 3 Performance Report 2018/19

Health O&S Sub-Committee

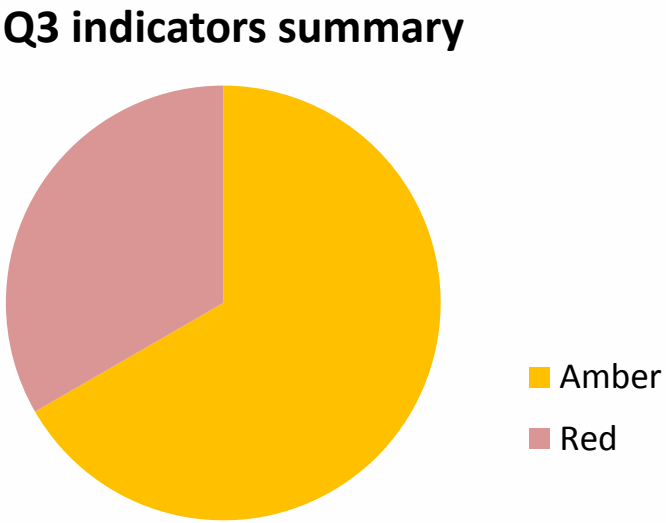
19 February 2019

About the Health O&S Committee Performance Report

- Overview of the Council's performance against the indicators selected by the Health Overview and Scrutiny Sub-Committee
- The report identifies where the Council is performing well (**Green**), within target tolerance (**Amber**) and not so well (**Red**).
- Where the rating is '**Red**', '**Corrective Action**' is included. This highlights what action the Council will take to address poor performance.

OVERVIEW OF HEALTH INDICATORS

- 3 Performance Indicators are reported to the Health Overview & Scrutiny Sub-Committee.
- Performance ratings are available for all 3 indicators.



Of the 3 indicators:

2 (67%) have a status of **Amber** (within tolerance)

1 (33%) has a status of **Red** (off target)

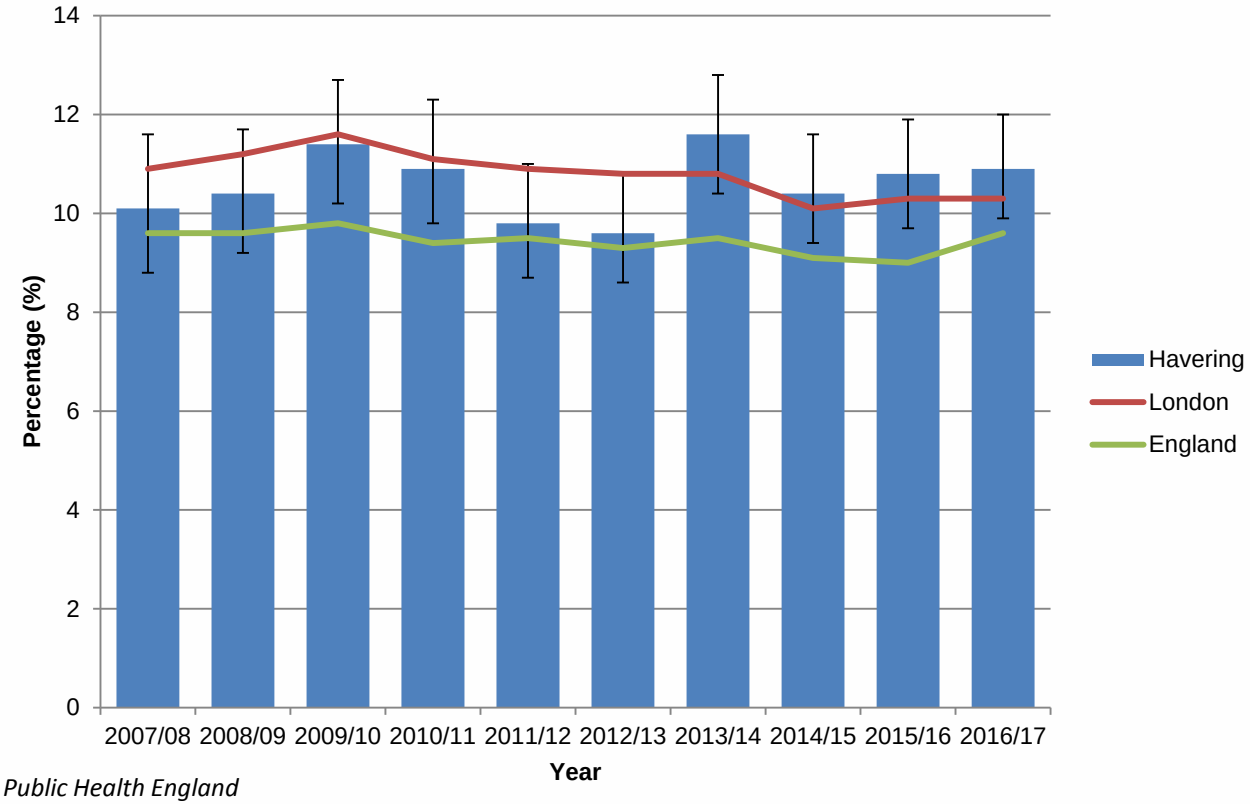
Quarter 3 Performance

Indicator and Description	Value	Tolerance	2018/19 Annual Target	2018/19 Q3 Target	2018/19 Q3 Performance	Short Term DOT against Q1 2018/19		Long Term DOT against Q3 2017/18		Service
Obese Children (4-5 years) (Annual)	Smaller is better	Similar to England	Better than England (9%)	Better than England (9%)	10.9% (2016/17) RED Worse than England	-	N/A	↓	10.8% (2015/16)	**Public Health**
Percentage of patients whose overall experience of out-of-hours services was good (Partnership PI) (Annual)	Bigger is better	Similar to England	Better than England (69%)	Better than England (69%)	64% (2018) AMBER Similar to England	-	N/A	↓	67% (July 2017)	**Havering CCG**
The number of instances where an adult patient is ready to leave hospital for home or move to a less acute stage of care but is prevented from doing so, per 100,000 population (delayed transfers of care)	Smaller is better	±10%	7	7	7.4	↑	7.8	↓	5.1	**Adult Social Care**

About Childhood Obesity

- Prevalence of obesity amongst 4-5 year olds in Havering has seen no significant change over the past 9 years. In 2016/17 Havering's performance remained significantly worse than England but similar to London .

Percentage of Obese Children, Havering, London & England, 2007/08 – 2016/17



Source: Public Health England

Improvements Required: Childhood Obesity

- Directed by Havering's 'Prevention of Obesity Strategy 2016-19', our borough working group continues to progress actions that are within the gift of the local authority and partners, and within available budgets.

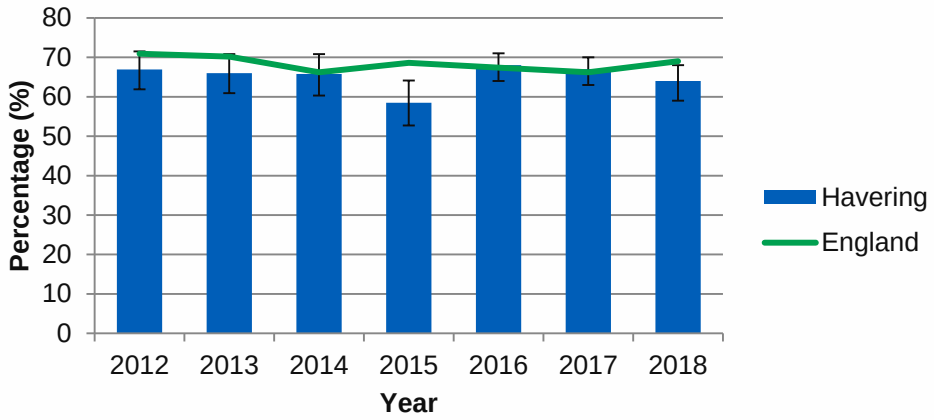
- Progress on actions since the last update are as follows:
  - ✓ A bid was submitted to the Childhood Obesity Trailblazer Programme fund that, if successful, in the initial phase will focus on engaging communities in Harold Hill and Rainham to develop their own solutions to tackling obesity.
  - ✓ A bid has also been submitted for funding of five public water fountains across the borough to encourage people to drink water instead of sugary drinks and reduce their plastic waste by refilling water bottles.
  - ✓ Obesity has been incorporated into the Council's Local Implementation Plan as part of the Healthy Streets Approach.
  - ✓ A further six Early Years settings in Havering have registered with the Healthy Early Years programme taking the total to 38. Sixteen have completed First Steps, four achieved the Bronze award and two the silver award.
  - ✓ Everyone Active is piloting a 12-week adult weight management programme at Hornchurch Leisure Centre combining nutrition advice and physical activity for individuals with a BMI of over 25.
  - ✓ HES Catering has promoted a SugarSmart campaign in secondary schools and will be introducing a traffic light system for menu items.
  - ✓ A weekly lunchtime walk has been introduced for LBH staff and changes have also been made in the Pantry, reducing sugar, introducing wholemeal pasta, reducing the price of water and adding more beans and pulses to the salad bar.

- Obesity is a complex issue and many of the opportunities to tackle it fall outside of the local authority's influence. As such, work continues at national level, guided by the national 'Childhood Obesity: A Plan for Action' and we continue to link with national campaigns and programmes where appropriate.

About Patient Experience of GP Out-of-hours Services

- The latest available data (2018) for patient experience of GP out-of-hours services shows no significant difference between the percentage of patients who are satisfied with the service in Havering (64%, 95%CI: 59%-68%) and the England average (69%, 95%CI: 68%-69%). This follows an overall improvement in the England average performance as compared to the previous year (2017 – 66%) whereas Havering's performance has not significantly changed. Use of out-of-hours services includes contacting an NHS service by phone (e.g. 111) and going to A&E - which a vast proportion (54% and 31% respectively) of the 882 Havering respondents who answered this question say they did.

The percentage of patients who are satisfied with the GP out of hours services, Havering & England 2012 - 2018



Source: NHS Digital & GP Patient Survey Database

Considerations for: Patient feedback on Out of Hours Services

- When practices are closed (outside of 8 am – 6.30 pm) they can provide their own Out of Hours (OOHs cover) or 'opt-out'. If a practice 'opts out' the commissioner is responsible for ensuring appropriate OOHs cover is in place.

- In Havering, all practices have opted out of OOHs, therefore the CCG commissions PELC to provide OOHs cover in which the clinical responsibility for patients is transferred to the OOHs provider. PELC provide services out of hours on the Queens and King George hospital sites and at Grays Court in Dagenham.

- London Ambulance Service took over 111 services from 1st August – they were previously provided by PELC. 111 are able to book patients into the GP OOH and the GP access hub services. There are seven GP hubs providing an out of hours service across BHR, two of which are in Havering, at Rosewood Medical Centre and North Street Medical Centre.

- A number of factors affecting use of OOHs have changed as part of the NHSE London Access strategy reflecting the ambition of the General Practice Forward View (GPFV). This includes increasing the number of slots offered by the GP access hub.

- The survey results are now collected only once per annum rather than every six months and are therefore slower to reflect changes. Trends will therefore only be discernible from the July 2017 data collection point onwards.

About Delayed Transfer of Care

- In the first eight months of 2018/19, there has been an average of 14.75 delayed discharges per month (7.4 days per 100,000) whereas at the same stage last year there had been an average of approximately 10.

- The vast majority of delays are in the acute sector and are the responsibility of Health.

- There was an increase in delays attributable to Social Care during the second quarter of the year, which continues to affect cumulative performance but the direction of travel over the past three months has been positive. There were a small number of lengthy delays in the summer due to the sourcing of specialist support. Some out of borough hospitals also reported delays against Havering which are being followed up.

- Actions being put in place to reduce delayed discharges include:
  - Care Homes in Havering being supported to create a 'Trusted Assessor' role, based primarily in BHRUT;
  - Establishment of a pilot bringing together therapy resources in BHRUT and NELFT to manage the hospital / community interface differently;
  - Simplification of discharge processes, including a revised screening and referral process for NELFT inpatient rehab beds.

Any questions?

This page is intentionally left blank

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 19 FEBRUARY 2019

Subject Heading:	Healthwatch Havering Reports – Maternity, In-Patient Meals and A & E Services
CMT Lead:	Mark Ansell, Director of Public Health
Report Author:	Ian Buckmaster, Healthwatch Havering
Policy context:	**The information presented covers reports on three local health issues compiled by Healthwatch Havering.**
Financial summary:	**No financial implications of the covering report itself.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The attached presentation gives details of the current position regarding blood testing services in Havering.

RECOMMENDATIONS

1. That the Sub-Committee considers the information presented in each report and takes any action it considers appropriate.

REPORT DETAIL

The reports attached at the next three agenda items cover investigations carried out by Healthwatch Havering of three important issues relating to local health services – maternity services, in-patient meal times at Queen's Hospital and A & E services.

Healthwatch Havering has the legal right to refer its reports to the Sub-Committee for consideration and/or endorsement. The Sub-Committee continues to work productively with Healthwatch Havering and Members are encouraged to discuss the findings and recommendations in the reports with the Healthwatch representative who is due to attend the meeting.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Enter & View

Queen's Hospital, Romford

Rom Valley Way

Romford RM7 0AG

Maternity and Women's Health: Third Visit

13 September 2018

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

We had previously visited the Maternity Unit at Queen's Hospital twice, in April 2014 and June 2015.

Key facts

The following table sets out some key facts about the Maternity Unit at Queen's Hospital. It is derived from information given to the Healthwatch team during the visit, and reflects the position at the time of the visit:

Number of births per annum:	**c.7800-7900 in 2018/19**
Number of birthing rooms available:	**23**
Number of midwives:	**287 WTE**
Number of medical staff:	**62 WTE**
Number of other healthcare professionals:	**110 WTE**
Number of management/admin/reception staff spoken to:	**1**
Number of patients spoken to:	**1**

The visit

The team were met by the Interim Director of Midwifery, who was open, honest and supportive of the visit, and was clued up and knowledgeable with everything that the team spoke about with her. She told the team that she was really enjoying her job, and it showed.

Demographic trends

The team were told that the birth rate seemed to be dropping, possibly as a result of the imminent departure of the UK from the EU: the number of people using the Unit who were of continental European

origin had dropped. There were around 8,200 births in the Unit during 2017/18, supported by a staffing ratio of 1 midwife to 29 births; targets were being met, with a current ratio of 1:26 and a ratio of 1:24 a possibility in the future. The number of births in the Unit was capped at 8,000 a year and the expected number in 2018/19 was 7,900.

Overseas patients are required to pay for their treatment. Many would present at around 36 weeks, when they should not even be travelling. The team noted that no mother-to-be was turned away but where payment would be required, the arrangements were dealt with after the birth. The number of overseas mothers-to-be presenting for births had fallen.

Teenage pregnancies were reducing, as societal changes were having an effect. There was a lead midwife for teenage pregnancies, and two midwives for safeguarding issues; although occasionally babies were taken into care immediately after birth, staff worke hard with social services colleagues to ensure that babies remained with their mothers so far as possible – there had been no recent instance of a neonatal baby being taken into care. 16-18-year olds were dealt with by the community midwives. There are two Safeguarding midwives, with at least 3 safeguarding cases each week.

There had also been increases in the number of mothers-to-be who had diabetes, and in pregnancies where the mother-to-be was older than 35.

There had been an increase of premature babies being born and the NICU had increased the number of cots by 6 to accommodate them. Queen's Hospital cared for babies who were ill up to level 2; more serious, Level 3 cases were referred to Homerton Hospital.

Pregnant women were not being referred to the unit by GPs at an early enough stage – within the first ten weeks – which meant that the Unit was unable to achieve the screening target of 50%. All women were screened by 12+6 weeks if referred within an appropriate time by their GP, so the screening was still as effective as it could be. 47% of

admissions were included on the "at risk" register. Most mothers-to-be were tested for HIV, with an opt-out (rather than opt-in) policy in operation.

Antenatal care

Mothers-to-be have long been advised at an early stage in their pregnancy about the risks of drinking alcohol, smoking and drugs etc; the team was told that this advice was repeated throughout the pregnancy, and a smoking cessation group was available. Mothers-to-be were also advised to avoid inhaling smoke from their partners' cigarettes. Dietary advice was given along with general health and wellbeing advice. Women who presented with drug and/or alcohol problems were referred to specialist services at King George Hospital (KGH), where there was an obstetrician with a special interest in those conditions and specialist midwives. Information about the Unit's facilities were available on the www.myhealth.london.nhs.uk website, along with that for other hospitals in the local maternity network, the Barts Health group (St Bartholomew's, the Royal London and Newham) and Homerton hospitals. 1hr 20 mins was spent giving advice on the first appointment. Women considered to be at high risk are seen by a doctor at 16 weeks; those at low risk remained under the care of a midwife. Three obstetric consultants covered the labour ward, elective LSCS, antenatal and postnatal ward each day and there were also consultant in the high risk antenatal clinic.

Mothers-to-be do not necessarily see the same midwife at each appointment. Around 5% of patients were able to see the same midwife each time, and 75-80% receive continuity care in the antenatal and postnatal period; the aim is to increase full continuity to 20% of women. This was dealt with by the Hilltop Team, with a named midwife going out into the community. Home birthing for second and subsequent babies was encouraged, but the team were told that many mothers did not want the inconvenience in their home; most mothers-

to-be with low risk pregnancies found the Birth Centre attractive and opted to give birth there rather than at home.

Consultants were urging GPs to take on board more minor maternity issues: for example, mothers-to-be attended the Unit with coughs, colds, toothaches and other minor ailments that GPs could more easily handle. It was hoped that outside community teams could be encouraged to take more of a part in supporting mothers-to-be.

Waiting times in the ante-natal clinic were shown on a new white board in there. The Matron or midwives regularly explained to patients the reasons for delays.

There was also now a midwife working on the very busy gynaecology ward. At KGH, there was a multi-disciplinary team (including a psychiatrist, doctor and midwife) to support women who had mental health issues and the community mental health service provided by NELFT also ran a psychological trauma team. The hospital's rate for elective caesarean births was comparable with that of other hospitals in London.

Care in the Labour Unit

On arrival, patients went through a triage process using a "traffic light system", whereby patients assessed as Red would be seen within 5 minutes, Amber within 30 minutes and those assessed as Green would be seen within the hour; 88% of patients were dealt with on time.

The team noted that privacy was not always possible: midwives liked to keep their eyes on the mothers-to-be, and conversations could not remain private with just a curtain round the patient. There was a similar problem in the triage area.

The labour ward theatres were in use at the time of the visit and the team was, therefore, unable to view them.

Pain management was registered on a dashboard and 95-98% of requests were dealt with within 30 minutes. Epidurals may not be

given if the birth has progressed too far, and Pethidine was available as well as piped Entonox.

There was no prescribing bay as it was not considered necessary as medication would not normally be needed. Post-natal care for mothers who had given birth by caesarean took place at the bedside.

The Snowdrop suite had been provided for the use of bereaved parents whose baby had died or was still-born; this had just been refurbished and ensured that such parents were not cared for alongside women who given birth to a living baby. The team noted that, where the baby had died prior to birth, it would be induced so that the need for the mother to go through a traumatic experience was not unnecessarily prolonged, but that, if one sibling of a multiple birth had died, the pregnancy would have to continue until it was viable to deliver the remaining baby or babies.

Post-natal care

Communications between the hospital and community midwifery teams were dealt with through secure email, and community midwives liaised with the Health Visitor prior to the mother being discharged. Community midwives were working hard to engage GPs in multi-disciplinary meetings.

Following the birth, babies were checked for jaundice and, once home, were visited by a midwife the first day and then the fifth day for the Guthrie test (heel prick), with a further visit on or about the tenth day if necessary. It was noted that some mothers preferred to visit a community clinic rather than be seen at home.

Mothers were encouraged to breast feed but supported in their choice of feed method; limited support was available in the community.

Accommodation and equipment

The Unit was fully air-conditioned.

Infection control is really good, with no C.Difficile or MRSA cases, and sepsis was not a concern. Some women who have caesarean sections contract infections and are reviewed to ensure that any concerns are identified and acted on.

Equipment was checked daily, and all rooms had a check list that staff were required to complete and record in their midwifery notes. All birthing rooms in the labour ward were fully equipped, including resuscitation, pre-eclampsia and obstetric trolleys. However, the team were told there were difficulties in arranging for equipment repairs, which could take some time to be completed. Moreover, the existing beds were nearing the end of the useful lives, but any repair needs were met in a timely fashion.

Record checks on the resuscitation trolleys were completed daily and, as failure to maintain these records was a disciplinary matter, they were at least 95% correct.

The IT system needed updating to make the systems in use more compatible, which would cut down time spent updating notes etc. Upgrading was due in 2019.

The phone help line was operating extremely well between 10am and 8pm, with script and electronic messaging. Discharged patients had access to a midwife, using a designated phone line. A next day visit would take place if necessary.

There was no security guard as one would be inappropriate, but each baby was allocated a pin number, and (in accordance with the Trust's processes and policies) no baby could be accessed without the correct pin.

The team noted that hygiene and cleaning protocols did not appear to be in place, and no timed cleaning schedules were observed on display, especially in the toilets; the team were told that similar problems were experienced in other parts of the hospital.

Parking was free only while the mother is in labour. All families were informed of this.

Staff

In addition to the Interim Director, there were three Matrons and three consultant midwives in the Unit, together providing 24/7 cover between them to the labour ward, birthing unit and the ante-natal wards. 26 midwives had recently been recruited and would be starting soon; many of the existing staff were long-time midwives. Most staff were permanent and had trained at the hospital; bank staff were occasionally used but never agency staff.

All mandatory training was up-to-date, covering all essential elements. Training was run in house for Level 2 Health Care Assistants and Level 3 Maternity support workers.

Patient's views

The team saw and spoke to a new mother, who was very, very pleased with the way everything had gone. She told the team that she could not find fault with anything; her experience with the birth had been "amazing" and she could not have been more pleased.

Recommendations

1 That a timed cleaning schedule be put in place, especially for vulnerable areas.

2 That the review of the IT system be brought forward in order to secure the smooth running of the department.

3 That the replacement of the 19 beds in the labour unit be carried out in the near future.

4 That consideration be given to a faster response to dealing with women's pain levels.

Healthwatch Havering thanks all service users, staff and other contributors who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 13 September 2018 and is representative only of those service users, staff and other contributors who participated. It does not seek to be representative of all service users and/or staff.

APPENDIX

BHRUT response to this report

The Trust recognises that the Healthwatch Havering report includes a number of recommendations. An action plan to address these recommendations has been developed and is included as part of this response. It should be noted that the majority of recommendations are actions which the Trust is already aware of and has plans to address. Where possible, the Trust current position is outlined on the action plan for assurance.

The Trust will monitor the action plan and update on a regular basis. A final version of the action plan will be submitted to Healthwatch Havering once all the actions are completed.

The action plan is set out on the next page.

ENTER AND VIEW VISIT – HEALTHWATCH HAVERING

MATERNITY & WOMEN'S HEALTH

13TH SEPTEMBER 2018

ACTION PLAN

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
1	Maternity	That a timed cleaning schedule be put in place, especially for vulnerable areas	Sodexho	Dec 2018	This is for the bathroom and toilets- this has been escalated to Sodexho via the patient experience meeting	
2	Maternity	That the review of the IT system be brought forward in order to secure the smooth running of the department.	Maternity SL/DO/JF/CO	April 2020	Currently reviewing the IT system and will be attending Stoke to review their system. The current contract does not expire till 19/20 so we are unable to bring forward the review. However we are developing the system in readiness for this date. This action cannot be completed at this time	
3	Maternity	That the replacement of the 19 beds in the labour unit be carried out in the near future.	Denise Gray Matron James Frost Speciality Manager	April 2019	Business case has been completed and submitted to the trust. Repairs are carried out immediately.	
4	Maternity	That consideration be given to a faster response to dealing with women's pain levels.	Maternity Department	November 2018	Currently our time from request to administration of pain relief is 94% achieved and our epidural rate is over 95%.	

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at @HWHavering

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Queen's Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone: 01708 303300

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at **@HWHavering**

healthwatch Havering

healthwatch Havering

Enter & View

Queen's Hospital, Romford

Rom Valley Way
Romford RM7 0AG

In-patient meals

Third visit
4 October 2018

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

In October 2016, following reports from patients and others alleging inadequate dietary arrangements (not necessarily at Queen's Hospital, Romford), Healthwatch Havering members visited Queen's Hospital to observe the serving of lunchtime food to patients in several wards [1]. During this visit, the team called at four wards – Bluebell A and B, Harvest A and Sunrise B. In October 2017, a further visit was carried out (over two days, on the anniversary of the 2017 visit) when the wards seen were Harvest A, Sahara A and B and Sunrise B.

Although the team noted improvements in the service in 2017 over 2016, members wished to visit again in 2018 to ensure that improvement had continued (accepting that nothing is ever perfect!). It was decided to carry out this third visit on the anniversary of the earlier visits.

Food served to patients at Queen's Hospital is procured on behalf of the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) by their contractor Sodexo Limited from Tillery Valley Foods[2], a specialist catering organisation based in South Wales. It is delivered to the hospital frozen and ready to be reheated. A range of foods is available through a variety of menus. Food for patients who do not have special dietary requirements is varied by rotation of menus over a two-week period; food for patients who have special dietary requirements is also available – should a patient require a specialised menu not generally catered for, a diet chef is available to discuss their specific needs with that patient.

[1] "Queen's Hospital, Romford: In-patient meals, October 2016" (Healthwatch Havering)
[2] It is understood that Tillery Foods is a subsidiary company of Sodexo

The reports of the earlier visits were shared with BHRUT (and other statutory bodies). BHRUT prepared action plans in response to it, which were published alongside the reports on the Healthwatch Havering website [3]. The most recent, updated version of the Action Log arising from the 2017 visit is set out in Appendix 1 to this report.

Appendix 2 sets out the formal response of BHRUT to this report and includes a further Action Log arising from the current visit and report. Healthwatch Havering welcomes in particular the statement at the end of the Action Log that:

> "In addition to the [clinical areas referred to in the report], consideration will be given to extending the recommendations Trust wide."

Nutritional standards

As reported after the first visit, NHS England (NHSE) has identified 10 key characteristics of good nutrition and hydration care [4]. These are:

1. Screen all patients and service-users to identify malnourishment or risk of malnourishment and ensure actions are progressed and monitored.
2. Together with each patient or service user, create a personal care/support plan enabling them to have choice and control over their own nutritional care and fluid needs.
3. Care providers should include specific guidance on food and beverage services and other nutritional & hydration care in their service delivery and accountability arrangements.
4. People using care services are involved in the planning and monitoring arrangements for food service and drinks provision.
5. Food and drinks should be provided alone or with assistance in an environment conducive to patients being able to consume their food (Protected Mealtimes).

[3] http://www.healthwatchhavering.co.uk/sites/default/files/full_report_final_queens_mealtimes.pdf and http://www.healthwatchhavering.co.uk/sites/default/files/170424_response_to_healthwatch_-_april_2017.pdf

[4] NHS England (NHSE) website: https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics

6. All health care professionals and volunteers receive regular raining to ensure they have the skills, qualifications and competencies needed to meet the nutritional and fluid requirements of people using their services.
7. Facilities and services providing nutrition and hydration are designed to be flexible and centred on the needs of the people using them, 24 hours a day, every day.
8. All care providers to have a nutrition and hydration policy centred on the needs of users, and is performance-managed in line with local governance, national standards and regulatory frameworks.
9. Food, drinks and other nutritional care are delivered safely.
10. Care providers should take a multi-disciplinary approach to nutrition and hydrational care, valuing the contribution of all staff, people using the service, carers and volunteers working in partnership.

The team who carried out this visit saw nothing that would have led them to question the conformity of the meals that they saw being served with the required nutritional standards.

The 2018 visit

For this visit, the teams called at four wards:

Sunrise A – where the process of ordering by the hostess was observed;

Sahara A and **HASU** - where observations were made in relation to the ordering process, serving of breakfasts, lunch etc. and food tasting; and

Ocean B - where the service of meals was observed and food was tasted.

Initially, the Team was met by a member of BHRUT's Patient Experience Team and a member of the Sodexo Meal Service, both of whom were very welcoming. After discussion as to which areas were to

be visited, the team began the visit accompanied by staff who were available to address any questions raised.

Food ordering is generally undertaken by Sodexo staff called Hostesses, although BHRUT nursing staff become involved on occasion, for example where patients are unable to make known their wishes, for example because they are asleep.

Sunrise A Ward

The team arrived at the end of the breakfast service and the Hostess was in the process of taking the lunch and evening orders on the Saffron System. Patients were given choices from the daily menu. Although the Hostess was friendly and introduced herself, some patients were unable to clearly understand her accent so she had to repeat herself. The ordering was carried out in a calm manner, an attitude that continued throughout the visit. If a patient was sleeping, the Hostess would attend that patient again after completing the rest of her round and if the patient was still sleeping then, she would take advice from the nursing team.

One patient was able to read the menu and make his own choices but did not appear to be aware that he could choose from the other menus. Another was being PEG fed and the Hostess was clearly aware of the procedure to follow. A further patient was read the daily menu but given only a limited choice; a member of staff explained that only the appropriate menu would be read to patients who had special dietary needs such as diabetic, gluten free etc.

Ocean B Ward

In this ward, the team observed the lunchtime food being distributed, which they felt this was much improved and very appetising. Patients

obtained the correct orders. The vegetables looked vibrant in colour and had not been "cooked to death", so maintaining nutritional value.

Speaking with patients after service, the team were informed that they were very satisfied with the food and could make no complaint: one gentleman told the team "in Royal London the food was diabolical" but here it was "excellent". He had requested a snack box one evening (these being stored near the switchboard for out of hours kitchen service) and advised this had also been excellent - in his words "it was like having a picnic".

Lunches being served were covered and help was given to those who required assistance with opening cartons etc.

One patient commented there was "too much lettuce" – the team advised that perhaps he could ask for a smaller portion – but that was the only negative comment.

Going around the bays of the ward, the team observed covered jugs of water on each table and glasses containing water or drinks within reach of patients, although they considered that some patients might need assistance.

There were notices at the entrances to the wards about protected mealtimes being between 12- 1 Lunch and 5 – 6pm Dinner. The team were told, however, that clinical staff very often would not adhere to this arrangement, thereby hindering the distribution of food and the assisted feeding of patients by the nursing staff and volunteers.

There was no need for red trays in this ward.

Patients were actively encouraged to drink and offered at least 7 drinks per day.

Indications of dietary need were observed on the nutrition board but the team did not see any notes above beds indicating needs other than how patients liked tea and coffee, with or without milk and sugar etc.

Although at mealtimes "all hands were on deck" to assist, including nurses and volunteers, there were only one or two volunteers and they did not attend every day.

Staff came in one day a month to help with a tea party, and quite often PAT dogs attend.

Owing to the nature of the conditions under treatment, on this ward patients were able to sit up in bed to eat but unable to sit at a table.

Serviettes were observed and hand wipes on some tables but patients did not appear to be encouraged to use them before eating.

All meals seen was served in appropriate crockery; main meals and deserts were served separately, and dirty crockery was collected at end of service. Patients had plenty of time to eat their food.

Food stored on the ward was kept in the ward kitchen fridge, which was monitored daily to ensure everything was in date and appropriately labelled. The team felt that, if possible, the monitoring could be undertaken by volunteers, allowing staff to make better use of their time.

The team were told that problems could arise when patients' own food was brought in from outside.

Fluid and food charts were completed by the nursing staff, and if appropriate patients for whom food and fluid charts were unnecessary would be weighed on admission and then weekly.

Comfort breaks were due be offered every 2/3 hours but nursing staff told the team that they were offered more regularly.

As noted earlier, a display board showed the dietary requirements of each patient and was updated regularly. Patients' dietary requirements were assessed on admission, when care plans were prepared.

Sahara A Ward and HASU (Stroke Unit)

Procedures on this ward were very similar to those on Ocean B Ward described above. In one bay, however, patients required assistance with feeding, which was given.

No cold drinks were available at breakfast. Patients told the team that they would have liked the option of fresh orange juice but (although the team were led to understand fruit juice was in fact available) it was not offered and patients were not aware it was available.

Not all menu cards were available on this ward.

Hand cleansing was available but patients' use of it was not monitored.

Although patients were free to sit at a table to eat, rather than sitting up in bed, they were not given strong encouragement to do so.

On this ward the clearing of breakfast dishes was slow.

Part of the ward is the HASU (stroke unit); its patients were given a Malnutrition Universal Screen Tool (MUST) Score in the Emergency Department (ED/A&E).

Menus

In all, 17 menus are available for patients to choose from, including the weekly menu list and the list for patients who miss a meal. There seemed to be a menu for all types of dietary requirements. However, if appropriate, a patient could choose from any menu provided their treatment did not require dietary restrictions.

A separate Diabetic Menu was available in order to stop diabetic patients being tempted to order the wrong food.

Menus were prepared on a two-weekly cycle with the main kitchen having a three-day supply of prepared food available to ameliorate any delays in food deliveries from the supplier. Fresh fruit and salad were

dealt with on site and store cupboard items obtained from another supplier.

Cutlery suitable for those patients who had difficulty using normal cutlery was being obtained and porridge was being introduced at the end of the month.

Food Tasting

A Food Tasting was arranged for the team on Sahara and Ocean B Wards, comprising samples of the daily menus, including gluten free, pureed, soft food etc. After each tasting the team were asked to score the samples; considering individuals' different preferences, the majority of scores were top marks.

Conclusions

Although there remain areas where improvement is still needed, overall the clear improvement since the first visit in 2016 noted last year has been maintained. The new system appears to be bedding in well.

The problems of mass catering for several thousand in-patients are not under-estimated and most people receive good quality food to their taste (and nutritional needs) served in a timely and appropriate manner. The recommendations that follow are, therefore, intended simply to ensure that the meals service continues to improve.

Recommendations

1 That consideration be given to the introduction of illustrated menu cards for the use of patients whose ability to read has been impaired (e.g. stroke patients or those living with dementia) so that they may make easier and better choices of food.

2 That efforts continue to recruit more volunteers to assist at mealtimes.

3 That consideration be given to using the volunteers to assist in checking fridges on wards for out of date food and ensuring that all patients have access to menu cards.

4 That Check Charts should be in place for out of date food and clearly marked daily.

5 That patients be encouraged to use hand cleaning wipes before they are served with food.

6 That, where possible and practicable, patients be encouraged to sit at table for meals.

The formal response of BHRUT to these recommendations is set out in Appendix 2 following.

Healthwatch Havering thanks all service users, staff and other contributors who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 4 October 2018 and is representative only of those service users, staff and other contributors who participated. It does not seek to be representative of all service users and/or staff.

healthwatch Havering

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

APPENDIX 1

ENTER AND VIEW – IN-PATIENT MEALS OCTOBER 2017

ACTION LOG FOR MATTERS ARISING FROM HEALTHWATCH ENTER AND VIEW INSPECTIONS

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
Page 57	Sahara B / Sodexo	Hostess did not wash or gel her hands throughout the visit	Karen Burroughs Nikki Dearson	29 December 2017	Further training to be carried out with immediate effect with the hostess, and supervisor to support this new starter on a daily basis for the next two weeks with effect from 11 December when hostess is back on shift.	
2	Sahara B / Sodexo	Hostess did not introduce herself or explain what she was doing	Karen Burroughs Nikki Dearson	29 December 2017	Further training to be carried out with the hostess and supervisor to observe over a two-week period. Refresher training on be carried out, this will be monitored by Sodexo Supervisor – This has now been completed. Ward Manager to log report any observed incidents to Sodexo supervisor. Breaches are managed through Sodexo disciplinary policy.	

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
3	Sodexo	Corridor leading to Catering dept. Floors had signs of spillage and general grubbiness	Karen Burroughs	11 December 2017	The corridor has been cleaned. These areas are scrubbed over weekend periods and mopped daily. Daily checks to be carried out by Patient Dining team and additional scrubbing can be requested by the ward manager or Sodexo supervisor mid-week as required. Sodexo run monthly audits to ensure cleanliness of areas	
Page 58	Sunrise B	Dishwasher out of action for at least one week.	Waldemar Szarek	11th December 2017	This was reported and dishwasher has been repaired. Correct process for reporting faults to be followed. All staff to be reminded of the procedure. Information being cascaded via Host Huddles.	
5	Trust wide & Sodexo	Sodexo review the training given to hostesses to ensure that they are fully aware of the importance not just of hygienic food handling.	Karen Burroughs	End of February 2018	A complete review of induction training for new hosts is currently underway, the new Patient Dining training pack being introduced in February 2018, which will be rolled out throughout the year covering a new topic.	

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
6	Trust wide & Sodexo	BHRUT and Sodexo review the training given to hostesses regarding general infection control	Karen Burroughs & Head of Infection Control	June 2018	Sodexo infection control passports being trained out to hostesses. 26% of staff currently trained. All hostesses expected to be trained on booklet by end of June 2018 Update:	
Page 59	Trust wide & Sodexo	Standardise approach to hostess and mealtime assistant tasks in order to minimise the risk that staff approach the job differently, with different outcomes for patients	Karen Burroughs & Ward managers	June 2018	A Hostess dining training is in place for all hostesses who complete a different module each month to complete the programme. Ward Managers ensure that meal times are being delivered consistently on their area. Ward managers add mealtime brief to morning huddles for ward staff and invite hostesses to attend.	
8	Trust wide & Sodexo	That greater co-operation between all levels of front-line staff, both BHRUT and Sodexo be encouraged, for the benefit of patients	Karen Burroughs & ward managers	March 2018	Karen Burroughs is part of the Nutrition Advisory Group with the Trust which meets quarterly and will request that this item be part of the agenda. Hostesses to be invited to ward huddles and team meetings. PE team attending meal time testing sessions monthly and provide feedback to Sodexo and ward. a regular basis.	

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
9	Trust wide & Sodexo	Review procedure for taking orders to ensure that ordering deadlines be clarified and adhered to and that those patients capable of informed choice be given menus to select meals from in advance of ordering their food	Karen Burroughs Ward Manager PE team	Feb 2017	Staff reminded that ordering deadline is 1015 hrs. Menus are placed on each bedside locker. Additional option menus are placed in menu holders in the central ward area. Supervisors to check that menus are available daily. Mealtime testing proforma to be drawn up by Sodexo and PE team to log and audit if patients are given menus in advance.	
10	Trust wide & Sodexo	That the range of foods on offer be reviewed to ensure that: (a) special dietary requirements are addressed as flexibly as practicable and (b) patients are not caused unnecessary confusion by being offered an overwhelming range of food choice	Karen Burroughs Gary Etheridge	11th December 2017	There are currently 17 menus available these take in to account dietary and religious needs as well as some cultural preferences based on the population. Meetings with the Trust and Sodexo are held monthly to review menu options.	

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
11	Trust wide & Sodexo	That greater priority is accorded to ensuring that drinking water is within reaching distance of ALL patients, that both BHRUT and Sodexo staff take every opportunity to encourage patients to maintain their hydration and that nursing staff be alert to the possibility that individuals are failing to maintain an adequate level of hydration.	Karen Burroughs, Ward Managers	29 December 2017	Water jugs are topped up by domestic staff through the morning and by hosts through the afternoon. Sodexo staff have been re-briefed Ward staff are monitoring and filling jugs if needed. Reminders to be added and documented as part of morning huddle. Management checks to be carried out on	

healthwatch Havering

APPENDIX 2

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

INTRODUCTION

Healthwatch Havering is the local consumer champion for both health and social care. Their aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally. Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

HEALTHWATCH REPORT DATE

Healthwatch Havering (HWH) undertook an Enter and View of Queen's Hospital In-patient meals on 4th October 2018 and this report was received on 5th November 2018.

BACKGROUND

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

BHRUT RESPONSE TO THE REPORT

The Trust would like to thank Healthwatch Havering for undertaking this visit and for providing us with an opportunity to respond to their final report. The second visit in 2017 showed clear improvement from the initial visit in 2016 and it has been noted that the improvements made in 2017 have been maintained.

The Nutrition Advisory Group will be overseeing the delivery of the action plan.

BHRUT RESPONSE TO HEALTHWATCH HAVERING REPORT

The Trust recognises that the Healthwatch Havering report includes a number of recommendations. An action plan to address these recommendations has been developed and is included as part of this response. It should be noted that the majority of recommendations are actions which the Trust is already aware of and has plans to address. Where possible, the Trust current position is outlined on the action plan for assurance.

The Trust will monitor the action plan and update on a regular basis via internal established processes. A final version of the action plan will be submitted to Healthwatch Havering once all actions are completed.

ACTION LOG FOR MATTERS ARISING FROM HEALTHWATCH ENTER AND VIEW INSPECTIONS

Item No	Ward	Issue	Lead	Target Closure Date	Action	Status
1	Trust wide	Consideration be given to the introduction of illustrated menu cards for the use of patients whose ability to read has been impaired (e.g. stroke patients or those living with dementia) so that they may make easier and better choices of food	Soft Services Contract Managers, QH & KGH	01/02/2019	Estates are in discussion with Sodexo on how to implement pictorial menus across the hospital. Action already included in Interserve contractual patient dining action plan and incorporated in PLACE action plan.	Amber
2	Trust wide	Continue to recruit more volunteers to assist at mealtimes.	Voluntary Services Manager	Ongoing	An ongoing process is in place to recruit ward befriender volunteers (since April 2018 twenty five have been appointed). As part of their role they undertake mealtime support. Staffs also volunteer to assist at mealtimes.	Green

Item No	Ward	Issue	Lead	Target Closure Date	Action	Status
3	Sunrise A Sahara A HASU Ocean B	Consideration be given to using the volunteers to assist in checking fridges on wards for out of date food and ensuring that all patients have access to menu cards.	Voluntary Services Manager Senior Sisters/Charge Nurses	31/01/2019	A formal Trust process to be considered and discussed at the Nutrition Advisory Group.	Amber
4	Sunrise A Sahara A HASU Ocean B	Check charts should be in place for out of date food and clearly marked daily.	Soft Services Contract Managers, QH & KGH	31/01/2019	Director of Nursing to explore at the Trust Nutrition Advisory Group on the process that needs to be implemented.	Amber
5	Sunrise A Sahara A HASU Ocean B	Patients be encouraged to use hand cleaning gel before they are served with food.	Senior Sisters/Charge Nurses Ward Staff	Ongoing	Ward staff actively encourage patients to clean their hands before meals with the hand wipes or gel provided. Adherence of the action will be monitored by the Matrons and Senior Sister/Charge Nurses. The report has been shared with all relevant staff.	Green

Item No	Ward	Issue	Lead	Target Closure Date	Action	Status
`	Sunrise A Sahara A HASU Ocean B	Where possible and practicable, patients be encouraged to sit at a table for meals.	Senior Sisters/Charge Nurses Ward staff	Ongoing	**Ocean B** Patients are actively encouraged to sit out of bed on a daily basis. Staff motivate and encourage all patients to have their meals around table, or in their chair.	Green
					Sahara A and HASU All patients with neurological conditions wherever possible are sat out of bed.	Green
					Sunrise A Patients are actively encouraged to sit out of bed on a daily basis.	Green

In addition to the above clinical areas, consideration will be given to extending the recommendations Trust wide.

Gary Etheridge
Director of Nursing, Safeguarding & Harm Free Care

December 2018

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at @HWHavering

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Queen's Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone: 01708 303300

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at **@HWHavering**

Enter & View

Queen's Hospital, Romford

Rom Valley Way
Romford RM7 0AG

Emergency Department (A&E)

Announced visits: 30 January and 19 September 2018 Unannounced visit: 9 March 2018

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

Queen's Hospital – background

The term "Emergency Department" is used increasingly within the NHS to describe the department previously termed "Accident and Emergency" and, before that, "Casualty Department". The term "Emergency Department" has yet to gain such currency among the general public as "Accident and Emergency" or "A&E", so in this report the term "A&E" will be used to avoid confusion.

Queen's Hospital is one of the largest and busiest hospitals in London, if not in the UK – in consequence of which, its A&E is also among the busiest in London, with an annual footfall in 2017 of 174 thousand patients, of whom nearly 50 thousand were brought in by emergency ambulance, principally by the London Ambulance Service (LAS) but also by the East of England Ambulance Service and various private and voluntary ambulance services. It draws patients not just from Havering and its neighbouring London boroughs of Barking & Dagenham and Redbridge, but from areas of Essex that also neighbour Havering – a population of, broadly, one million.

Across England, hospitals are increasingly coming under what are termed "winter pressures" – a significant rise in attendances at A&E that coincides with the winter months and particularly the Christmas/New Year period. Whilst clearly the adverse weather conditions most likely to be experienced then can affect anyone, but especially the elderly, the rise that has been experienced cannot be explained by weather alone: many other factors affect the position.

Queen's Hospital opened in December 2006. From the beginning, A&E came under pressure, pressure that has increased steadily ever since.

In an attempt to relieve some of that pressure, the public access to A&E was re-designed and rebuilt, opening in early 2018; the re-building resulted in changes to the pre-treatment processing of patients, that evolved during 2018. The system has evolved; patients are now (at the time of publication of this report) seen by a streamer (simple stream) initially who will then stream the patient to Triage (complex stream), Minor Injuries, GP or Majors/Resuscitation. The patient is registered to the appropriate area following this simple streaming process [1].

Queen's Hospital is provided and managed by the Barking, Havering and Redbridge University Hospitals Trust (BHRUT), which also manages King George Hospital (KGH), Goodmayes, where there is a smaller A&E department (now termed an Urgent Care Centre). It remains a long-term (but controversial) ambition of the NHS to close the A&E at KGH and concentrate A&E activity at Queen's Hospital.

Why Enter and View?

Healthwatch Havering carried out an Enter and View (E&V) visit at A&E in June 2016, and colleagues from Healthwatch Redbridge visited in April 2015 as part of a project across North and East London to assess how "friendly" A&E departments were to patients who had hearing impairments.

The visits now reported were carried out in part because Healthwatch wished to review progress since those earlier visits, in part to observe how the winter pressures in 2018 had been addressed, and in part to ascertain what, if any, effect the rebuilding of the access area had had on the department.

Initially, only a single announced visit was planned but, as will be seen from the report, issues emerged which it was judged could better be understood by carrying out a further, unannounced, visit a month or so later. These visits were followed up by a further announced visit in the

[1] This streaming is undertaken by a separate organisation, PELC (a co-operative of GPs). A separate report on streaming will be published following this report.

autumn of 2018.

The team would like to thank all staff and patients who were seen during the visits for their help and co-operation, which is much appreciated.

They enjoyed taking time to understand the new system now in place, and the challenges the staff are facing. With numbers attending increasing all the time (summer 2018 was simply a continuation of the 2017/18 "winter pressures") and with the prospect of considerable population growth in Havering and the surrounding areas, a robust system is needed. The team felt that the third visit was a much more positive experience, were encouraged to see and feel an improving atmosphere and felt that staff were to be congratulated on the way A&E is progressing and moving forward.

It should also be acknowledged that the changes in A&E that began in January 2018 have been constantly developed since then, and the arrangements in the Department have changed markedly since then and continue to change. Many of the points made in the accounts of the visits now reported on have since been addressed or are to be dealt with as part of continuing improvements.

BHRUT's Action Plan following the visits is appended to this report.

Announced visit, 30 January 2018

The Healthwatch team arrived at Reception at 8.30am on a Tuesday morning and were met by a member of the Patient Experience Team, who introduced the Matron (who had been in post for only 7 weeks).

Although the team did not see a security guard on duty in the Urgent Treatment Centre part of A&E during the visit, BHRUT have confirmed that the A&E department has a security guard 24 hours a day, 7 days a week and that the area is routinely covered by security staff who patrol regularly. All public areas had CCTV, and all bays had panic buttons.

The team interviewed the matron and felt she was open, honest and enthusiastic, and a real joy to talk to.

At this first visit, the team were told that, within 15 minutes of arrival, patients were registered and were simply streamed to be seen either by a GP or a triage nurse (complex stream), depending on whether their condition was simple or complex, or if in a serious condition were streamed to Majors/Resuscitation. The terms "simple" and "complex" are set out in Royal College of Emergency Medicine guidelines of February 2017.

If assessed as needing the simple stream, the patient would go on to see a relevant healthcare professional staff; complex cases, requiring blood tests or X rays etc. would return to the waiting room until called.

From time to time streamers would observe the waiting room to see if anyone needed immediate attention.

The team were told that an IT system known as Symphony was used to provide an overview of the patient's journey in real time, tracking patients throughout the A&E department unless the patient was to be seen by a GP, where a separate system called Medway was used to track patients. Neither system was able directly to communicate with the other, or with the Medway IT system, in use in the rest of the hospital. BHRUT has given assurance that its administrative teams are fully trained to help interlink between the two systems.

Patients who had intolerances, dementia, learning disabilities or who were otherwise vulnerable, were flagged to alert all staff to their individual special needs. Vulnerable patients would be sent straight to Majors, and there was a room specifically designed for patients presenting with mental health problems to undergo assessment; staff were supported for this purpose with a security camera. Patients are given comfort rounds whilst waiting for a member of the liaison staff.

There was one room allocated for isolation and gynaecology issues in Majors.

Patients that required treatment and care in Majors and the resuscitation area were assessed for conditions over and above their medical needs (for example, to determine the presence or otherwise of pressure sores) and a management plan would be put in place to reduce risk if required. Once a clinician had determined that a patient was medically-fit for discharge, dependent upon their mobility and social needs, other agencies and teams would assist with a safe discharge e.g. the FOPAL Team (Frail Older People Liaison) and the Community Treatment Team (CTT).

When asked if patients were turned away or signposted to other agencies, the Matron replied, "We don't turn anyone away as we have a duty of care". There was a GP on site and patients were also advised to contact their own GP, to consult a GP through NHS111 or the GP Hub or to see a pharmacist, using the most appropriate services and clinicians to deal with the patient's needs.

4 bedded Male and 4 bedded female observation bays were also available.

Children coming into A&E had to initially register alongside adults but were then signposted to the children's patient waiting area, which is separate from the adult patient waiting area.

On a busy day, 12-18 ambulances could attend within one hour to the department. Patients do not wait in the ambulance but are at times waiting to be transferred from the ambulance trolley bed to an available trolley bed in A&E. Penalties are imposed if an ambulance crew are waiting in A&E for more than an hour to transfer their patient.

Patient experience

The team spoke to a number of patients who were awaiting treatment.

Most patients had been directed correctly from other pathways and were aware of NHS 111, the Polyclinic and the HUB.

The flow of registration and streaming appeared to be going very smoothly and patients were happy with this.

However, patients told the team that they would have preferred more privacy at the point of streaming. Since this visit took place, changes have been made to the streaming pods to address this point.

Patients had been waiting around 30 minutes at most for blood tests after streaming and were content to do so; they were also aware of what tests they were waiting for.

Generally, all patients spoken to during this visit were happy with the service.

Unannounced visit, 13 March 2018

This visit was intended to observe A&E at a different time to the first, to ascertain how different it might be. After mid-day, the number of people coming through the doors increases as the day wears on. At the time of this visit, there were up to 70 people in the room, with many more patients waiting for treatment – for example, the associated Urgent Care Centre was almost full, with patients likely to experience a long wait before being seen.

The team arrived at about 3.30pm. On their arrival at the internal door to the area, it was immediately apparent that people arriving were confused by directions given to continue on to Ambulatory Care, Children's A&E, Majors etc. There was a long walk to those areas and, seemingly, no one was on hand to guide people to them. While carrying out an initial discussion, the team observed the "comings and goings". They remarked to staff that wheelchairs for patients' use would be useful, volunteers/staff to help people find their way about, and porters ought to be available to take patients in wheelchairs where they needed to go. Again, there did not appear to be security guard on duty in case of disruption (although, as already noted, BHRUT has given assurance that one is on duty at all times and undertakes regular patrols).

A lack of staff behind the Reception Desk was noticeable. The number of staff registering patients varied between one and two; a third person sitting typing at a desk in the background did not move to support the front of house staff (on the previous visit, there had been three Receptionists at all times). The atmosphere was quite calm, but a disabled patient with learning disabilities, who was also diabetic, was shouting out asking for food and drink – no staff went to their assistance while the team were observing.

BHRUT has commented that the third person referred to above may have been engaged on duties precluding their offering assistance to colleagues.

Interaction with patients

Although staff regularly and frequently carried out observations to see if any very ill people needed to be fast-tracked through the system, patients in the waiting room were not necessarily aware of that and some felt left to their own devices for long periods of time. During this visit, as soon as the public realised they could approach the team, they were spoken to on numerous occasions asking for help and advice. The following three cases exemplify what was seen:

- At one point, the team were approached by a lady whose husband had four weeks previously suffered a stroke. She was desperate for some help for him; he was very agitated and obviously very unwell, and his wife was concerned that he was about to pass out – while the team were with him, the colour drained from his face. The team told his wife to speak to the desk staff, to no avail. A member of the team then also spoke to the desk staff.

  Staff reacted inappropriately, behaviour that was observed for the rest of the time they were there. There appeared to be no procedure in place for dealing urgently with patients whose condition was deteriorating. It took 8 minutes for staff to respond

to the team's calls for help, and even then, the man was required to walk to receive attention rather than being placed in a wheelchair or on a trolley.

This event did raise the question of what sort of training had been given to desk staff.

- Another couple who spoke to the team had been waiting since 10am, having been sent by their GP as the wife had presented to him three times with the same problem and he could no longer help her. They had been waiting over six hours and eventually found out they had been missed out on the system during triage etc. and were dismayed at having a nurse say to them "you should not even be here" and then being told to register anew and start the whole process over again!
- A third family told the team that they had "waited 45 mins to be triaged", then had a further wait of two and a half hours for an ECG; they had then been waiting for almost another hour to see a doctor for the results.

The team asked a few patients how the new arrangements in A&E compared with the old, but none was able to give an answer to that.

In response to these points, BHRUT has expressed disappointment that patients were unhappy with their experience. It has stated:

> "Patients are always prioritised by their medical need and they are managed accordingly. This can result in longer waits for those with minor conditions. The sickest patients are prioritised, but unfortunately at times with high volumes of patients attending the Emergency Department, streaming can go over time.
>
> "The receptionists are not medically trained therefore they would alert the streamer or nursing staff if a patient required more urgent assistance. All staff are briefed regularly and processes are reiterated to them."

Conclusion

It was not the purpose of the visits or this subsequent report to be critical of A&E staff who clearly carry out difficult tasks under great pressure. At the time of the first two visits, there were insufficient staff because of recruitment issues but an ever-increasing patient-load.

It cannot be over-emphasised that staff were doing an excellent job despite the pressures they were faced with.

But it was obvious from only the cursory experience of these visits that there remained organisational issues, not least when a revamp of the Department to improve patient-flow had (at least on the evidence of the visits) not met expectations.

It seemed to the team that carried out the visits that a number of possible improvements could usefully be introduced:

1. A fast track arrangement at entry for emergency registrations
2. Registration of children separately from adults
3. Provision of a TV set in the children's waiting area to distract them while waiting for attention
4. Staff be briefed and kept up to date with directions to other departments and useful locations within the hospital so that they can guide patients with confidence
5. Provision of more wheelchairs to assist patients who have limited mobility, whether the result of a pre-existing condition or of their present injury/illness
6. That staff carrying out streaming be more conscious of patients' privacy
7. That better ways of calling patients be explored, perhaps by installing an electronic calling/pager system
8. Provision of improved signage, to avoid confusing and

disorienting patients and other visitors

It was also clear to the team that the inability of the IT systems, Symphony, Medway and Adastra, to communicate with each other was a potential disadvantage to patients. Processes were in place to ensure that patients were not adversely affected by this, but it was not ideal. This clearly could not be resolved simply or, probably, at moderate expense – but it was also clear that patients could be disadvantaged, not least because of the possibility (however remote) of vital information being missed, or misinterpreted, during the process of updating one system manually with information from the other. While Healthwatch was not in a position to make specific recommendations in that respect, efforts to find a way forward that avoided unnecessary duplication would be welcomed.

Discussion with BHRUT

Following these two visits, the conclusion was discussed at length with A&E and other BHRUT staff. BHRUT had clearly recognised that the new arrangements in A&E were not working optimally and that the changes that had been introduced needed to be refined in the light of experience. Healthwatch therefore agreed that, rather than publish the report of the two visits while changes were being made, it would be better to postpone doing so until change had been effected and then carry out a third visit with the intention of comparing the then current position with the previous experiences.

On the question of staffing, BHRUT have advised that vacancies in A&E have reduced from the time of the first visit, when there were 50 whole time equivalent (WTE) band 5 vacancies, to 34 WTE band 5 vacancies. At the time of the first visit there were 16 WTE Band 2 vacancies; that is now 2 WTE band 2 vacancies. And active efforts continue to recruit to vacancies.

Announced visit, 19 September 2018

Introduction

This visit followed up the challenges faced by A&E identified during and following the two prior visits.

The team were met by the Deputy Matron, who was pleased to have the chance to talk, to share her knowledge, and to show them around. She explained the process of triaging patients, and that the streamers' target for completion of streaming before registration was within 15 minutes of a patient's arrival. Patients were given cards and sent to the area appropriate to their treatment needs: waiting times depended on the degree of a patient's need, in some cases of perhaps two hours and others up to the guideline limit of four hours. Patients who needed little more than reassurance would be referred back to their own GPs at this stage.

The team were told that various systems had now been put in place in the new area/room accommodating A&E, to promote the flow of patients through the system. As with all A&E Departments, people turned up with all manner of different complaints and injuries resulting in a number of different areas being needed within A&E into which to channel patients. This involves Rapid Assessment & First Treatment (RAFT) which most arriving ambulances book into, Majors, Majors lite, Ambulatory Care, the Urgent Treatment Centre (UTC), a GP Unit, Resuscitation (Resus) for very seriously ill people, and the Children's A&E Unit.

During the previous visits, the team had been very concerned about the triaging system that was then in place and one reason for this third visit was to see what actions had been taken to improve the triage system and area from the patients' point of view and how much safer were the newer arrangements.

The team were pleased to learn that the discussions with BHRUT and suggestions of triaging patients before registration, as well as internal review by BHRUT itself, had led to significant changes.

The team felt that the new approach provided a safer method of initial assessment, that was less likely to result the more seriously ill patients (who would inevitably be less vocal than those who were not so ill) being missed out – but did not avoid that possibility altogether. They felt assured that the new stand-up queuing system was constantly being checked to see if anyone waiting to be streamed to the correct service by a simple triage assessment was in a deteriorating condition and needed priority attention.

A&E streaming was run by PELC (Partnership of East London Cooperatives), which had originally run the local NHS111 system (which had now been taken over by the LAS (London Ambulance Service)). BHRUT's A&E staff worked together with PELC, as commissioned by the CCG, to deliver the whole of the A&E service [2].

Patients' initial contact on arriving at A&E was with "streamers" working in individual cubicles known as "pods". These pods provided a degree of privacy for patients.

The streaming process

The team noted that the streamers tended to call 'next please', when they were supposed to walk to the queue and approach patients (who, in an attempt at more privacy, were now a reasonable distance from the pods). Having the streamers go out and visually scan the queuing patients was an important part of the safety system, especially in order to identify seriously ill patients who might not be vocal enough to alert staff to their condition themselves. It was also noticeable that the security guard was sitting down in one of the patient seats at the entrance to A&E, when he should have been walking around. For patients over 75, the Frail & Older Persons Assessment and Liaison team (FOPAL) may be involved after streaming, with some patients being given access to Team 3 of the Outpatients' Department at a later

[2] **Note**: the authorisation for this Enter & View visit did not extend to the area run by PELC so a separate visit has been undertaken and will be reported on after this report

date. They are assessed and given a nationally recognised frailty score. Care plans and body mapping were undertaken as a matter of course on vulnerable patients, and all pressure sores were documented in patient records but for those assessed at level 2 and above a formal report would be completed. Unfortunately, some walk in patients arrived with pressure sores, of which staff were not always made aware as walk in patients were not routinely checked for pressure sores.

The team were told that there were no plans to register children separately; but, once registered, they were referred to Children's A&E, which is run by BHRUT, where there was a TV available.

The queuing system for patients on arrival was now behind a barrier at the back of the A&E reception room, which means the two TVs on the wall by the reception desk are now visible within the whole area. The timings of messages etc., on the screen had been increased and so everything was more readable and information more accessible. The drinking water fountain had to stay where it was because of plumbing difficulties. It was noted the 'Hearing Loop' sign had not been enlarged or moved to be more easily seen.

Some of the team's questions needed to be verified by the PELC Team, hence the subsequent visit there. As with all systems, it took time for change to bed in. This present triage system had now been in place since 1 September. From the very short time that the team observed triage in operation, they felt it was much calmer, and gave confidence that everything was much improved.

It was, however, noted that the logging in and out time of patients in A&E did not comply with national guidelines. The registering of patients on the Medway system flags up arrival times. At King George Hospital (also run by BHRUT) there was a ticket machine for patients to record their arrival.

BHRUT have subsequently commented that clinically it is more beneficial to stream patients first before they are registered.

However, the time of streaming is logged and this time is booked onto either Symphony or Adastra and therefore the national guidelines are being adhered to. A ticket machine similar to the one at KGH which logs arrival times is being procured.

Referral elsewhere for treatment

Not all cases presenting at A&E and accepted for treatment were dealt with at Queen's Hospital. Injuries and eye problems that needed to be dealt with by other hospitals were assessed, and then either sent to the appropriate hospital by patient transport services (available throughout the day, every day) or appointments were made for the patient to be seen there within the next day or two. Hospitals referred to in this way included Broomfield at Chelmsford (for limb nerve injuries or plastic surgery) or Moorfields Eye, or one of the major London Hospitals. The Queen's Outpatient A&E Eye Unit, located elsewhere in Team 2, was only open from 8am-4pm Monday to Friday.

Accommodation and facilities

Food was not available in the waiting area, but there are commercial food outlets available in the main Atrium entrance of the hospital. A&E staff were able to order food from the kitchens if needed urgently, and tea/biscuits were regularly offered in the BHRUT-run parts of A&E. It was also pointed out to the team that people who had eaten recently could not always be assessed/treated optimally.

The team were assured that staff were well informed about directions to the various departments within the hospital, including the "Hot Clinics" (surgery and ENT) but there was no signage to them. The team felt that patients would find colour-coded, easy-to-follow guide lines, on floors or walls, indicating the directions to specific areas helpful.

Majors had 26 beds, with 1 infection control room, and a psychiatric room available. There were 8 beds in Resus and 9 beds and 2 infection

control beds in Children's A&E. Staff were well aware of the lack of space in all areas, and that re-designing the area including RAFTing and the Children's A&E was desperately needed. The team noted that the financial position facing BHRUT meant that major alterations were unlikely but were told that a bid had been made on central funds for this work. The team felt the staff were trying exceptionally hard, and under great pressure to keep the service on an even keel. As previously noted in other reports, staff retention has been a difficult area and lots of ideas were being tried out in an effort to improve retention, along with a refreshed recruitment drive for nurses.

The lack of space was a particular problem when it came to moving trolleys, wheelchairs etc. through A&E. One trolley was kept in the UTC, although it was unclear what would happen if this trolley was in use; lack of trolleys or wheelchairs was also a major issue. The distance from the new A&E area to the areas within the old A&E, where the units still were, was another problem for sick patients to cope with. The team felt that this was far from ideal and hoped that when the re-design of A&E finally happened, it would lead to improvements.

The Team were also told that patients, or their carers, departing after treatment, often left wheelchairs in the car park areas and no one appeared to be responsible for retrieving and returning them to the main hospital building. This inevitably led to an unnecessary shortage of wheelchairs for patients in need of them. BHRUT have observed that arrangements are in place for wheelchairs to be "rounded up" regularly.

The team felt that signage, or lack of it, was an issue that need to be addressed. They were told that internal signage was being looked at, and some funding might be available. The external signage was another problem, with a lot of ideas needing to be thought about. For example, many patients who needed A&E and who had come out of the car park had no idea where to go and ended up in the main Atrium. The access road from Oldchurch Road going past A&E was reserved for

use only by emergency vehicles and buses, so the only vehicular access for patients arriving by car or taxi was through the main entrance in Rom Valley Way, where signage was needed. There was also no signage directing patients in cars to the drop off point (past the old entrance). The team felt the small notices at the ring road entrance were not sufficiently clear, and the lack of direction once past them was very poor.

BHRUT has subsequently advised that, following review, new internal signage has been ordered; external signage is under review.

Privacy in all areas of A&E was a well-known problem throughout the country. It seems that staff are well aware of this, but lack of space does not permit a very good response; curtains between beds particularly allow very little privacy.

Communication

Looking at the System as a whole, the need for a loud-speaker system for calling patients was apparent (with some form of pager for those patients who were hard of hearing). Such a system would help both staff and patients. For staff to call patients for attention in the current way is unacceptable. It was also felt a process chart should be displayed, to help with directions and so that patients can see the various services that may be directed to.

Multiple IT Systems (Symphony, Medway and Adastra (used by PELC)) were in use but did not readily communicate with one another. The team felt that this lack of inter-communicability could be detrimental to patients, with vital information being missed or duplicated unnecessarily, possibly leading to errors with potentially devasting effects. This needed to be addressed for safety reasons and the team felt that this needed to be addressed as a matter of urgency.

BHRUT has subsequently confirmed that a loud=speaker system is to be installed.

It was noted that relatives of patients could ask the reception staff in A&E for the whereabouts of their loved ones, which is available on the Symphony system but not the others.

Recommendations:

1 That, when eventually the re-design of A&E areas takes place (which it is accepted will be a massive task) opportunity be given for staff, patients and members of the public to be involved in all stages of planning.

2 That further consideration be given to means whereby streamers can identify seriously-ill patients at an early stage in order to avoid delay in their receiving attention.

3 That the need for all IT Systems to be compatible with one another, so as to avoid mistakes etc., be addressed as a matter of urgency.

4 That both internal and external signage be improved, again as a matter of urgency; and the possibility of providing "guiding lines" on floors or walls to provide easy-to-follow, colour-coded directions to specific areas.

5 That the arrangements for the availability and storage until required of trolleys and wheelchairs be reviewed to ensure that so far as possible, a sufficient supply is available to meet patients' needs.

Disclaimer

This report relates to the visits on 30 January, 9 March and 19 September 2018 and is representative only of those patients and staff who participated. It does not seek to be representative of all service users and/or staff.

APPENDIX

BHRUT: QUEEN'S HOSPITAL EMERGENCY DEPARTMENT (A&E)

ACTION PLAN

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
1	ED	That, when eventually the re-design of A&E areas takes place, opportunity is given for staff, patients and members of the public to be involved in all stages of planning.	ED Service Manager	April 2019	There is a Patient Partner involved in the meetings for the new rafting area.	
2	ED	That the need for all IT Systems to be compatible with one another, so as to avoid mistakes etc, be addressed as a matter of urgency.	ED Service Manager	September 2018	Process changed with streamer. Admin staff are trained to interlink between the systems, to help improve the flow of patients.	
3	ED	That both internal and external signage be improved, again as a matter of urgency.	ED Service Manager Estates management	March 2019	Internal signage has been reviewed and improved signage is on order. Estates are reviewing the external signage, some of which are not covered BHRUT.	

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
4	ED	That arrangements for the availability and storage until required of wheelchairs be addressed, including arrangements for the prompt retrieval of wheelchairs left by users in areas away from the main buildings and their return to a central point from which they can be collected when needed by incoming patients	ED Service Manager Estates management	March 2019	Sodexo carry out three sweeps throughout the car park daily. ED alongside Maternity and Oncology do their own separate sweeps. Estates will be auditing this for compliance. However, this is not an action that can be completed without support from those who use the wheelchairs in returning them.	
5	ED	A fast track arrangement at entry for emergency registrations	ED Service Manager	September 2018	The process of streaming allows patients to be prioritised and emergency registrations	
6	ED	Registration of children separately from adults	ED Service Manager	15th January 2019	Any child that goes through to children's ED will be registered in children's ED. Any child that needs GP will be registered in reception.	
7	ED	Staff be briefed and kept up to date with directions to other departments and useful locations within the hospital so they can guide patients with confidence	ED Service Manager	October 2018	There are daily briefings currently in place.	
8	ED – PELC	That staff carrying out streaming be more conscious of patient's privacy	ED Service Manager	September 2018	The streaming pods have been moved to improve privacy	

Item No.	Area	Recommendation	Lead	Target closure date	Action	Status
9	ED	That better ways of calling patients be explored, perhaps by installing an electronic calling system	ED Service Manager	April 2019	As part of Rafting there will be a tannoy system in place, due March 2019	
10	ED - PELC	Enlarge/move the 'hearing loop' sign at the registration desk.	Estates management	January 2019	To move the 'hearing loop' sign so it is more visible to visitors. Completed 04.01.19	

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at @HWHavering

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Queen's Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone: 01708 303300

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at **@HWHavering**

This page is intentionally left blank