Healthwatch LLR Quarterly Meeting with CEO UHL NHS Trust

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Healthwatch have compiled the following questions informed through engagement events, information & advice service including drop-in clinics and other sources; news, journals, reports. The themes are grouped by 'Caring at its Best' standards which outline the essentials of care for patients in UHL Hospitals the services that all patients should receive in every department /area from all members of staff working together.

Theme: Emotional Wellbeing | Documentation

Question 1	a) What risk assessments are made when monitoring a patient's health and wellbeing when being assessed for Crisis intervention? b) How does this influence conditions and preparation for discharge?
UHL Response	All patients presenting a mental health crisis will either be triaged by the Urgent Care Centre (UCC) or ED Nursing Teams within the assessment bay upon arrival. Assessment of risk is made on initial assessment and at regular intervals throughout a patient's stay in the department when observations and other care are provided. The responsibility for full mental health crisis assessment within the Mental Health Teams is provided on a daily basis on site by LPT. Discussions regarding Mental Health Wellbeing readiness for discharge and follow-up will be made by the Mental Health team providing that assessment within UHL. We are working with the Leicestershire Partnership Trust as a matter of urgency to make sure that across the health and social care system we have the right level of resource to respond to patients in crisis. A jointly owned and agreed CQC MH crisis Action Plan is also being implemented and the impact monitored on the aspects of this plan in UHL's gift to manage. Concerns over mental health provision are also under active discussion at the Urgent Care Board.

Background: Patient reports poor risk assessments undertaken to decide if the patient who has been admitted to A+E for an overdose should be referred for acute inpatient services. *"I was kept waiting in EDU all night following overdose, left in the assessment room for 2 hours whilst on-duty psychiatrist contacted the Crisis Team. I was finally given a bed at 5,30am. Following 2 hours sleep at the most I was seen again was by another team member who was impatient and lacked empathy. They told me I would be seen by the Crisis Team at home in the afternoon but that I would not be admitted as I did not fulfill the criteria and that I would be discharged by the Crisis Team for 'failure to engage with treatment'. I was then discharged being told to call my husband to pick me up. In a lot of distress and being delirious due to poor mental state, lack of sleep and food and with no money - I left the hospital. I got lost and walked home from the LRI to Loughborough. In the mean time, my husband contacted the hospital to be told I had been discharged but staff unable to say how I was getting home, consequently I was added to the missing persons list until i returned home mid afternoon."*

Source: HWL Outreach and engagement

Theme: Privacy and Dignity | Caring for Patients Emotional Well-being

Question 2	Could we have an update on the Younger Disabled Unit at Leicester General Hospital? We would be grateful for a progress report addressing: - 1. **Immediate -** The dismal and unsafe conditions in the current unit we found in June 2014. 2. **Intermediate** - Progress with creating a unit in Ward 2 of LGH until the permanent replacement is ready . 3. **Longer term -** progress with developing a new and purpose built unit as part of the redevelopment of LGH as part of Better Care Together.
UHL Response	Remedial works have been undertaken to remedy immediate concerns raised by the CQC and Healthwatch in early 2014. In November / December 2014 we commissioned a full condition survey on the unit. The survey revealed that the cost of addressing structural and infrastructural repair (particularly to the roof, electrics and flooring) would exceed £1.3 Million + VAT & fees. We are also awaiting confirmation of the drainage condition which has substantial tree route ingress and is likely to raise this initial figure. Based on these findings and in the context of the longer term configuration of services at the LGH a feasibility study and option appraisal, chaired by

	the Director of Facilities, is currently being undertaken. The option appraisal will be discussed this week (w/c 09/02/15) at CMG Board and will also be raised at the Clinical Directors' meeting on Tuesday. The appraisal will take in to account the needs of YDU patients and the importance of adjacencies with therapy and hydrotherapy facilities. Although there has been some question over the relocation of YDU to Ward 2 in light of the Trust's longer term strategy, the option appraisal will still focus (for the intermediate period) on an LGH solution for YDU this year. Ward 2 is still being considered as one of several options. However, given the long term strategy for the Leicester Diabetes Centre of excellence it is not the preferred option. Among the intermediate options under consideration is the possibility of refurbishing Ward 1 at the LGH for YDU. This would see Day Case moving to an alternative space. One advantage of this move is access to the area of pleasant space between wards 1 and 3. Through the option appraisal process the service will define what it requires (e.g. ground floor, LGH, close to hydrotherapy) and work with the Estates team to find an optimum solution. For the longer term, early discussions have taken place which began to explore the feasibility of a partnership with a military rehabilitation facility in Stamford Hall, Loughborough. Such a facility could be world class and may be something we would partner with other Trusts to create. The potential for this should become clearer over the next year. As with the intermediate solution, this will be one of a number of options considered.

Background: *Informal Visit by Healthwatch Rutland and Leicestershire to the Younger Disabled Unit Wakerley Lodge – University of Leicester - Hospitals - Leicester General Hospital Site*

Source: *(original report as separate attachment)* by HWLC and HWR

Theme: Communication

Question 3	a) Which department should patients be refereed to in UHL for GP blood tests? b) Should special referrals be made by GPs for those who require butterfly needles for blood taking due to existing health conditions? c) What process is used for requesting tests on blood samples?

UHL Response	Clinical Commissioning Groups do not currently commission a 'GP direct access' phlebotomy service from UHL. Historically however, some GPs (overwhelmingly those in the city) have sent their patients in to UHL. Rather than cause further inconvenience to the patient, the UHL phlebotomy service has bled these patients. Volumes of GP-referred patients have now risen to a material level such that this service cannot continue unfunded, consequently this has been raised by UHL as a 'counting / coding change' as part of the acute contract negotiations. Discussions are currently in process between Cogs and UHL as to whether the service will be commissioned for the 2015/16 financial year. If the service is commissioned, then GPs will be able to refer some (possibly not all) patients in to UHL. If the service is not commissioned then the expectation will be that GP patients will receive a service outside of UHL, to be determined locally by each practice. If the service is commissioned then any specific requirements for "difficult to bleed" patients will be addressed and standardised across UHL.

Background: A patient reported being refereed from her GP to the LRI for 'GP bloods' but when she arrived for her appointment she was told that she would have to go the Glenfield hospital, as this was the wrong department and they could not perform butterfly needle for blood taking. Glenfield reported that they would take the patients blood on this occasion but that it was also not the appropriate department. The patient's bloods were eventually taken successfully but they were later informed that all the necessary tests (e.g. Lipid profile tests, including HDL) had not been completed due to a fault in the computer registration. This caused distress to the patient, as they had made dietary changes prior to the blood sample being taken and their illness restricts the use of needles.

Source: HWL Information and Advice Service

Theme: Communication

Question 4	a) What is the process for receiving results from the Thyroid Register? b) Is there a process and timescale for when patients will receive their results? c) If the GP has the results can these be shared with the patient?

UHL Response	The Thyroid Register was established about 20 years ago as a joint initiative by the Department of Chemical Pathology and the Department of Clinical Endocrinology, and it is run by the Department of Chemical Pathology. In total, over 9000 patients have been registered over the years of whom approximately 1200 have since died and approximately 2000 have been made inactive for various reasons (eg. moved from area, transferred to Endocrine Clinic, monitoring taken over by Primary Care etc.) The Thyroid Register allows for long term monitoring of patients on thyroid hormone replacements (ie. hypothyroid patients) without a need for them to attend their GP Surgeries or hospital out-patient departments. These patients have regular blood tests, usually annually, but occasionally more frequently if their results remain abnormal or there is a clinical indication. Once the patient has been contacted and has had a blood test (please see an attached two page copy of the request form), the results are directed to both the Thyroid Register and electronically to the patient's GP Surgery. When results are within normal range, a standard letter is sent by the Thyroid Register Co-ordinator to both the patient and their GP informing them of the results and that the patient should continue on their current thyroid hormone replacement dose, and the dose and date of next blood test will be stated in the letter. However, if results are abnormal, they are reviewed by a member of the senior laboratory medical team (Registrar or Consultant) and a standard letter is again sent to both the patient and their GP with treatment recommendations. From time to time, additional non-standard letters are sent to the GP with a copy of the patient, advising of management recommendations. All prescriptions for Levothyroxine are provided in Primary Care and occasionally GPs may request additional repeat tests in the interim period or change treatment as clinically justified. Therefore, the management of patients on the Thyroid Register still remains a Shared Care arrangement as GPs can adjust doses when they consider it appropriate and the Thyroid Register is usually informed of such changes. This is important as GPs have the opportunity to review their patients at the Surgery (when necessary) and take the full clinical picture into account when making their recommendations. However, patients may also contact or leave a message for the Thyroid Register on the dedicated telephone/answerphone (0116 2585202). Additionally, a member of the Thyroid Register team can also contact patients directly by letter or telephone in situations where poor compliance is thought to be an issue. However, quite frequently compliance is not an issue but often the patient has been started on calcium, iron or other medication which may lead to reduced Levothyroxine absorption from the intestines and thus lead to persistent abnormal thyroid results. In such cases the appropriate clinical advice may then be provided over the telephone. The results of our last Thyroid Register patient survey were as follows: **Thyroid Register Patient Survey** Returns received by 01/07/2013

Questions	Strongly agree	agree	disagree	Strongly disagree
I am satisfied with the quality of service provided by the Thyroid Register	60.6%	38.0%	1.4%	0.0%
Communication between myself and the Thyroid Register has been satisfactory	60.6%	38.0%	1.4%	0.0%
I wish to continue receiving support from the Thyroid Register	98.6%	0.0%	0.0%	1.4%

What is the process for receiving results from the Thyroid Register?

When the patient receives the blood test request form through the post, they may have the blood test at either their GP Surgery or at the sites detailed on the attached copy of the request form, and the results should usually be available within 24 to 48 working hours. The results are directed to the Thyroid Register and electronically to the patient's GP Surgery. Once the results are available and where necessary have been reviewed by the laboratory senior medical staff, a standard letter is sent to the GP and the patient usually within 7 working days.

Is there a process and timescale for when patients will receive their results?

As already stated above the results are sent to both the Thyroid Register and electronically to the GP Surgery and a letter is sent usually within 7 working days with the treatment recommendations. However, there may be some delays due to annual leave, bank holidays or sickness but this should not lead to any clinical risk as the majority of patients on the Thyroid Register are usually stable and are monitored annually. Occasionally, telephone calls to patients from the Thyroid Register team may be necessary and additional non-standard letters may be sent to patients and their GPs to aid management.

I do appreciate that the communication between the patient and the Thyroid Register should be robust and with minimal delay. Regrettably, I do not have this patient's details to allow me to further investigate this case. However, it appears that the length of delay in communicating results in this case was unacceptable.

If the GP has the results can these be shared with the patient?

As stated above, the GP Surgery also receives the thyroid function tests results at the same time as the Thyroid Register. GPs may alter Levothyroxine doses when clinically justified, and we are often informed of such changes. Furthermore, the Surgery or patient can

	contact the Thyroid Register directly whenever necessary for clarification or further information. Therefore, it would have been most appropriate if the Surgery had provided her with the results or asked her to contact the Thyroid Register directly on our dedicated line, which all patients are provided with when their names are added to the Register.

Background: A patient has diabetes and an underactive thyroid. She monitors her blood levels so that she can manage her illnesses. She visited *The Leicestershire* Thyroid Register at Leicester Royal Infirmary for a blood test on 27 November.

That was 8 weeks ago and she has not heard anything since. She visited her GP Practice and they had received the results (2-3 days after the test) but the receptionists told her that they could not release the results until they had been checked by the lead registrar (who they believe was on holiday over Christmas).

The GP Practice has said that because they did not instigate the test they cannot give the results until a letter is sent from the Thyroid Register. The patient has been told that 'no action' has been written on the results but she wants to know what the results are. For over 15 years, the patient has had the results regularly and has been able to manage her conditions and wants to be able to verify the results against her diabetes readings.

The patient felt that patients with multiple conditions need to know as a change in medication can have an adverse reading on other tests.

Source: HWL Outreach and Engagement

Theme: Communication

Question 5	When requesting hospital records, what can a patient expect to receive in terms of X-rays records?
UHL Response	UHL no longer have the facility to create films, x-ray at UHL is now digital, this means that any copy has to be created on a CD. We are sorry to hear the copy received is not satisfactory. It is not usual for a black box to obscure the x-ray, we would be happy to investigate if the patient would like to contact the department.

Background: A patient informed us that they have requested their full hospital records on two occasions, paying the fee of £50 each time. They requested specifically to see the x-rays records and have been sent a CD disc with the images

recorded. Patient said the images had been distorted due to a black box across most of the x-ray image. Patient would like to know why UHL can not have the film hard copy sent to her.

Source: HWL Information and Advice Service

Theme: Communication

Question 6	a) What is the current waiting time for the Restorative services for Endodontic treatment at the Glenfield Hospital? b) What are patients and dentists being told in reply to their referral? c) What are patients being informed regarding the status of endodontic services?
UHL Response	The department currently have 32 patients who are being treated beyond 18 weeks with the longest wait for treatment standing at 49 weeks. The overall waiting time is slowly reducing due to the appointment of a locum consultant who started in September 2014 and the establishment of additional clinics to start treatments. Endodontic work is an element of the overall waiting list and the service closed to endodontic referrals at the beginning of last year due to a lack of capacity to treat the patients within a timely manner. Our commissioners and the Local Dental Committee (LDC) are fully aware of the decision taken by the service. The service has developed a business case requesting a third restorative consultant to accommodate the endodontic activity once the service opens again. This business case has been approved by the Trust's revenue and investment committee so long as the commissioners approve the case. A meeting is being scheduled for mid-February. Some discussions have already taken place with the commissioners and the business case has been shared with them ahead of this meeting. The service will accept endodontic referrals once again to a revised referral criteria which has been approved by the LDC. A standard letter has been drafted which is sent to the General Dental Practitioner which states Unfortunately, as from January 01st 2014 and until further notice, the orthodontic & restorative dentistry department at Glenfield hospital is no longer able to provide root canal treatment for any referred patients. Please accept our apologies for any inconvenience this may cause. Additionally written advice is provided to practitioners where appropriate. All endodontic referral letters are reviewed by the clinicians and those who are deemed to have an immediate requirement to be seen are accepted and offered an appointment.

Background: A patient has been been referred to endodontic services at the Glenfield Hospital for a dental procedure. They have had their referral declined on three separate occasions although the dentist says it is medically necessary. In the letters received from Glenfield by the patient they are being told that Glenfied no longer provided this service. This means the patient is not on a waiting list and has not been referred to alternative options which it appears there are none.

This has been discussed with the NHS Local Area team (September 2015) who says the Restorative services is suffering from a year long waiting list but that they have introduced a new consultant to help with these referrals. They also said that more urgent cases are being fast tracked but patients should not be informed that the service is closed or no longer provided.

Source: HWLC Information and Advice Service

Theme: Documentation

Question 7	a) Do you have any statistics regarding the number of hearing aids prescribed by UHL each year? b) Do you know how this compares with National figures for prescribed hearing aids from other hospital NHS Trusts?
UHL Response	a) 2013/2014 number of hearing aids prescribed 6825 b) No… we feel it is non-comparable, we prescribe where clinically appropriate.

Background: A patient told HWL that he had made a FOI request with UHL regarding statistics of hearing aid prescription; patient said the request was formally acknowledged but has never received the information he asked for.

Source: HWL Outreach and Engagement

Theme: Privacy and Dignity | Caring for Patients Emotional Well-being

Question 8	Healthwatch would like to better understand what is the position regarding the new temporary wards in light of the difficulties with beds and patient throughput? What impact does staffing levels have on this?
UHL Response	We have closed ward 2 so that staff can be transferred to one of the wards. The other ward is transferred from Fielding Johnson so is a change in location rather than an additional ward. The same measure such as FFT, surveys, ward dashboard and ward review tools are

	applied to these wards to monitor them in the same way as all other wards across UHL. We have undertaken a nursing acuity review which will be presented at ET imminently to highlight any staffing under or over establishment areas. These wards are under constant review from the HoN and Corporate Nursing.

Background: Healthwatch Leicestershire Board discussion

Source: HWL

HWL – Healthwatch Leicestershire

HWLC – Healthwatch Leicester City

HWR – Healthwatch Rutland