Healthwatch Leicestershire Quarterly Meeting with Chief Executive of University Hospitals of Leicester

Patient Questions Submission

2nd December 2015

Theme: Communication

Question 1	Why was the Balmoral Reception desk closed without a temporary replacement when renovation work commenced on Friday 9th October 2015?
Background	At the Leicester Royal Infirmary the main pedestrian entrance is via the Balmoral Building, upon entering the building a person is faced by Balmoral Reception. Reception staff provide: • Directions to clinics for those who have not brought letters with them they identify clinics and provide directions • Identify wards relatives/friends are on, • Provide directions to urgent care or give directions to find relatives who have been brought in by ambulance, • Help in arranging taxis, • Take receipt of medical items delivered by taxi from other hospitals and provide assistance to commercial delivery drivers. This reception provides a very important function in assisting those who attend the LRI. Healthwatch member has written in as they observed people walk in and stare in bewilderment at plastic sheeting where the reception had been. It was left to volunteers to provide what assistance they could and it took a member of Volunteer Services to telephone the Duty Manager before a temporary replacement reception was set up in the early afternoon.
Response	**It was always intended to have a temporary desk in the reception whilst the main desk was being replaced. Clearly something went wrong in the co-ordination of these two events a situation which was quickly rectified but it is regretful that it occurred.**

Theme: Privacy and Dignity

Question 2	What is the agreed procedure for camera observations? Do dialysis patients always require camera observation when receiving treatment at Loughborough Hospital?
Background	Patient called the HWL information and advice service quite distressed due to

	being regularly observed by camera during her 4 hour dialysis treatment, during which she heard nursing staff make uncomplimentary comments on her personal appearance and behaviour. The Patient explains that she goes to Loughborough hospital regularly and has been a long-term patient and it has been previously been agreed that camera observation was no longer necessary and that she can call for assistance when required. However the patient still is aware of staff sitting in the observation room to monitor. The patient has discussed her concerns to nursing staff but it continues to be an issue at her appointments. The patient would like clarification regarding the agreed procedure for camera observation and how they assess what is required? Patient has contacted PALS with support from a letter from her GP.
Response	**The CCTV system has been in place since the Loughborough Renal Unit opened in April 2002 as part of our commitment to safe care. The use of CCTV in the side rooms and waiting area is essential to patient safety as, due to the design of the side rooms, it is difficult to observe patients in these areas. We made a decision earlier this year, following advice from UHL Privacy Team and with the support of the UHL safeguarding team, to continue with the use of CCTV and have ensured that there are notices advising patients that CCTV is in use and the reasons why along with the details of who they should contact if they have any queries or concerns regarding this. These notices are clearly placed on both side room doors and within our waiting area. If a patient does have concerns and requests not to have CCTV we will offer alternative safe dialysis settings (e.g. non side room area) The CCTV is only in operation during the dialysis session as the unit is an outpatient facility. The CCTV system does not record and is in real time only. There is no auditory setting and is a visual safety aid only.** **We are in the process of developing a capital bid to alter one of our side rooms into a high visibility isolation area, which in turn will reduce our requirement for CCTV in that area.**

Theme: Documentation

Question 3	What is the timeline for patients to receive a letter setting out details discussed following a consultation with a Doctor or Consultant? Are the notes from the Multi Disciplinary Team (MDT) written up and provided to the patient as a matter of routine or do they need to be requested by the

	Patient?
Background	Patient has several health issues and is seeing different consultants at different UHL hospitals – LRI, Glenfield and the General. The patient has not received written information as promised (within two weeks) and without family support his records would not have been sent to the right consultant.
Response	**We fully accept that for all patients, and particularly those who have more than one condition or who are being cared for by more than one clinician either within UHL or across primary and secondary care, that it is important that information is shared between treating clinicians and with patients and their carers in a timely way.** **With this in mind, and in support of moving to our full electronic patient record, we have introduced systems that allow discharge and outpatient letters to be electronically sent to primary care clinicians using our ICE system. These electronic letters are also available for UHL clinicians to view through ICE.** **The vast majority of our discharge letters are sent on the day of discharge using the ICE system but there are still delays in the time that it takes to type and approve outpatient letters and the Operations Directorate are currently undertaking a review of typing back-logs and approval delays to determine what more we can do to reduce these to our agreed standard of routine outpatient letters being received electronically by their primary care clinician within 10 working days.** **If the patient concerned would be prepared to provide more details, we would be happy to investigate the circumstances around this case in more detail.**

Theme: Caring for Patients' Emotional Well-Being

Question 4	What is the protocol for informing patients with cancer diagnosis? What is the cancer pathway once diagnosis has been made?
Background	Patient was given cancer diagnosis without prior information to be accompanied for the appointment. The appointment notification was given by the GP practice so patient had no letter – just a message to be at the General hospital at a particular time. The patient has Bladder cancer.
Response	**Most patients with suspected bladder cancer are referred through the 2 week wait via their GP's who should tell them they are being referred with a 'suspected' cancer. They will then be sent an appointment for the haematuria clinic which has an accompanying booklet which explains the**

	tests which includes the line 'You may want to bring a relative or friend to any appointments you have' If a bladder tumour is found at that appointment the patient will be given the chance to see one of the Clinical Nurse Specialist team and also given the CNS contact details. They are given a further information leaflet about having the bladder tumour removed which also explains a little about bladder cancer and again suggests they bring a relative or friend to their follow-up appointment. It also explains the role of the key-worker and again includes the CNS contact details. When the patient returns to clinic for their histology results they are again given the opportunity to see a CNS/Key-worker to discuss their results and explain their pathway from this point, a holistic needs assessment should be undertaken at this point. The bladder cancer pathway following diagnosis will vary according to the grade and stage of their cancer, this could be anything from routine check cystoscopy (surveillance) to intra-vesicle bladder instillations to chemotherapy/radiotherapy and cystectomy (removal of the bladder) The pathway is determined and individualised to each patient through the MDT meeting. The MDT outcome is sent to the GP, there is a statement on the outcome that informs the GP that the patient may not be aware of their diagnosis in order to try to prevent the situation described in the question.

Theme: Continence. Bladder and Bowel Care

Question 5	Who is eligible for the external catheter system? Why do medical professionals in hospitals not inform patients of this option?
Background	Patient has regularly used convene sheaths, incontinent pads and urethra catheters. After doing his own research he came across information about the external catheter urine collection systems such as AFEX and UROX systems and Beambridge Funnel Urine Bottle and was prescribed the equipment from his GP. He said the equipment is comfortable, hygienic and more user friendly and there is a clear financial benefit.
Response	**Penile sheath systems "Conveen" (Rochester Clear Advantage) are available via supplies for all UHL wards and all male patients are eligible to use them following assessment. NB Not all male patients may be suitable for a penile sheath system. All wards have continence link nurses who are aware of the penile sheath system used on male wards. All new HCAs and RNs starting at UHL are taught how to assess and apply the sheaths plus drop-in sessions are held twice a year. A discussion has been held in the past with the Infection Prevention team of the possibility of using the more specialised urinals in some ward areas**

	on an individual patient basis. The idea would be for the patient to use the urinal on the ward taking the urinal home on discharge but Infection Prevention had concerns regarding the cleansing of the urinals between use & therefore we couldn't go ahead with this plan. Ward staff in areas such as Stroke Units, Neuro rehabilitation unit, stroke rehabilitation and orthopaedics are aware of the Beambridge specialised urinals and the Continence Team do have samples for patients to handle (but not use)- if we feel that any of these urinals would be useful for discharge, we arranged a supply via the GP. **The AFEX & UROX systems are more specialised pieces of equipment of which there are many. It would be difficult for the Medical Professionals and for the general ward nurses to know about all of the equipment available. This type of equipment requires more specialised assessment and it can take time to find the right piece of equipment suitable for each person's needs and abilities. Due to the AFEX & UROX system not being disposable, cleansing within Infection Prevention protocol would be difficult. All wards are aware of the Continence Team and can refer inpatients to the team for bladder and bowel assessments. Usually if following assessment any specialised equipment is felt that it could be beneficial, the team provides advice and arranges further follow-up after discharge.**

Healthwatch Rutland

Theme: Communication

Question 6	Ambulance handover times - Is there yet any sign of improvement?
Response	**Ambulance handovers at the LRI are a long standing problem which have increased in size over the last six weeks. There are eight key reasons for this:** **1. Growing emergency attendance, admissions and EMAS conveyance (volume not %).** **2. Increasing acuity of the patients accessing the emergency services.** **3. Specific challenges with paediatric flow linked to acuity of patients presenting.** **4. Poor estate and suboptimal capacity within ED to manage peaks in demand.** **5. No obvious locations to increase capacity near ED to manage overflow.** **6. Staffing numbers reduced by the agency cap.**

	7. Closure of base ward beds at LRI and GGH to support CQC work and ICU reconfiguration. 8. Despite pressures reducing a little over the summer, staff have not really had a period of respite and are feeling very pressurised and tired. Working with partners across LLR, in particular EMAS, we have developed a series of actions to try and alleviate the key reasons above. Key actions taken include: 9. EMAS and UHL bringing in consultancy support called Unipart to help standardise the process of handover between EMAS crews and UHL staff in the assessment bay. Their initial assessment is attached and wc 16 November 2015 is their fourth of eight weeks on site. 10. A joint LiA event between EMAS and UHL staff to identify and agree on the improvements required for a reduced handover time. 11. A detailed pan LLR action plan has been agreed to reduce admissions and attendance, improve flow and discharge. This is monitored via the fortnightly UCB. 12. A detailed UHL action plan, which is a subsection of the above is monitored through the emergency quality steering group and is attached. 13. The medical director and chief nurse have met with the paediatric ED team and wider paediatric team on three occasions in the last week to see what else can be done to support paediatric flow. 14. Adult and paediatric elective work at the LRI has been taken down to accommodate emergency activity. Recently there has also been a reduction in cancer work. 15. It has been agreed that the ED team can increase their nursing numbers from 25 qualified nurses per shift to above 30. This enables all the resus bays and assessment bays to be open and the overflow facility to be staffed. Unfortunately, since this change was made last week, we have not seen a fill rate over 25. 16. An area has been identified to cohort patients, for a short period of time, from majors ED who need to be admitted when there currently isn't a bed for them, but unfortunately due to UHL and EMAS staffing pressures we have been unable to open this. 17. We are working to re-open one adult bay and one paediatric bay at LRI, again because of staffing constraints, we have been unable to

	do this. **Conclusion** **The time it is taking to handover some patients from EMAS crews to LRI staff is unacceptable. EMAS and UHL are clear about our joint responsibility for this and are working closely to try and rectify the many problems. Whilst focussing on improving the estate, staffing levels and handover process, we also need to be clear that we will continue to have a problem until emergency demands reduce.** **W/e 16 November 2014 we had 4,195 patients through ED and UCC. W/e 15 November 2015 we had 4,724 patients through ED and UCC. This is a 12% increase or an additional 75 patients every day! If we were asked to care for an additional 75 patients every day last year we would have said it was impossible. Whilst the outcomes are unacceptable, we cannot be surprised by them given the pressure we are under.**

Theme: Infection Control; Personal and Oral Hygiene

Question 7	We still hear concerns about food and cleanliness. Are these matters nearing resolution
Response	**We continue to monitor feedback from patients and our staff about cleaning and catering services in our hospitals. We reserve the right within the contract to issue a service warning notice to Interserve if they fall below the standards expected in the contract.**

Theme: Caring for Patients' Emotional Well-Being

Question 8	Dementia - Despite your new policy, we still hear reports of inappropriate care of people with Dementia in UHL beds. Could we please have an update on implementation?
Response	**The Trust has an agreed Dementia Implementation Plan with Key Performance Indicators set for 2014-2016. There is also a Dementia Implementation Plan Task Group meeting that is very well attended by staff committed to lead improves in dementia care.** **This plan has eight ambitious work streams which reflect the National Dementia Audit recommendations. A total of 46 actions have been identified for 2015-2016, of which to date:** • **11 actions completed** • **27 on track**

- 6 not yet commenced
- 2 revised objectives

Therefore the plan is on track and has already achieved some great successes in quarter one and two, some highlights are:

- Increased the number of staff that volunteer to undertake additional training and an additional role as a Dementia Champions – current number is 315 Champions.

- Nutritional intake for patients with dementia has been supported, work has been carried out in quarters one and two to focus on snack menus and ensuring the older peoples wards provide 'finger foods' - known to help patients with dementia.

- A new Dementia Care Pathway has been designed to guide and signpost staff to sources of additional support for people admitted with dementia. Functioning as an aide-memoire, the pathway aims to be holistic, multidisciplinary and non-prescriptive. The pathway was launched in quarter two.

- The Trust continued to screen over 90% of patients for the early signs of dementia. See tables below:

Title in Brief	Quarter One			Quarter Two		
	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015
% of patients aged 75 years and over who were appropriately screened for dementia	91.3%	92.4%	96.4%	90.4%	91.8%	91.1%
% of patients identified as potentially having dementia or delirium who are appropriately assessed	100%	96.3%	96.2%	100%	95.6%	96.0%

- The Meaningful Activity Team, continue to provide additional, bespoke clinical support for patients with dementia and their carers. In quarter

one; the service increased their support to 13 wards; including Older People, Acute Frailty, Diabetes and Trauma Orthopaedics at the Leicester Royal Infirmary and now wards 15, 29 and CDU at Glenfield Hospital. Data results for April-September 2015 show:

- 1270 patients were supported, of which 978 patients had a confirmed dementia diagnosis, 201 query and 91 patients with other complex behaviour needs
- Over 824 patients were provided with additional nutritional support
- 369 carers were involved with activities
- 1168 patients were noted to have increased well-being and after being involved with activity which supported reduction in agitation and aggression

Dementia Implementation Plan is meeting key performance indicators within the relevant time frames and is proving to successfully bring together all activity across the Trust.

Carer Feedback

Although the Dementia Implementation Plan Task Group participates are pleased with progress against the Dementia Implementation Plan it is important to constantly seek feedback from patients and carers about their experience. Therefore we undertake a monthly audit of carers of people with dementia and delirium to test whether they feel supported.

For quarters one and two (April-September 2015), 137 carers responded to the surveys of how supported they felt by the hospital. This can be broken down as follows by month:

Carer response felt:	Quarter One			Quarter Two		
	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015
Fully supported	77%	62%	73%	60%	82%	75%
Partly supported	23%	35%	23%	36%	14%	20%
Not supported	0%	4%	4%	4%	4%	5%

Comparison by quarters one and two in 2014 and 2015

Carer response:	Quarter One		Quarter Two	
	2015	2014	2015	2014
Fully	71%	63%	72%	54%

Theme: Communication

Question 9	We have raised the upgrading of YDU and are pleased that this is now happening. Could you please update us and also let us know the long future of both the unit and hydrotherapy pool in the light of the Better Care Together changes.
Response	**The Trust has had to review its capital expenditure in light of the current financial situation. It is currently proposed that the YDU scheme will start in January 2016 giving a delay of approximately 8 weeks. If approved this will have knock on effect of delaying YDU moving back until May 2016.** **The Trust remains committed to funding this scheme.** **Within the Better Care Together programme the UHL strategy team is engaging with key stakeholders (including patients and the neurology service) to formulate the list of services that will remain on the general and those that will be moving to support the three to two site future state model. This process is at an early stage and the long term plan is not yet agreed.**