TOWER HAMLETS

Meeting of the

# HEALTH SCRUTINY PANEL

**Tuesday, 25 January 2011 at 6.30 p.m.**

**A G E N D A**

**VENUE**
**M72, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG**

| **Members:** | **Deputies (if any):** |
| --- | --- |
| **Chair: Councillor Tim Archer** | |
| **Vice-Chair:** | |
| **Councillor Abdul Asad** | Councillor Dr. Emma Jones, (Designated Deputy representing Councillor Tim Archer) |
| **Councillor Lutfa Begum** | Councillor Mohammed Abdul Mukit MBE, (Designated Deputy representing Councillors Abdul Asad, Anna Lynch, Lesley Pavitt, Rachael Saunders and Kosru Uddin) |
| **Councillor Anna Lynch** | |
| **Councillor Lesley Pavitt** | |
| **Councillor Rachael Saunders** | |
| **Councillor Kosru Uddin** | |

**[Note: The quorum for this body is 3 Members].**

**Co-opted Members:**

| | | |
| --- | --- | --- |
| Myra Garrett | – | (THINk) |
| Dr Amjad Rahi | – | (THINk) |

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Zoe Folley, Democratic Services,
Tel: 020 7364 4877, E-mail: zoe.folley@towerhamlets.gov.uk

**LONDON BOROUGH OF TOWER HAMLETS**

**HEALTH SCRUTINY PANEL**

**Tuesday, 25 January 2011**

**6.30 p.m.**

## 1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

## 2. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

| | | PAGE NUMBER | WARD(S) AFFECTED |
|---|---|---|---|
| **3.** | **UNRESTRICTED MINUTES**<br>To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 26th October 2010. | 3 - 10 | |
| **4.** | **REPORTS FOR CONSIDERATION** | | |
| **4.1** | **Ocean Estate GP Update on consultation - NHS Tower Hamlets** | 11 - 16 | |
| **4.2** | **Complaints services in Tower Hamlets- NHS Tower Hamlets** | 17 - 30 | |
| **4.3** | **Maternity Service - Update - BLT - Briefing Paper incorporating comments from the recent CQC Survey** | 31 - 42 | |
| **4.4** | **Joint Report on the Public Health White Paper- NHS Tower Hamlets** | 43 - 66 | |
| **4.5** | **Transformation of Adult Social Care & the Personalisation Agenda - NHS Tower Hamlets** | 67 - 74 | |
| **4.6** | **Response to THINK Recommendations** | 75 - 110 | |

## 5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

## DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

**Declaration of interests for Members**

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

**What constitutes a prejudicial interest?** - Please refer to paragraph 6 of the adopted Code of Conduct.

**Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-**

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

**LONDON BOROUGH OF TOWER HAMLETS**

**MINUTES OF THE HEALTH SCRUTINY PANEL**

**HELD AT 6.30 P.M. ON TUESDAY, 26 OCTOBER 2010**

**ROOM M72, 7TH FLOOR TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG**

**Members Present:**

Councillor Tim Archer (Chair)

Councillor Lesley Pavitt
Councillor Anna Lynch

**Other Councillors Present:**

Councillor Bill Turner (Items 4.1 – 4.2)

**Co-opted Members Present:**
Nil

–

**Guests Present:**

| | | |
|---|---|---|
| Ben Vinter | – | (Head of Corporate Affairs, NHS Tower Hamlets) |
| Bethan George | – | (NHS Tower Hamlets) |
| Judith Bottriell | – | (Associate Director Governance, Barts & The London Trust) |
| Dianne Barham | – | (Director THINk) |
| Caroline Alexander | – | (Director of Quality Development, NHS Tower Hamlets) |
| Alan Steward | – | (Deputy Director, Delivery Directorate, NHS Tower Hamlets |
| Paul James | – | (East London NHS Foundation Trust) |
| Christine Bevan Davies | – | (Quality and Effectiveness Manager Barts and the London NHS Trust) |
| Dr Somen Banerjee | – | (Co – Director, Public Health NHS Tower Hamlets and LBTH) |

**Officers Present:**

| | | |
|---|---|---|
| Afazul Hoque | – | (Scrutiny Policy Manager, Scrutiny & Equalities, Chief Executive's) |
| Katie McDonald | – | (Scrutiny Policy Officer, Scrutiny & Equalities , Chief Executive's) |
| Rachael Chapman | – | (Strategy & Policy Officer) |

Zoe Folley – (Committee Officer, Democratic Services Chief Executive's)

–

**COUNCILLOR TIM ARCHER (CHAIR) IN THE CHAIR**

## 1. APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Councillors Rania Khan, Shelina Aktar, Abdul Asad, for whom Councillors Lesley Pavitt and Anna Lynch were deputising.

Apologies were also received from Dr Amjad Rahi and Myra Garett, Co-opted Members.

## 2. DECLARATIONS OF INTEREST

Councillor Anna Lynch declared a general personal interest in the agenda on the basis that she was an employee of the Barts and the London NHS Trust.

Councillor Lesley Pavitt declared a general personal interest in the agenda on the basis that she was a member of THINk.

## 3. UNRESTRICTED MINUTES

That the minutes of the meeting of the Panel held on 27th July 2010 be agreed as a correct record.

**Matters Arising:**

(Item 5.1) NHS White Paper. The Chair reported that the Panel's response to the paper, taking into account the views expressed at the recent Challenge Session, had now been submitted to the consultation.

(Item 6.1) Improving Physical Access. The Chair had received a response from Officers clarifying the Council's powers/duties in relation to this matter and would be sending this to Mr Brian Harvey (Trust Member of the East London NHS Foundation Trust).

In relation to meeting support, it was **Agreed**

(a) that fruit be provided instead of biscuits;
(b) that where possible reports be printed doubled sided to save paper and that blank pages in the agenda be removed.

## 4. REPORTS FOR CONSIDERATION

### 4.1 Access to GP services – the Ocean Estate - NHS Tower Hamlets - Verbal Update.

It was noted that the regeneration of the Ocean Estate could result in changes to the shape of GP services on the estate. The purpose of this presentation was to establish the current position in respect of these plans and how the Panel may input in to this process.

The Chair welcomed to the meeting Ms Bethan George (NHS Tower Hamlets) who reported that, as part of the Ocean Regeneration Project, it was planned that the local GP practice be relocated to the new Hartford Street Building with a timeline of late March 2011 for completion. It was planned that the new facility would also comprise a pharmacy and dental facilities.

It was also noted that Officers had sought feedback from patients and had carried out surveys to identify what they would like to see included in the new practice. Officers were currently assessing the feedback and were happy to share this with Members. Ward Members had been invited to the meeting and to input into the consultation.

A Member expressed disappointment over the absence of a written report for this item and expressed concern over the adequacy of the consultation methods, (over reliance on online consultation, lack of other means)

In reply to further questions from the Panel, Ms George reported the following points:

- The plans solely involved the re - provision of the existing GP practice with the two extra facilities. There were no plans to install any other additional facilities.
- That the needs assessment identified a need for a new pharmacy in the area.
- That there would be no disruptions in services during the move. There would be a seamless transfer.
- Outlined the Staffing plans.
- Referred to separate plans to provide a Café on the other side of the building.
- Referred to the plans to remarket the service to increase public trust.

It was also noted that Officers were willing to meet separately with Members outside the meeting, if they so wish, to discuss the plans and feedback their comment/any issues.

It was **Agreed** that a further update report be submitted to the next meeting and the report from the outcome on the consultation be sent to the Health Scrutiny Panel.

**4.2 Joint Report on Complaints across the three local Trusts - NHS Tower Hamlets**

Ms Caroline Alexander (Director of Quality, NHS Tower Hamlets) and Ms Judith Bottriell (Barts & London NHS Trust) presented the report covering the key complaints issued at the three local health trusts.

Members considered a summary of complaints received during 09/10, the top issues, action to benchmark data, changes made as a result of the report, the ombudsman cases, (indicating few had been upheld, that the full report was on line) and overall themes in complaints.

In response to the presentation, Members expressed dissatisfaction at the complaints process. It was considered that the complaints process was very long, complex and needed to be made more user friendly and accessible to all groups.

In relation to Bangladeshi service users, consideration also was given to the low number of complaints from this group. The Panel discussed the reasons for their apparent reluctance to make a complaint, and that steps be taken to ensure they found the complaints systems accessible. Members considered that a further breakdown of the numbers would be helpful to cast light on this problem.

Ms Dianne Barham (THINk Director) also suggested that the Hospital Board's Membership should include a Patient representative to facilitate patient engagement.

It was also considered that the complaints procedure should be clearly publicised (in GPs surgeries etc.)

In response to the presentation, Ms Alexander and Ms Bottriell reported that:

- It was acknowledged that the Quality Assurance/Complaints Team attempted to deal with complaints informally first.
- Steps were being taking to ensure Bangladeshi people could access the complaints system. The team were looking at possible barriers to use, engaging and holding training sessions with them to improve experience.
- Explained in detail the complaints and investigation process.
- The website included complaints information. There was also a dedicated complaints e-mail address.
- Recent improvements – Service now provided a much more personalised complaints service. They were also in the process of collecting/analysing customer feedback regarding complaints.
- Outlined the plans to scrutinise the whole process to identify and address the key causes of complaints.

- Clarified the differences between the data in the Ombudsman Report and the report in the agenda (Due to the fact that they related to different stages of the compliant process).
- Complainants could approach the complaints service first, they did not need to go to their own GPs.

The Chair thanked the representatives for their informative presentation and noted that by bringing all the trusts complaints together in this format was particularly useful for the Panel to understand patients concerns about health service in the borough.

**Resolved:**

That the information set out in the presentation be noted.

### 4.3 East London and City Alliance Commissioning Strategy Plan Update - NHS Tower Hamlets

Alan Steward (Deputy Director, Delivery Directorate, NHS Tower Hamlets) presented the update report which provided a summary of progress of developing the NHS Tower Hamlets contribution towards the East London and City Alliance Commissioning Strategy (ELCC). It also updates on the impact of current initiatives to close the financial gaps.

Mr Steward reported that the review of current initiatives indicated that, with resign they were closing the financial gap. However, a substantial financial gap remained. Further work was therefore proposed to bridge the gaps.

Consideration was given to options for bridging the gap with minimum impact. It was planned that Mr Steward's team would carryout out a review of non mandatory services with a view to identifying savings. The team would then draw up a list of possible savings in this area and would consult extensively on the proposals.

It was **Agreed** that, when drafted, the list of potential savings in non mandatory services be presented to the Panel for consultation.

Consideration was also given to other options for achieving savings, around unnecessary use of A&E – need for more preventive work around this, reducing repetition in services. The Panel also stressed the importance of reasonable waiting times and the need to protect this.

**Resolved:**

(1) That the proposals in the report be noted; and
(2) That, when drafted, the proposed savings list be submitted to the Panel for consultation.

### 4.4 THINk Patient and User Comments Report and Recommendations 2010 - Presentation

Ms Dianne Barham (THINk Director) presented the Think Patient and User Comments Report and recommendations. (Tabled at the meeting.) The Panel were invited to consider the comments collated between from October 2009 to July 2010, and how they may wish to help address these issues.

The Panel considered the feedback regarding the following issues and steps for improvement:

- General Practice – length of appointments, quality of services from GPs.
- Royal London Hospital – staff attitudes, patient expectations – need to better communicate expected standards so patients could press for this, state of the buildings, accounts of poor patient experiences,
- Mental Health.
- Older People.
- Social Services.

Ms Barham invited the Panel to read the comments in detail in the tabled report.

The Panel felt that this was very valuable piece of work and that the report should go to the services provides so that they were aware of the issues.

It was therefore **Agreed** that Ms Barham should be invited to the next meeting of the Panel with a report on how services providers had responded to the issues. If necessary the Panel may wish to invite them into a meeting to discuss issues of concern.

**Resolved:**

(1) That the user comments report and recommendations be noted; and

(2) That a further report be submitted to next meeting of the Panel detailing service providers responses.

### 4.5 Update on Joint Strategic Needs Assessment - Briefing and Presentation

Dr Somen Banerjee (Co – Director, Public Health Tower Hamlets and LBTH) presented the update on the Joint Strategic needs assessment (JSNA), summarising the 2009/10 findings and recommendations.

The Panel were invited to consider and comment on the content of the JSNA and approach for 2010/11.

In response, the Panel felt that the problems around overcrowding in the Borough – lack of adequate housing should be investigated and be included in the plan. The Panel also considered that the problems around older people

feeling isolated - the need for a voluntary cost effective befriending service should also be explored.

The Panel expressed a desire to be involved in the process, and it was **Agreed** that details of future events be circulated to Members.

It was also intended that a fuller report on the assessment would be brought to a future meeting of the Panel next year.

**Resolved:**

(1) That the contents and approach towards the JSNA for 2010/11 be noted and that the Panel's suggestions be included in the assessment; and

(2) That it be noted that a further report will be submitted to the Panel at a future meeting.

### 4.6 Health Scrutiny Panel Work Programme

The Panel considered their draft work programme.

The Panel considered the need for extra meeting of the Committee next year given the amount of work in their programme. Consideration was also given to the possibility of holding a Saturday Morning session, and the merits of having a consistency in Membership across municipal years to harness skills and expertise.

**Resolved:**

(1) That the draft work programme items and schedule attached at Appendix 1 and 2 attached to the report be noted; and

(2) That the work programme be reviewed every quarter

## 5. ANY OTHER BUSINESS

### 5.1 Update on:1) INEL JOSC 2) Polysystems Challenge Session Report.

(1) NEL JOSC

The Chair confirmed the details of the next meeting of the JOSC to be held at 9:30pm at the Town Hall, London Borough of Newham. The agenda could be found on the Council's website. All Members were welcomed to attend this meeting.

Resolved

(1) That Cllr Lesley Pavitt agreed to attend this on behalf of Tower hamlets Health Scrutiny Panel.

(2) Polysystems Challenge Session Report.

The Chair reported that this was a really good session and that the draft report and recommendations would be sent to all the stakeholders for comments before it is considered by the Overview and Scrutiny Committee.

## 6. KATIE MACDONALD – SCRUTINY AND POLICY OFFICER

The Chair reported that this would be the last meeting Katie Macdonald would be attending. The Panel thanked Katie for all her hard work in supporting these meeting and wished her all the best for the future.

The meeting ended at 9.15 p.m.

Chair, Councillor Tim Archer
Health Scrutiny Panel

| Committee<br><br>**Health Scrutiny Panel** | Date<br><br>**25 January 2011** | **Classification**<br><br>**Unrestricted** | Report No. | Agenda Item No.<br>4. 1 |
|---|---|---|---|---|
| **Report of:**<br><br>NHS Tower Hamlets<br><br>**Presenting Officers:**<br><br>Bethan George | | **Title:**<br><br>Report on Ocean Estate GP update on the consultation<br><br>**Ward(s) affected:**<br><br>All | | |

## 1. Summary

This report sets out the background and results of the questionnaire undertaken with local residents as part of the changes to the Ocean Estate GP service and discusses how these have been incorporated into the design of the new service.

## 2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the information set out in the report.

### 1. Background to the Harford Street Development

Harford Street is a new community and residential development by East Thames[1] at the junction of Harford Street and Ben Jonson Road, E1 within the Stepney & Whitechapel Network (Local Area Partnership 3). It will include a new Health Centre that will accommodate GP services to be transferred from the adjacent Stepney Health Centre, which is scheduled for closure and demolition in 2011.

The new Harford Street Centre will provide purpose-designed facilities to accommodate core and enhanced GP services, alongside a new dental practice and a new community pharmacy to be procured by the PCT. It will improve the range, capacity, quality and accessibility of services for patients within the St Dunstan's and Stepney Green ward, and on the nearby Limehouse Fields Estate.

The Stepney Green Practice list size is currently around 9,200 and is projected to grow to approximately 12,000 by 2015/16 reflecting expected increases in the local population due to construction of new residential units for the Ocean Estate regeneration. The GP practice once transferred to Harford Street will provide a range of services, including child health surveillance, cervical cytology, contraceptive services, adult and child vaccines and maternity medical services.

The pharmacy will provide the full range of services including provision of NHS treatment for minor ailments, emergency contraception, stop smoking services and blood pressure checks. The pharmacy will have private consulting space enabling the provision of high level pharmacy advice and intervention.

[1] East Thames is a Registered Social Landlord, a registered charity and company limited by guarantee.

The dental service will provide mandatory general dental services and incorporate oral health prevention programmes which focus on healthy lifestyles, such as smoking reduction and healthy nutrition.

A key goal of the services in the centre will be to offer a range of health information services and to encourage healthy lifestyles. Self-help will be encouraged, for example through posters and leaflets and use of information technology in waiting areas to signpost local services. All facilities and information will be designed to meet the needs of a multicultural population.

**2. Why did we set out to gather local views about this development?**
This development is part of the Improving Health and Well-being Programme. The program has undergone extensive public consultations over the last 2 years. For this specific development the PCT and Local Strategic Partnership were keen to incorporate local views about how services could be improved and the additional services people would like to see offered into the contracts for services to be included in the building.

**3. How did we gather local views?**
The patient and public engagement for Harford Street consisted of the development of a questionnaire which was available for people to complete in the following ways:

a) Online through the PCT's website from 27th September to 25th October
b) With the support of PCT commissioning and public engagement officers and LBTH regeneration officers who completed surveys with local residents at information days held in community settings, LIFRA Hall, Ocean Estate Tenants and Residents' Association and
c) Via the GP practice, where surveys were available in the waiting room for people to complete, and Bengali speaking Community Engagement worker attended baby clinic and surgery times to promote consultation and support completion of forms. Surveys were also distributed to the local Children's Centre.

**4. What did the questionnaire tell us?**
Questionnaires were returned by 60 people in total, although not all respondents answered all questions.

**a) GP services**
Of 54 people who responded to this section of the questionnaire 65% of respondents expressed a desire for extended opening hours. This included people who were unaware that Stepney Health Centre already offer Saturday morning opening. Fifty percent of all respondents indicated that they were aware of the availability of Practice Nurse appointments at Stepney Health Centre, and less respondents were aware of the availability of Healthcare Assistant appointments, repeat dispensing and medication use review. Eighteen percent of respondents indicated that they were aware of the Pharmacy First Scheme.

Respondents were most interested in services for staying healthy, self-care for long term conditions, services for the under 5s and women's health and online booking of appointments.

General comments made were about improving the customer service skills of both administrative staff and clinicians at the practice.

**b) Dental Services**

Of the 58 people who responded to this section of the questionnaire 79% currently access NHS dental care and 19% were not registered with a dental practice at all (NHS or private). Three quarters of respondents stated they usually attend a Tower Hamlets dentist.
Fifty eight percent of people indicated they visit the dentist only when they have a problem with their teeth and 27 respondents indicated they don't go to the dentist because they don't need to. The majority of people indicated their last NHS appointment had been an urgent rather than a routine one. The majority of people indicated that they had last attended an appointment 1-2 years ago.

Sixty eight percent of people who responded to the questions on dental services wanted Saturday and emergency opening, with 36% requesting late evening appointments.

Respondents were most interested in staff being friendly and welcoming, the appearance of the dental practice, and NHS dental practices being co-located with other NHS services.

**c) Pharmacy Services**
Of the 54 people who responded to this section of the questionnaire 63% visit a pharmacy once a month or more. Most people said they visited the pharmacy to obtain prescription or over the counter medication. 76% were visiting for themselves or on behalf of a child under 16. Ninety six percent of respondents to this section of the questionnaire always or usually use the same pharmacy, largely because it is close to home, they like to speak to the same pharmacist or because it is near to their GP.

Between 30-40% of people were aware of services available through a pharmacy such as stop smoking advice and flu vaccinations, with requests for additional services including contraception and pregnancy support.
Improvements requested were around ensuring the supply of medication, a larger pharmacy and improved customer service skills.

**5. How representative was the questionnaire?**
A section of the questionnaire requested that people provide details to monitor equal opportunities. Fifty six of the 60 respondents provided information on their gender, (54% male and 45% female). This compares to the GP practice list as of 31st December 2010 which was 51% male and 49% female, i.e. slightly more men than expected from the practice demographics completed the questionnaire.

Fifty eight people provided information on their age (61% 25-54 years). The table below compares the age bands collected via the questionnaire to the practice list demographics.

| Age | Questionnaire responses % | Practice List % |
|---|---|---|
| >5 | 0 | 10 |
| 5-15 | 0 | 17 (5-14 year olds) |
| 16-24 | 12 | 17 (15-24 year olds) |
| 25-34 | 28 | 23 |
| 35-54 | 33 | 22 |
| 55-64 | 17 | 5 |
| 65+ | 10 | 7 |

Fifty four people provided ethnicity information, with 67% of respondents Asian Bangladeshi, 11% White English and 22% Others. Practice level ethnicity data is not available, but overall LAP 3 has an ethnicity breakdown of 68% Asian Bangladeshi and 19% White and 13% Others.

## 6. What are we doing about it?

### a) GP Services

The practice is currently undergoing a Personal Medical Services (PMS) contract review to be completed before the move to Harford Street. The review aims to ensure the contract reflects the needs of the local population through the range of services and the key performance indicators (KPIs) included. The consultation results will be used as part of the negotiations in the review.

The practice already offers some extended opening hours and increased opening hours will be a part of the PMS contract review.

Services for children under 5 and women's health services are currently provided, this will be enhanced through network provision of under 5's immunisation and women's screening. In the lead up to the move we will be working with the practice on an action plan around promoting their services – including opening hours and services available through nursing and health care assistants.

The practice will offer online appointment booking through the EMIS system. The practice already has automated 24/7 booking via the telephone.

The practice is aware of the need for customer service skills improvement. Some training has already completed and the Practice Manager who joined the practice in December is working on how this can be improved both now and in the new health centre.

There will be a touchscreen set up in the waiting room of Harford Street, which can include questions about the quality and range of services.

The touchscreens provide real time data at the point of service delivery that can then be used to make alterations to services and highlight areas of excellence and areas for development.

### a) Dental Services

We are implementing a Personal Dental Services (PDS) Plus contract in Harford St. The issues highlighted in the questionnaire have been incorporated into the service specification and procurement of the service will therefore address each of these through contractual performance and KPIs. One of the KPIs will be monitoring the number of unique patients attending the service in previous 24 months.

The potential provider is also required to demonstrate at the tendering stage how they will engage with the local population and what steps they will regularly undertake to ensure that their service is accessible to NHS patients. A specific response is requested from the bidders on how patients will be involved in the design of services. Bidders are required to describe how they will identify local hard-to-reach groups and ensure equity of access and includes the process they will undertake in identifying patients who do not routinely access dental services. They are also asked how they will encourage hard to reach groups to participate in oral health promotion and disease prevention activities, and indicate of how the dental services will contribute to overcoming local oral health inequalities.

The potential provider will be expected to maintain an ongoing professional relationship with their patients by drawing up a comprehensive treatment plan for each patient. It is hoped this will help to prevent patients only attending for dental treatment when they are pain. The dental provider will also be expected to adhere to an effective care pathway for patients who require more specialist dental intervention.

Extended opening is also incorporated into the contract. The service will regularly be monitored through the mid year and annual review process with particular emphasis on patients' access, experience and quality of dental care provided.

**b) Pharmacy Services**

Similarly to dental services, the findings of the questionnaire were incorporated with the Pharmaceutical Needs Assessment (PNA) and other local intelligence into the specification for the Local Pharmaceutical Services (LPS) contract.

The contract and the procurement process will be used to secure services such as emergency contraception and pharmaceutical support for long term conditions for the Harford St site. The contract will also ensure adequate opening hours and include KPIs to secure high quality pharmaceutical services for the local population.

Tower Hamlets are currently part of a pan London programme to introduce the provision of oral contraception in community pharmacies as an NHS service. Currently it is anticipated that up to 4 pharmacies in Tower Hamlets will participate in 2011.

The responses to the questionnaire will be used to review the promotion of the Pharmacy First scheme (minor ailments scheme). The PCT and local pharmacies currently promote the scheme in a number of different ways including

- Posters and leaflets in all community pharmacies and GP practices in Tower Hamlets.
- Ad hoc training for GP and pharmacy staff
- Integrated into other PCT initiatives – e.g. the current "Get the right treatment"

This page is intentionally left blank

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **25 January 2011** | **Unrestricted** | | **4. 2** |
| **Report of:**<br><br>NHS Tower Hamlets<br><br>**Presenting Officers:**<br><br>Caroline Alexander, Director of Quality Development, NHS Tower Hamlets<br><br>Vanessa Lodge, Associate Director, Quality and Governance, NHS Tower Hamlets | | **Title:**<br><br>Complaints services in Tower Hamlets<br><br>**Ward(s) affected:**<br><br>All | | |

**1. Summary**

This paper summarises the complaints services from Barts and the London NHS Trust (BLT), East London NHS Foundation Trust (ELFT), Tower Hamlets Community Health Service, NHS Tower Hamlets (PCT), responding to questions raised at the Health Scrutiny Panel meeting held on 26th October 2010.

**2. Recommendations**

The Health Scrutiny Panel is asked to consider and comment on the information set out in the paper.

This paper summarises the response from Barts and the London NHS Trust (BLT), East London NHS Foundation Trust (ELFT), Tower Hamlets Community Health Service, NHS Tower Hamlets (PCT) on questions raised at the Overview and Scrutiny Panel meeting held on 26th October 2010 about the Complaints services in Tower Hamlets. A full PALS (patient advice and liaison service) report will be presented at the next meeting following the transition of the Panel.

Individual organisational responses are attached as appendices to this report.

<u>How accessible the complaints process actually is in each of the provider organisations – i.e. how easy is it for local people to navigate the system?</u>

- Each Trust has a designated PALS and Complaints departments
- Overall all four complaint departments feel that access to complaints was good
- Each Trust has PALS and Complaints information and links on the Trust's websites
- Good access to free phones numbers as well as direct external numbers
- Good relationship with Think/Link (Local Involvement Network) support in raising awareness of PALS and Complaints services
- Well distributed leaflets, posters within hospital wards, services and practices
- Proactive PPI/PPE work in the community and with services
- Regular liaison and update with wards, Practices and services
- Collaborative work with community organisations, marginalised communities, and faith groups in raising awareness of PALS and Complaints services
- "Tell us what you think" leaflets and options on the website
- NHS Choices information allowing patients and public to comment on practices and enable practices to respond and improve services as result of comments

<u>How well front line practitioners and admin staff in primary care know how to help patients navigate the complaints system and that they inform patients that they can ask the PCT to investigate if they want a more independent response?</u>

- NHS Tower Hamlets Trust Policy provides corporate induction to all new staff joining the PCT including general practice staff
- Regular corporate / internal training on complaints management and the implications of the 2009 Health and Social Care Complaints Regulation provided to Trust and independent contractors and their staff
- Regular presentation to practices/forums about the complaints department and implications of the 2009 Health and Social Care Complaints Regulation
- Outreach sessions in GP surgery/health centres provided
- Close working relationship with Practice Managers, Admin staff and receptionists
- Involvement in joint work and working forums to raise awareness of PALS & Complaints
- Promotion and event raising awareness of PALS & Complaints
- PALS & Complaints Posters and leaflets circulated in all independent contractor practices (GP, Dentists, Pharmacy, Opticians), community organisations, THINK / LINKS
- Complaints leaflet clearly states that PCT will investigate independently when requested

The rates of complaints from the Bangladeshi community – are very low. What measures are in place if there are blockages?

- The PALS and Complaints services feel that there aren't any blockages in the system for Bangladeshi patients and the public to raise or make a formal complaint. A representative proportion of Bangladeshi patients/public call and access the PALS service to raise concerns, which results in resolving their complaint at an early stage therefore becoming unnecessary to escalate or present as a formal complaint later on.

- A proportion of formal complaints from the Bangladeshi community are also received. Sometimes it is the lack of ethnicity data records that may imply that this is the case; however the teams feel that a good proportion of Bangladeshi patients are making formal complaints.

- With regards to East London NHS Foundation Trust (ELFT) it is accepted that complaints from the Bangladeshi community may be low. There is some information to suggest that they are more likely to access the PALS service. In terms of ELFT there is evidence that the Bangladeshi community is well represented in terms of Trust members. The Membership Office outlined how this had partly been achieved through attendance at events within the Bangladeshi community. It has been agreed that in future, where possible, staff from the Complaints department should attend these events with a view to hearing the views of the community on the complaints service and publicise its function more generally.

**Appendices:**

1. NHS Tower Hamlets (PCT)
2. Tower Hamlets Community Health Services (CHS)
3. East London NHS Foundation Trust (ELFT)
4. Barts and The London NHS Trust (BLT)

**Appendix 1.**
**NHS Tower Hamlets (PCT) Complaints Update**

How accessible the complaints process actually is in each of the provider organisations- i.e. how easy is it for local people to navigate the system?

NHS Tower Hamlets Complaints process provides easy access to patient and the public by having:

- A free phone and 3 external telephone lines
- Policy to provide a phone service between 9.30-4.30 between Monday to Friday. An answer phone facility when office is closed and when officers are out of office on meetings, training or dealing with other queries and complaints.
- Switchboard service at Aneurin Beven House (ABH) to transfer calls to the Complaints team
- PALS and Complaint teams detail on the Trust Website
- Drop in Service or appoint to see officers on request
- PALS and Complaints training provided to front line staff to be able to pick up issues early and resolve the situation then and there where
- "Tell us what you think" leaflets and website information- integrated information of PALS and Complaints about health and Social Care Complaints teams
- All 3 of the PALS and Complaints staff speak English as well as Bengali therefore are able to communicate with this client group easily and allow access without having to arrange to interpreting ( for Bengali speaking callers)
- The team is based at Aneurin Bevan House, 81 Commercial Road, E1 which is reasonably centrally located and with easy transport facilities. PALS and the Complaints team are flexible in meeting patients and public requirement to meet more local or preferred venue such as a community centre or library or their health centre/GP surgery if appropriate.
- Collaborative PPI / PPE activities and joint work with community organisations and groups, health events

How well front line practitioners and admin staff in primary care know how to help patients navigate the complaints system and that they inform patients that they can ask the PCT to investigate if they want a more independent response?

- NHS Tower Hamlets Trust policy provides induction programme to all new staff joining the PCT which includes general practice staff.
- Outreach sessions in GP surgery/health centres provided
- Close working relationship with Practice Managers, Admin staff and receptionists
- Involvement in joint work and working forums, events to raise awareness of PALS & Complaints
- PALS & Complaints Posters and leaflets circulated in all independent contractor practices (GP, Dentists, Pharmacy, Opticians), community organisations, THINK / LINKS (local involvement network)
- Regular corporate Complaints training on managing complaint and the implication of the 2009 NHS complaints regulation
- Regular PALS and Complaints presentation and training providing to GP and practice staff, including dentists and dental practice staff

The rates of complaints from the Bangladeshi community - are very low. They want us to understand more fully why and put measures in place if there are blockages.

The PALS and Complaints department does not feel there are any blockages, a representative proportion of Bangladeshi patients/public call and access the PALS service to raise concerns, with would result in resolving their complaint at an early stage therefore becoming unnecessary to escalate or present as a formal complaint later on. We also receive a well proportion of formal complaints from the Bangladeshi community as a result of wide publicity and collaborative activities with the wider health services and the communities.

For period January 2010 to December 2010 PALS and Complaints team have dealt with 547 recorded concerns/cases as well as 1200 adhoc enquiries; a total of 1747 PALS enquiries of which

- Bangladeshi - 118
- White- 279
- Unknown – 150
- All Adhoc cases are unknown

**Appendix 2**
**Tower Hamlets Community Health Services (CHS) Complaints Update**

How accessible the complaints process actually is in each of the provider organisations – i.e. how easy is it for local people to navigate the system?

Tower Hamlets Community Health Services' (CHS) starting point for considering access to the complaints systems is to look at the services we provide and the client group and base our access methods on these. For example, as CHS provides and audiology and Speech and Language Therapy Service, we expect that service users in the client group are able to access the system conveniently. Therefore, a generic e-mail address accessed by all team members is in place. There is also a confidential fax line, and a freepost address, as we provide services for older people, some who still prefer to correspond by writing and posting in their concerns.

There is a free phone number for landline users, thereby enabling them to make free calls and there are 4 other direct landline numbers which mobile phone users find much cheaper. CHS' local policy is that between the hours of 9am – 5pm, Monday to Friday, there is always someone to answer the phones and the phones are never turned over to the voice messaging service during these hours except all team members are on the phone at the same time or callers call out of hours. That way if service users prefer not to contact the services they are concerned about directly they can access the complaints team more quickly.

Through training, staff are made aware of the principals of attempting to resolve issues in the first instance before they forward clients on to the formal complaints process as a last resort.

CHS uses local voluntary services in the community as a source of access and liaises closely with such groups via PALS out reach work.

The service's details are advertised in all health centres and areas patients frequent and also on the Trust's website. The full complaints policy is also uploaded on the website so service users are aware of how the service operates and the process their complaint goes through.

The complaints team engage in patient facing discovery interviews as part of their PALS workload and use that opportunity to raise awareness about the system in a non intrusive manner

The service is also promoted through the advocacy service so that service users without English as a first language can get in touch via an advocate

How well front line practitioners and admin staff in primary care know how to help patients navigate the complaints system and that they inform patients that they can ask the PCT to investigate if they want a more independent response?

Through complaints training, the service advocates the use of PALS skills by everyone at front line as a way of diffusing situations and attempting to resolve concerns for service users. Staff are aware through training and induction that the next course of action, if they are unable to resolve an issue, is to either direct service users to the complaints team or to contact them directly for advice. The team provide a drop in

service, so staff on site often walk patients over to meet the team, or send them along for further assistance.  Literature displayed around the community health service sites guide both staff and patients and gives a summary of what to do.

The rates of complaints from the Bangladeshi community are very low. What measures are in place if there are blockages?

Firstly the use of PALS for the Bangladeshi community seems a more favourable option, therefore it is not that that the rate of complaints from the Bangladeshi community is low, rather, sufficient ethnicity data to reflect the number of contacts for any particular ethnicity group was unavailable at the time of reporting

CHS have therefore tightened up on how this data and demographics generally is collated.

**Appendix 3**
**East London NHS Foundation Trust (ELFT) Complaints Update**

How accessible the complaints process actually is in each of the provider organisations – i.e. how easy is it for local people to navigate the system

In terms of ELFT, I feel it is reasonably accessible. The website has a box with a direct link through to PALS – there is then information about how PALS can be contacted, including free phone telephone number and an email address. In addition, the Trust's complaints service is separately listed on the homepage, again with a link to PALS, as well as details of how to contact the complaints service. The latter includes a free phone, freepost address and a leaflet that can be downloaded with a form to make a complaint (or comment or compliment). There is no separate email post-box for complaints because of it is felt that this may increase the risk of sharing confidential information about service users on insecure networks.

In addition, as noted in earlier submission, the Trust publicises complaints/ PALS through leaflets and posters in its wards, Community Mental Health Teams (CMHT) and other service centres. Since September 2010, there have been concerted efforts on the part of FLORID (a service users' group) to audit ward, CMHTs and centres to ensure that these are in place and readily available to service users. There is now a laminated card next to the Patient's telephone on all wards, with details of the free phone. There is also a locked display cabinet on wards exhibiting posters.
Information about the Complaints Service is included in Welcome Packs which are distributed to patients on our wards, service users using particular services for the first time and carers.

The Complaints Manager is due to write to all CMHT / Ward Managers to explain how leaflets can be ordered directly from the service.

Advocacy services operate throughout all the localities, supporting complainants to make complaints.

The Free phone telephone is staffed weekdays from about 8:00 to 5:30 daily. The service estimates that there is a fairly even spread in terms of complaints coming through in by telephone and letter. The service is not aware of any particular difficulties faced by service users in getting through to the service – for example, service users do not allude to difficulties they have experienced getting through.

How well front line practitioners and admin staff know how to help patients navigate the complaints system and that they inform patients that they can ask the Trust to investigate if they want a more independent response?

All incoming staff attends an induction which includes a module presented by the Complaints Manager / PALS officer on their respective services. The Complaints Manager also does a presentation for Junior Doctors on rotation every six months. She holds four half day complaints training sessions every year for staff with responsibility for investigating complaints.

However, in addition, she runs similar sessions in localities, on wards and within particular services such as CAHMS, the Older People's Team for managers and other

staff. She also runs sessions for groups of professionals, such as OTs and Administrators. For the year 2010, a further 12 sessions were run on this basis.

Low reporting of complaints from Bangladeshi community.

It is accepted that complaints from the Bangladeshi community may be low. There is some information to suggest that they are more likely to access the PALS service. In terms of ELFT there is evidence that the Bangladeshi community is well represented in terms of Trust members. The Membership Office outlined how this had partly been achieved through attendance at events within the Bangladeshi community. It has been agreed that in future, where possible, staff from Complaints should attend these events with a view to hearing the views of the community on the complaints service and publicise its function more generally.

‘Number of Bangladeshi Members: 936
Current Membership total: 8410
Total Bangladeshi population in Trust area: 93,248

So 11% of our total public members are Bangladeshi which is pretty close to being representative of the Bangladeshi population of around 14%

Last year the Membership Office attended two Bangladeshi specific events to engage with and recruit Members. These include ‘Community Fair’ and ‘Bangladeshi Disability Awareness Day Event’.
The Complaints Service will be looking to canvass the views of its Bangladeshi membership to find out their views on the complaints service and ways it might be made more accessible to the Bangladeshi community.

**Appendix 4**
**Barts and London Hospital Trust Complaints Update**

Below are screen shots that show the steps to use (I assume that the other means of accessing our complaints process, as previously mentioned at the meeting, are already noted. I'm thinking of things such as our Tell Us booklets - both standard and easy read versions?) :

Step 1 click on "For patients and visitors" tab:

Step 2 click on: "Comments, suggestions and complaints"...Tell us what you think:

http://www.bartsandthelondon.nhs.uk/forpatients

Tell us what you think

**Comment, suggestion or complaint**

We are committed to providing a high-quality service for all our patients, and will do everything possible to make sure that your visit to our hospital is as comfortable as possible. We are constantly developing the services we provide for patients and visitors, and would welcome your input.

If you'd like to make a comment, suggestion or complaint, please do one of the following:

- Speak to the staff at your clinic/department
- Read the**Tell us what you think leaflet** and complete and return the form. The leaflet can be downloaded from the link above or picked up from clinics and wards in the hospital.
- Download an **Inpatient feedback form** or e-mail your complaint to complaints@bartsandthelondon.nhs.uk
- Contact our Patient Advice and Liaison Service (PALS) on tel **020 7943 1335** or email **PALS@bartsandthelondon.nhs.uk**

**Alternatively you can fill in the below feedback form online.**

Patient details

Name (Mr/Mrs/Ms/Miss)

Hospital No. (If known)

Address

Tel No. (incl. code)

Date of birth

Email address

If you are completing this form for somebody else, please give your details below

Name (Mr/Mrs/Ms/Miss)

Address

Tel No (incl. code)

Email address

Relationship to patient

Your comments, complaints or suggestions

The next set of questions allows us to monitor who gives us feedback so we can ensure everyone has equal opportunity to raise issues and concerns. You do not have to complete this section although we would encourage you to.  We can assure you that your answers will have no bearing on your right to complain or how your complaint is dealt with.

Age

☐ Child (16 or under)

- [ ] Adult (17-64)
- [ ] Older adult (65 or above)
- [ ] I would rather not answer

Gender

- [ ] Male
- [ ] Female
- [ ] I would rather not answer

Sexuality

- [ ] Gay
- [ ] Lesbian
- [ ] Heterosexual
- [ ] Bisexual
- [ ] I would rather not answer

Ethnic origin

- [ ] Bangladeshi
- [ ] Indian
- [ ] Pakistani
- [ ] Other Asian background
- [ ] White & Asian
- [ ] White & Black African
- [ ] Whi & Black Caribbean
- [ ] Other mixed background
- [ ] Caribbean
- [ ] Other black background
- [ ] British
- [ ] Irish
- [ ] Other White background
- [ ] Any other ethnic group
- [ ] I would rather not answer

Religion or beliefs

- [ ] Atheism
- [ ] Buddhism

- Christianity
- Hinduism
- Islam
- Jainism
- Judaism
- Sikhism
- Other
- I would rather not answer

Disability Discrimination Act 1995

**Disability Discrimination Act 1995**

Under the terms of the Act a disability is defined as a 'physical or mental impairment which has a substantial and long term effect on a person's ability to carry out normal day to day activities'. NHS employers welcome applicants from disabled people.

Do you consider yourself to have a disability?

- Yes
- No
- I would rather not answer

If yes, please give the details

Submit Query | Reset

Forms.HTML:Reset.1

Below is a bullet point and chart (7) from a report Sam Rashid put together re PALS (note the entry re the Bangladesh community), to add to complaints data already submitted at the Health & Scrutiny Panel.

**Barts and the London Trust PALS contact and ethnicity Data for 2010**

Forms.HTML:Reset.1

- The service dealt with 2215 cases this year compared to 2309 cases last year in 2009
- PALS strive to ensure that the service is available in a variety of ways, and is committed to making the service as accessible as possible. As with past trends the main method of contact continues to be by telephone.
- The majority of enquires to the service this year falls under the 'Issues and Concerns' category. Cases under this category are typically more complex and

enable us to act as an early warning system, potentially preventing issues escalating to a formal complaint

- The team continues to provide a fast and responsive service with 98% of cases being resolved within 24 hours. These figures are among the highest turnaround figures since the services inception in 2000.
- Although PALS are part of the Trust the service has an independent and confidential approach to their role and clients provide as much or as little personal detail to PALS as they feel comfortable to do so and details are recorded as appropriate to the enquiry. As a result this impacts on how individual service user ethnicity data can be captured by the service
- Analysis of previous ethnicity data show a slight increase in the number of Bangladeshi clients accessing the service who choose to provide individual ethnicity information.

Forms.HTML:Reset.1

| BLT PALS clients Ethnicity profiles | Total |
|---|---|
| White - British | 548 |
| White - Irish | 21 |
| White - other white | 70 |
| Mixed white and black Carribean | 2 |
| Mixed white and black African | 2 |
| Mixed white and Asian | 1 |
| Other mixed | 7 |
| Indian | 27 |
| Pakistani | 18 |
| Bangladeshi | 84 |
| Other Asian | 22 |
| Black Carribean | 35 |
| Black African | 7 |
| Other Black | 41 |
| Chinese | 11 |
| Other ethnic category | 40 |
| Not stated | 209 |
| Totals: | 1145 |

Forms.HTML:Reset.1
Forms.HTML:Reset.1

| Committee<br><br>Health Scrutiny Panel | Date<br><br>January 2011 | Classification<br><br>Unrestricted | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Report of:**<br><br>**Maternity Services**<br>**Barts and the London NHS Trust**<br><br>**Presenting Officer:**<br><br>Sandra Reading<br><br>Head of Midwifery and Women's Health | | **Title:**<br><br>**Maternity Picker Survey (CQC) 2010**<br><br>**Ward(s) affected:**<br><br>Maternity Services including:<br><br>The Royal London Hospital<br>The Barkantine Birth Centre<br>Community Midwifery Services | | |

## 1. Summary

This briefing sets out the background to the Care Quality Commission 'Picker Survey' into Maternity Services (2010) which follows previous surveys carried out into maternity services provision in 2007.

The Health care Commission Survey into maternity services was first completed in 2007 where all women who gave birth during the month of February 2007 were sent an extensive survey questioning all aspects of maternity care provision throughout the antenatal, labour and postnatal care periods. This survey which was produced in September 2007 gave particularly poor results for the majority of London Maternity units and particularly disappointing results for Barts and the London NHS Trust.

Following the survey a detailed improvement plan was agreed between the Trust and the PCT and a number of monitoring tools were introduced to implement changes in the maternity services.

This report gives feedback on the subsequent survey completed in February 2010 as a 3 year follow up. The survey was completed by the Picker Institute and commissioned by the Care Quality Commission.

There have been a number of significant changes to maternity care provision over the last 2 years resulting in clear care pathways for women and key quality improvements based on national guidance. The impact of these changes will be described in presentation (see attached).
Improving women's experience of the maternity service has been one of the main targets for the service and detail of improvements to date and ongoing actions will also be discussed.

## 2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the proposals set out in the report and the maternity unit presentation of changes that have been implemented during the past 2 years.

# BARTS AND THE LONDON NHS TRUST

## Picker Survey Results 2010

## INTRODUCTION

This report presents the findings from the 2010 Maternity National Picker survey. It identifies areas where improvements have been made in the maternity unit based on a comparison of the 2007 and 2010 national surveys. The report also identifies where women report the most concerns and actions that the maternity unit have progressed or are planned to continually improve the service offered to women and their families.

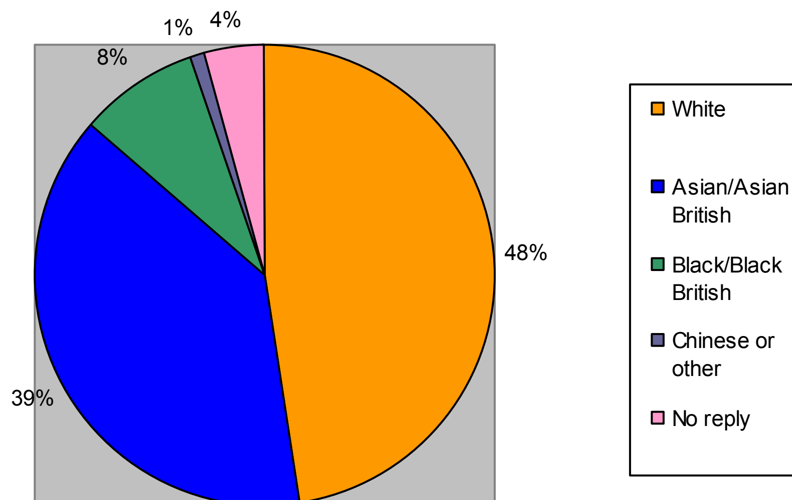
## 1. Background

1. The Picker Institute carried out a Maternity Survey in February 2010, asking women's views on their experiences during pregnancy, birth and the postnatal period. This report was published in September 2010 and has provided information to the Healthcare Commission.

   The Picker institute was commissioned by 64 Trusts to undertake the NHS Maternity Survey 2010. A total of 331 women from our Trust were sent a questionnaire. 321 women were eligible for the survey of which 110 returned a completed questionnaire giving a response rate of 34.3%. The average UK response rate was 49.8%.

## 2. About the responding patients

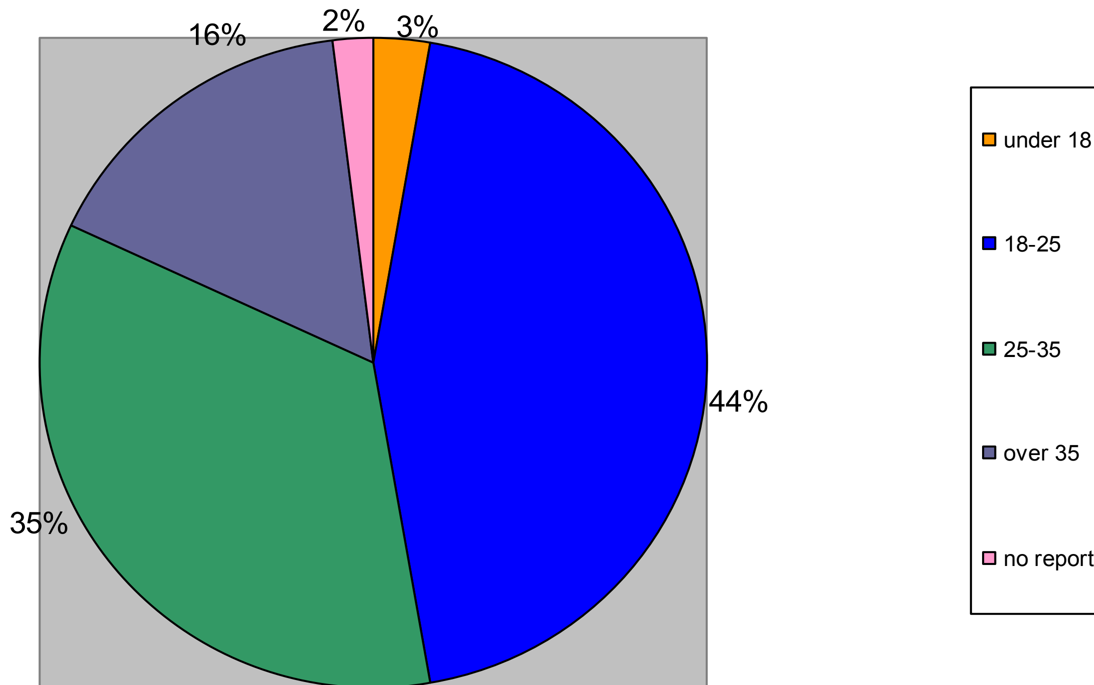
Respondents stated their ethnic background as;



The ethnicities of our respondents closely reflect the local maternity population.

Further statistical analysis was undertaken in order to identify any significant differences in responses between groups. This was done by comparing responses of the white group to that of the all non white groups collectively. The analysis showed that there was no significant difference in the overall rating of care.

**Age ranges of our respondents**




## 3. Key Findings

- The survey has highlighted many positive aspects of the patient experience. 81% of women rated their hospital care during pregnancy as excellent, very good or good, with 18% rating it as fair or poor
- 85% of women rated their hospital care during labour and birth as excellent, very good or good, with 14% rating it as fair or poor
- 67% of women rated their hospital care after the birth as excellent, very good or good with 29% rating it as fair or poor.
- 44% of women attended antenatal classes provided by the NHS
- 76% of mothers were given a choice of where to have their baby at the start of their pregnancy
- 67% had a vaginal birth and 32% or respondents had their baby by caesarean section
- 35% of women were left alone by midwives or doctors at a time when it worried them
- 87% of respondents had given birth previously

The survey also noted that the Trust

- has improved significantly on 13 questions

- has worsened significantly on no questions

- was significantly better then the 'Picker Average' on 2 questions

- was significantly better than previous survey but worse then picker average on questions

- There were no questions where performance was both below average and had worsened since the last survey

- Compared to the 2007 maternity survey, the Trust has improved significantly on number of questions

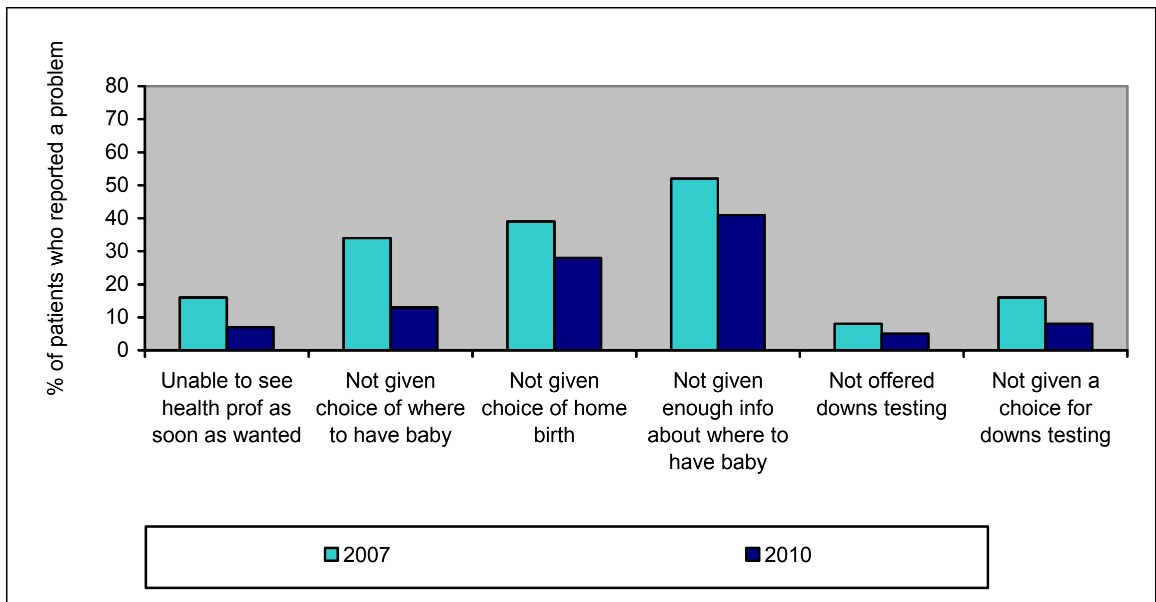
**4. Historical comparisons**

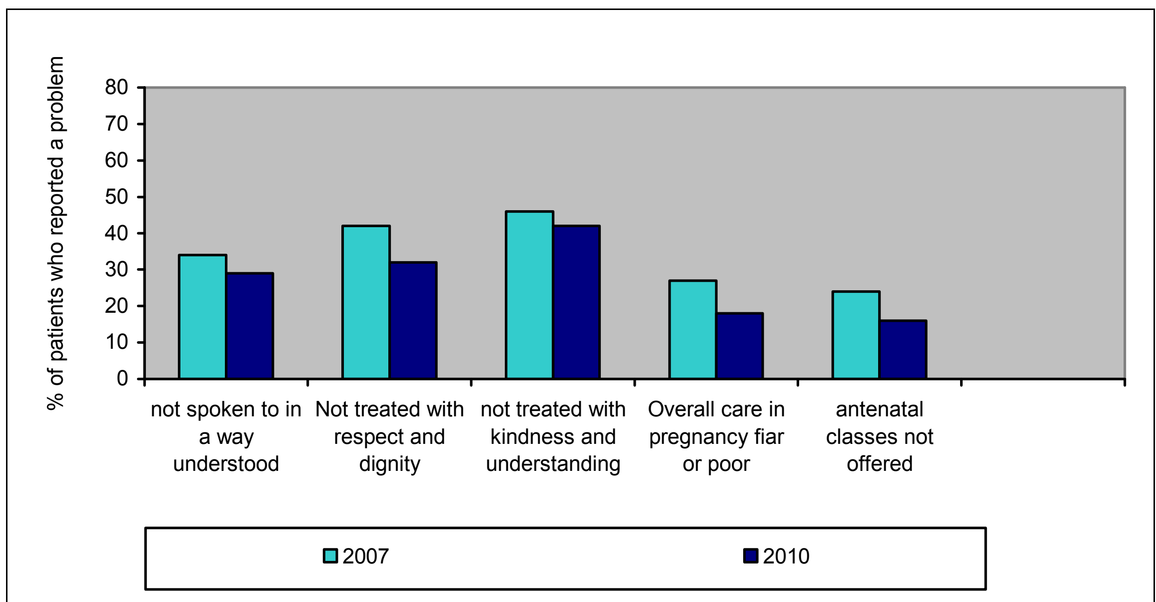
Understanding the results

The Picker Institute presents the survey results in the form of **problem scores.** The problem score shows the percentage of maternity patients for each question who, by their response, have indicated that this particular aspect of their care could have been improved. The following should be kept in mind when looking at the results:

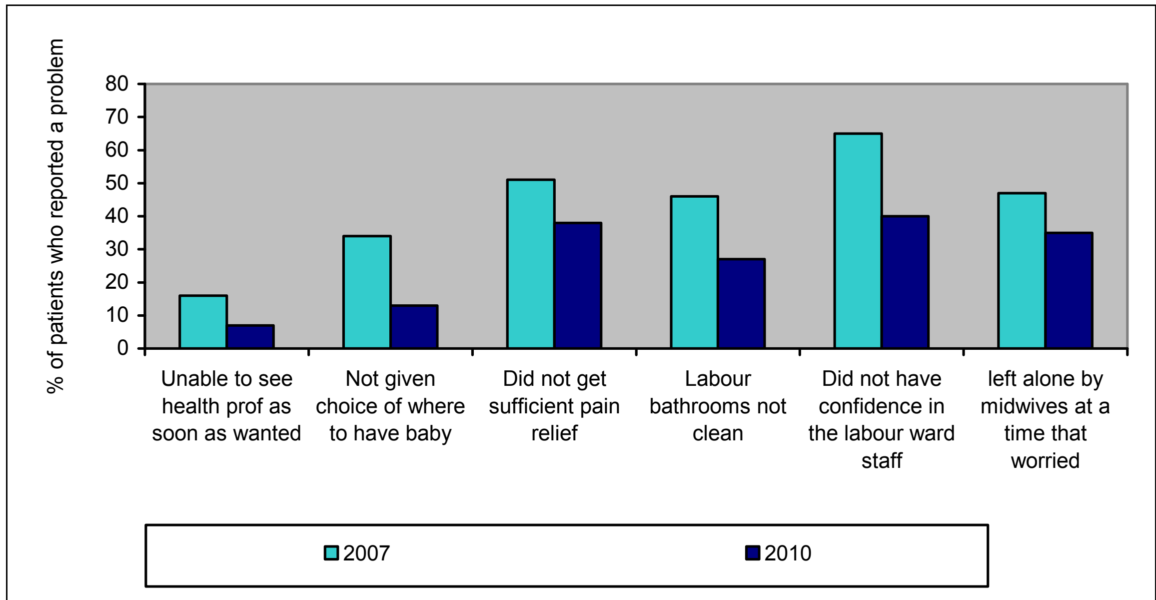
- Lower problem scores are better
- Problem scores are a simple summary measure used for comparison and for helping to focus on areas for quality improvement

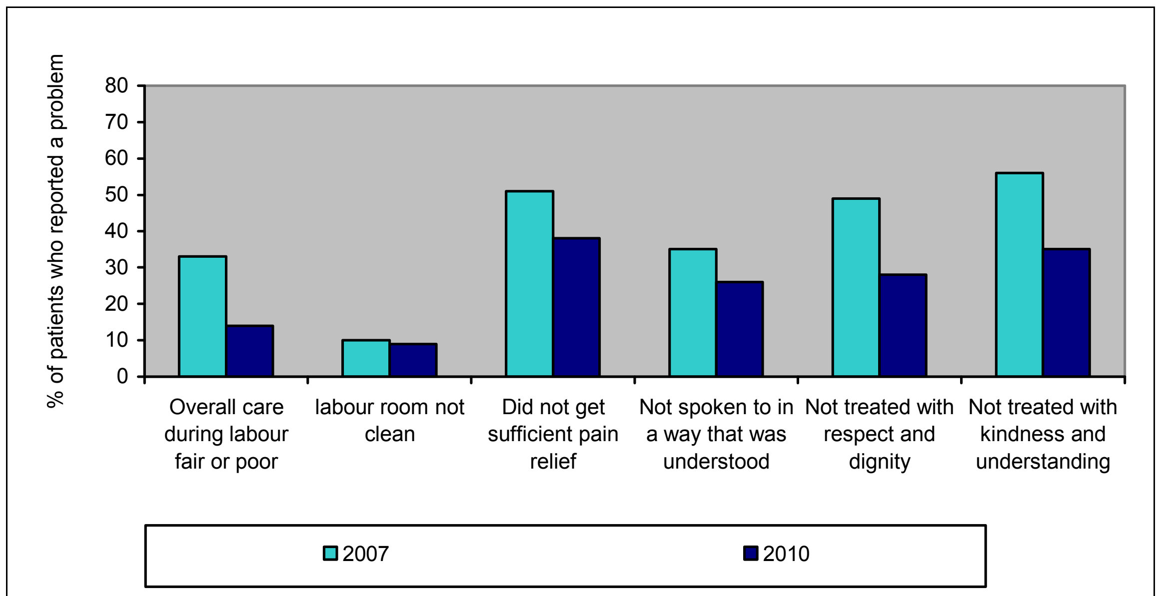
## Antenatal care



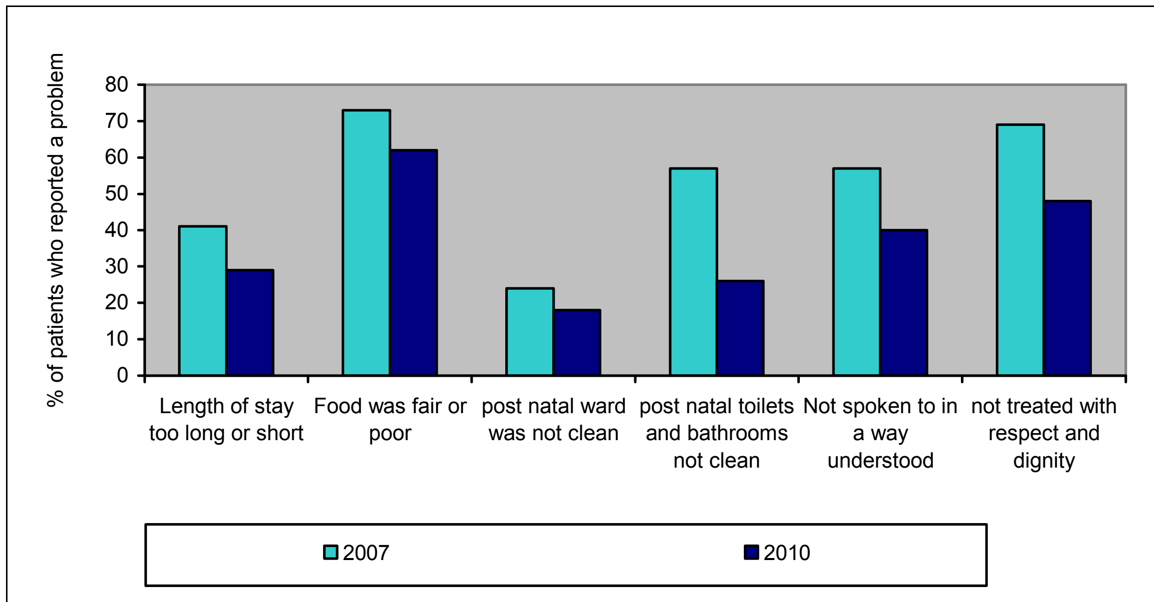



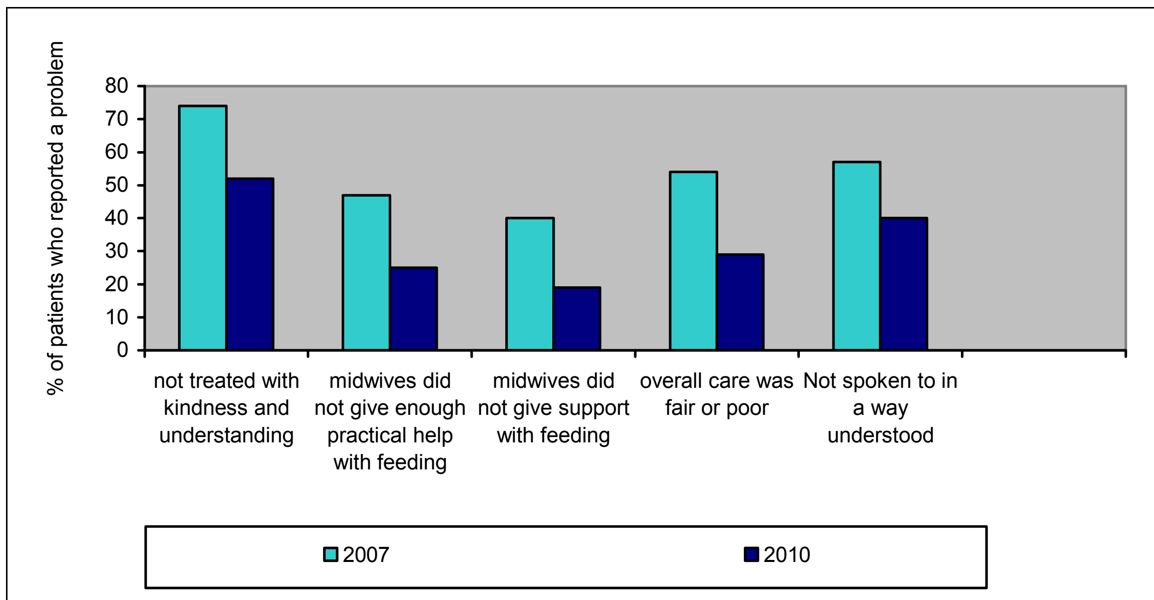
## Labour care



**Care in hospital after the birth**




## 5. Areas where women reported the most problems for our Trust

The survey has been analysed to assess areas where women reported the most problems for the Trust compared to the Picker average of the Trusts who took part in the survey.. These were mostly related to parts of the service during the postnatal period either at hospital or at home. They have been themed under the heading of antenatal or postnatal care:

| | Average Trust | Picker |
|---|---|---|
| Antenatal - Not given a choice where to have check ups | 71% | 73% |
| Antenatal – Did not see the same midwife every time | 55% | 44% |
| Antenatal – not given information about NHS choices website | 64% | 59% |
| Postnatal – Did not receive help/advice about the baby crying | 67% | 57% |
| Postnatal – Did not receive enough advice about baby skincare | 66% | 52% |
| Postnatal – not given enough information | 65% | 45% |
| Postnatal – Not always a member of staff to help | 62% | 49% |
| Postnatal – Postnatal hospital food was poor | 62% | 49% |
| Postnatal – Did not receive enough advice about baby sleeping | 61% | 40% |
| Postnatal – Not given enough information about emotions | 59% | 54% |
| Postnatal – Not given enough information about baby health | 54% | 42% |
| Postnatal – Not treated with kindness and understanding | 52% | 33% |
| Postnatal – infant feeding not fully discussed during pregnancy | 52% | 45% |
| Postnatal – saw a midwife to frequent/too seldom | 50% | 26% |
| | | |

## 6. Priorities for improvement

The Picker Institute have recommended that maternity units have three main actions for development following the survey. Based on this the maternity unit have agreed the following action plan to have the highest impact for improvement and change across the maternity care package.

**Antenatal Birth and Expectation preparation**

- All women will be offered an appointment at home between 30-34 weeks gestation to go through the birth plan and discuss all options for labour choices.
- The meeting will individually discuss preparation for normal birth (where applicable) and management of early labour at home.

**Early labour management and assessments**

- An early labour lounge will be developed to offer open access to women requiring extra support or assessment during the passive stage of labour (prior to 4cms). This area will offer alternative therapies for pain relief, relaxation areas. Midwives will all be updated in early labour care, alternative therapies and normalising birth.
- Talbot ward will be re-developed to triage women appropriately who do not

require admission. FMAU will take all non-labour assessments during daytime hours (Mon-Fri) – the new unit will increase these hours to 12 per day.

**Post natal care and discharge home meeting**

- Prior to leaving the maternity unit all women will be have a 1:1 meeting with a senior midwife. The postnatal care plan/check list will be completed and all aspects of questions regarding baby care, baby crying, expectations for baby health will be covered and signed as complete by midwife and mother. Maternal emotions will be discussed and normal recovery for childbirth.
- All women who are breast feeding their baby will have breast feeding support from individual midwives and breast feeding support worker team (hospital and community). Contact numbers for support will be given to all women and signed as completed prior to discharge home.
- All new first time mothers will be offered the opportunity to watch practical demonstration of baby bathing etc New ways of offering teaching are also being reviewed by the parent education team

An action plan will be developed and progress will be assessed as achieved through the maternity audit programme for 2011.

Other areas where specific actions will be monitored are:

**Food and food service**

- The snack service will be reviewed for post natal women. Options for advertising the service to women will be considered
- To monitor trends through real time feedback, internal bedside surveys, complaints and PALS

**Cleanliness of the environment**

- Working in partnership with CHL, the Trust has implemented an agreed version of the 2007 national cleaning standards across the Trust from 26th of July 2010. All current cleaning schedules displayed on the wards and departments will be updated to reflect what services are being provided. This will be included in the auditing process both with CHL and the Trust performance team.
- Cleaning audit results are part of the monthly contractual meetings where actions to maintain standards, prevent failures and improve, will be agreed.
- On-going monitoring of cleaning standards and audit results are displayed for women in all ward areas.
- Monitor trends from patient perspective though real time feedback, internal surveys, complaints and comments

**Improving trust and confidence in nurses**

- CQUIN target monitored by the specific question in real time feedback,

internal bedside survey, complaints and PALS.

- The work of East London Partnership for Compassionate Care will focus on addressing the needs of staff and patients in order that care is provided with compassion. Talbot ward is one of the pilot sites for this project.

## 7. RECOMMENDATIONS

The Health Scrutiny panel is asked to

- Note the results of the Maternity Picker Survey and the improvements achieved from 2007 – 2010 survey results.
- Approve the priorities for improvement and the monitoring structure
- Advise on any additional work that may enhance the patient experience

**Sandra Reading**
**Head of Maternity**

**Kay Riley**
**Chief Nurse** **10th January**
**2011**

**APPENDIX 1**

**Reporting and Monitoring Structure**

Trust Board – Executive team

- Agrees patient experience standards
- Reviews summaries of national patient surveys and external benchmarks
- Quarterly headline reports from complaints, PALS and real-time feedback trends
- Receives reports on improvement plans and initiatives
- Agrees publication strategies
- Board 'Listening Events'

Divisional/CAU Boards

- Identify women's experience and involvement leads for audit against objectives
- Reviews monthly trends and issues and monitors against set standards reporting though performance dashboards
- Reviews action plans and outcomes
- Provides progress/exception reports to board sub-committee

Maternity Experience/User Group

- Interprets, analyses and monitors women's experience through annual PCT survey / Quarterly Birth reflections survey and feedback.
- Monitors the agreed action plan and enhanced action plan based on Picker report.
- Facilitate and develop additional user involvement activity
- Provides progress and overview reports to the Maternity Strategic Board and CAU
- Provide external reports
- Builds and maintains good relationships with external involvement groups and organisations, communicating feedback, facilitating responses and actions in response.

Wards and departments

- Identify local quality improvement measures and agrees strategy for involvement with compassionate care project.
- Display feedback reports and include data on ward dashboards
- Report trends to CAU
- Implement changes based on patient feedback
- Evaluate impact of changes
- Communicate actions taken in response to feedback, to patients and others
- Share work and successes through dashboards and feedback boards

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **25 January 2011** | **Unrestricted** | | **4.4** |

| **Report of:** | **Title:** |
|---|---|
| London Borough of Tower Hamlets<br><br>NHS Tower Hamlets | Joint report on the Public Health White Paper |
| **Presenting Officers:** | **Ward(s) affected:** |
| Deborah Cohen – Service Head Commissioning and Strategy, London Borough of Tower Hamlets<br><br>Dr Somen Banerjee - Director of public health for NHS Tower Hamlets (interim): | All |

## 1. Summary

This paper sets out the key elements of the Public Health White Paper and outlines plans for local implementation.

## 2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the information set out in the presentation and the briefing paper.

# 'Healthy Lives, Healthy People' - What are the key issues?

## 1. Purpose

The purpose of this paper is to summarise the key elements of the public health white paper and outline plans for local implementation.

## 2. Background

'Health Lives, Healthy People: Our strategy for public health in England' was published at the end of November 2010. Its purpose is to set out the principles and framework for developing a public system that effectively addresses the public health challenges currently faced by the nation. The white paper sets out to:

- Assess current public health challenges
- Critique the current approach to improving population health
- Set out principles and values underpinning a new approach
- Identify priorities for intervention
- Outline a new structure for public health delivery
- Set out a timeline for transition to the new structure

These steps are set out below.

## 3. An assessment of public health challenges in England

In order to inform the approach and priorities of the White Paper, the Government conducted a review of health trends in England and published these in a document that accompanied the White Paper ('Our Health and Wellbeing Today'). The findings highlighted the following public health challenges that the White Paper seeks to address:

- The growing burden of ill health as life expectancy increases
  - 79% of the burden of ill health is accounted for by muscular, circulatory and mental health conditions
  - Healthy life expectancy is rising at a slower rate than life expectancy indicating that people are living longer in poorer health
  - Increasing numbers living with multiple chronic conditions

- The impact of lifestyle on prevalence of major chronic disease
  - Increasing obesity will drive a continued increase in diabetes
  - Rising levels of harmful alcohol use are driving a rise in chronic liver disease

- Poor mental health as a significant contributor to the burden of ill health
  - Estimates range from 9% to 23%
  - 1 in 5 of adults experience mental ill health at any one time
  - Substance misuse and mental health problems frequently coexist

- The social cost of substance misuse
    - Drunkenness is associated with almost half of assaults and 1 in 4 incidents of domestic violence
    - Drug associated crime has an estimated societal cost of £13.9bn a year

- The threats to health from environmental factors and infectious diseases
    - The quality of the physical and social environment have an important influence on health and wellbeing of the local population
    - Climate change is likely to pose challenges in terms of long term health services planning and emergency preparedness.
    - Rising trends of TB and sexually transmitted infections are currently of concern

- The importance of mental wellbeing for both mental and physical health
    - Rates of wellbeing can vary widely between localities and measures are being developed nationally to understand these variations better
    - Strong social networks and high levels of social capital are recognised as important factors for health and wellbeing

- The persistence of health inequalities despite improvements in life expectancy
    - The gap in life expectancy between richest and poorest neighbourhoods in England is 7 years and the gap in disability free life expectancy is 17 years
    - There are measurable variations at small area level in health outcomes these are related to deprivation

- The importance of getting early years right and understanding public health challenges at different stages in people's lives
    - As set out in the Marmot review, positive and negative experiences accumulate over life to affect health outcomes and at population level differences in these experiences linked to deprivation underpin health inequalities
    - From a policy perspective, this means focussing on the key stages in life that affect people's future health trajectory (preschool, school, employment/training, family-building and retirement)

## 4. A critique of current approaches to addressing these challenges

The White Paper set out the Government's assessment of existing approaches to addressing the challenges set out in the previous section and concluded the following:

- The current approach and system is 'not up to the task of seizing these huge opportunities for better health and reduced inequalities in health'
- The role of central government needs to be reframed as 'top-down initiatives and lectures from central government about the 'risks' are not the answer
- Public health budgets have 'too often been raided at times of pressure in acute NHS services and short-term crises'

- Public health professionals 'have been disempowered and their skills not sufficiently valued when compared to counterparts in NHS acute services'
- The current system for health protection is fragmented and 'the system lacks integration and is over-reliant on good will to make it work'
- Arguments about when it is appropriate for government to intervene in people's health have become oversimplified and neglect the range of approaches possible

## 5. Principles and values underpinning a new approach

The White Paper seeks to address this critique by a 'radical new approach' that will 'reach across and reach out'

- Fundamental to this approach is getting 'to the root causes of people's circumstances' and integrating mental and physical health
- This means recognising that wider determinants of health - such as education, employment and the environment - need to be addressed to tackle health inequalities
- Responsibility to address these issues 'needs to be shared across society - between individuals, families, communities, local government, business, the NHS, voluntary and community organisations, the wider public sector and central government'.
- Whilst the NHS continues to have a crucial role, the White Paper recognises that local government 'is best placed to influence many of the wider factors' affecting health and wellbeing and this provides a rationale for positioning public health in the local authority

Characteristics of the system that will deliver this change are set out as follows:

Responsive

- Local government and local communities will be freed up to decided how best to improve health and wellbeing with local partner (through new freedoms and funding for public health in local government)
- This will be within a context of a public health outcomes framework and a 'health premium' incentivising local government and communities to improve health and reduce health inequalities

Resourced

- Public health funds will be ring-fenced from within the overall NHS budget to ensure that it is prioritised
- These funds will be allocated to local authorities for public health

Rigorous

- Public Health England will be established as a 'uniting force for the wider family of professional who also spend time on improving people's lives and tackling inequalities'
- This will be a vehicle for the development and application of an evidence base of 'what works' and for driving a culture of innovation and evaluation

Resilient

- A strong, integrated system of health protection will be developed with ‘clear line of sight from the top of government to the frontline’
- Functions of the Secretary of State for Health will be enhanced with clear lines of accountability

The conditions for government intervention are an important theme within the White Paper and these are informed by ‘core values’ around balancing freedoms of individuals and organisations with the need to avoid harm to others:

- The ‘ladder’ of interventions developed by the Nuffield Council of Bioethics is set out as a potential framework for thinking through how to intervene and to what extent
- This sets out eight potential levels of intervention ranging from doing nothing or just providing information to eliminating choice through legislation (see page 30)
- Behavioural science techniques are seen as a way of minimising the need to ban or significantly restrict choice through approaches ‘nudging people in the right direction’
- The Public Health Responsibility Deal reflects this approach through proposals to establish voluntary agreements with business and other partners around food, alcohol, physical activity, health at work and behaviour change

## 5. Priorities for intervention

The White Paper sets out priorities for action based on local empowerment of government and communities and a life-course framework for intervention, reflecting its analysis of public health challenges and the principles set out above,

The fundamental approach is to address wider factors that affect people at different stages and key transition points in their lives and reflecting the principle of ‘proportionate universalism’ as set out in the Marmot Review - ‘by which the scale and intensity of action is proportionate to the level of disadvantage’

Priorities, interventions and commitments are set out within a life course framework as follows.

Starting well

- This refers to early intervention and prevention as a key priority through strong universal public health and early education with an increased focus on disadvantaged families (reflecting the principle of ‘proportionate universalism’)
- Specific commitments include increased investment in health visitors (leading and delivering on the Healthy Child programme), doubling the capacity of the Family Nurse Partnership programme and continuing to tackle child poverty (strategy due in spring 2011)

Developing well

- Schools are identified as a major focus for promoting better health outcomes for children and the shift of power from central government to schools and local communities is seen as an opportunity to drive this

- The Director of Public Health is seen as having a lead role in determining local strategies for improving child health and wellbeing and bringing together partners including local authority children's services colleagues, schools and others
- The period in which young people move from teenage years and make the transition into adulthood is seen as a priority for investment in interventions to reduce susceptibility to harmful influences in areas such as sexual health, teenage pregnancy, drugs and alcohol
- A range of priorities to promote healthy lifestyles in children and young people are set out including
  - Schools based mental health programmes
  - Broadening Change4Life across a wider range of childhood issues
  - Maintaining the requirement to provide physical education in maintained schools
  - Increasing the take up of competitive sports
  - Continuing the Healthy Child Programme and the National Child Measurement Programme
  - Developing a new vision for school nurses reflecting their public health role
  - Promoting mental health resilience in children and adolescents with mental health problems
  - Examining legislation on plain packaging of tobacco products
  - To support the transition from school to further education or work, 75,000 more apprenticeship places are planned by 2014/5 and the National Citizen Service will be piloted in 2011

Living Well

- This sets out general proposals around supporting healthy lifestyles and reflects the perception of the ineffectiveness of central government 'lecturing people how to live well' and the need for local solutions
- The Public Health Responsibility Deal referred to in the previous section is a key component of the approach and in early 2011 is expected to deliver agreements with business and other partners on salt reduction, better information for consumers on food, socially responsible retailing and consumption of alcohol
- A range of initiatives of are set out led by a number of government departments
  - Provision of evidence on making regular physical activity and healthy food choices easier drawing on evidence from 'Healthy Towns' as well as sustainable travel and cycle towns
  - Support for local sustainable transport through a £560m Local Sustainable Transport Fund
  - £100m Mass Participation and Community Sport Legacy Programme
  - Support from the Department of Communities and Local Government on streamlining planning policy
  - Development of a new designation to protect green areas of importance to local communities and community ownership of green spaces
  - Publication of information on local air quality and noise levels to enable local government and communities to act
  - Overhaul of the Licensing Act to increase local powers to remove licenses from clubs, bars or pubs causing problems

- Expanding range of settings for NHS Health Checks to include pharmacy, community and workplace settings
- Strengthening work with the pharmaceutical industry and community pharmacists to promote smoking cessation
- Alignment of funding streams on drug and alcohol treatment services across the community and in criminal justice settings to divert people from the criminal justice system to heath services
- Development of a cross government drug strategy and a local role for public health professionals in implementation
- Development of an integrated model of service delivery for sexual health services including linking services with broader risk taking behaviour (e.g. alcohol)
- Development of a social marketing strategy based on life stages and using emerging ideas from behavioural science
- Setting out a public health role in tackling violence and abuse

Working Well

- This recognises the health benefits of secure employment, the importance of safeguarding health at work and also using the workplace setting as an opportunity to improve health
- Measures to increase employment combine job creation programmes with reforms to the benefit system
- Work with the Faculty of Occupational Medicine seeks to develop an accreditation process for new occupational health standards and to expand the role of occupational health professional to prioritise preventive initiatives
- The Public Health Responsibility Deal is seen as a vehicle for developing a partnership with employers to improve health at work
- There is pledge in the NHS Constitution to provide support and opportunities for staff to maintain their health, wellbeing and safety

Ageing Well

- Public health is seen as having a major leadership role in promoting active ageing recognising that 'key moments such as retirement or bereavement' are not inevitably part of ageing
- Public health will have key role in integrating with 'areas such as social care, transport, leisure, planning and housing, keeping people connected, active, independent and in their own homes'
- The importance of integrated working between NHS and local government is emphasised in delivery of programmes to promote active ageing and enabling people to live independently e.g. re-ablement, falls prevention and support for carers
- It is envisaged that Directors of Public Health and Directors of Adult Social Services will work together to commission services for older people and those who care for them
- Phasing out of the default retirement age is a commitment along with maintenance of the state pension

## 6. A new system for public health delivery

In order to deliver on the priorities outlined in the previous section, the White Paper sets out a radical restructure of the public health system in England. The two major developments are the transfer of local health improvement functions to local government and the establishment of Public Health England.

Local Government role

- **'Local leadership will be at the heart of the new public health system with new ring-fenced budgets, enhanced freedoms and responsibilities for local government to improve the health and wellbeing of their population and reduce inequalities'**
- From 1 April 2013 it is proposed that upper tier and unitary local authorities will have a duty to improve the health and wellbeing of their population
- The Government will requires Directors of Public Health to be employed in upper-tier councils and unitary authorities to lead local public health efforts (the role can be shared with other local councils if agreed locally)
- Health and Wellbeing Boards will bring together key NHS, public health and social care leaders in each local authority to work in partnership to establish a shared local view on the needs of the local community and support joint commissioning of NHS, social care and public health services
- The proposed minimum membership would be elected representatives, GP consortia, Director of Public Health, Directors of Adult Social services, Directors of Children's Services, local Health Watch and, where appropriate, participation of the NHS Commissioning Board
- The White Paper emphasises the critical role of local government in ensuring the coherence and integration of commissioning strategies across the NHS, social care, public health and other local partners.
- To support this it is envisaged that health and wellbeing boards would develop joint health and wellbeing strategies based on the assessment of need outline in the Joint Strategic Need Assessment
- There will be sufficient flexibility within the legislative framework for health and wellbeing boards to go beyond their minimum statutory duties and this opens the potential to join up a broad range of local services to meet local need more effectively and efficiently

Director of Public Health role

- The Director of Public Health will be employed by local government and jointly appointed by the local authority and Public Health England
- They will be strategic leaders for public heath in local communities with professional accountability to the Chief Medical Officer and part of the Public Health England professional network
- Directors of Public Health will be responsible for the health improvement functions of upper-tier and unitary authorities and will be required to prepare an annual report on the population's health. They will need to be supported by a team with specific public health and commissioning expertise

- In order to discharge these responsibilities they will need to promote health and wellbeing within local government, advise and support GP consortia on population aspects of NHS services and work with Public Health England health protection units

Public Health England

- Public Health England will be a new, dedicated and professional public health service within the Department of Health with an overarching remit to unite the public health community
- Its roles will include provision of public advice to the Secretary of State and wider system, delivery of effective health protection services, commissioning of national level interventions (including from the NHS), allocation of funding to local government, appointment of directors of public health and promoting public health research. It will fund those services that contribute to health and wellbeing primarily by prevention rather than treatment aimed at cure
- It is proposed that Public Health England should be responsible for funding and ensuring the provision of services such as health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion and some elements of the GP contract (e.g. immunisation and contraception)
- It will include the current functions of the Health Protection Agency and the National Treatment Agency (which will become functions of the Secretary State for Health)
- The budget for the new public health system will be ring fenced within the overall NHS budget and it is estimated that the current spend on areas likely to be the responsibility of Public Health England could be over £4b.
- This will be allocated across three funding routes
    - The public health ring-fenced budget to local government
    - Asking the NHS Commissioning Board to commission services e.g. screening service and elements of the GP contract
    - Commissioning or providing services directly e.g. vaccines, national communication strategies or health protection functions (currently provided by the Health Protection Agency)
- Health visiting, school nursing and the child health protection services that they lead will be funded from the Public Health England budget with the NHS Commissioning Board leading the commissioning of health visiting services on behalf of Public Health England

Local Public Health Budget

- Public Health England will allocate ring fenced budgets, weighted for inequalities to upper tier and unitary authorities which will fund both improving population health and wellbeing and some non discretionary services (e.g. open access sexual health services and certain immunisations)
- The new health premium will seek to incentivise action to reduce health inequalities by providing local authorities with an incentive payment based on progress in improving local population health
- Disadvantaged areas will receive a greater premium if they make progress in recognition of their greater challenge

- ‘Shadow’ allocations will be made to local authorities for each local areas for the budget in 2012/13 to enable planning before allocations are introduced in 2013/4

The new Public Health System and the NHS

- The NHS has a crucial role in public health in relation so promotion of health, preventing avoidable illness and emergency preparedness
- There will therefore need to be close partnership working at national level between Public Health England and the NHS Commissioning Board and at the local level between local government, Directors of Public Health and GP consortia.
- The NHS role in public health will be embedded in the mandate that the Secretary of State sets for the NHS Commissioning Board.
- The public health role of GPs will be strengthened through the role of GP consortia in maximising their impact on improving health and reducing health inequalities, the further development of prevention-related measures in the QOF
- It is proposed that 15% of current value of QOF should be devoted to evidence based public health and primary prevention indicators from 2013 (funded from the Public Health England budget)
- Public Health England is expected to influence the development of the community pharmacy contractual framework and primary care dentistry contracts through the NHS Contracting Board

## 7. Next Steps

Substantial work is needed over the next two to three years at both national and local level to manage transition in the context of significant restructure in other parts of health and care sector (e.g. the development of GP consortia and the abolition of SHAs and PCTs)

Department of Health timescales are as follows:

- From December 2010 to March 2011, consultation on three documents
  - ‘Healthy Lives, Healthy People"
  - The public health outcomes framework
  - The funding and commissioning of public health
- During 2011
  - Shadow-form Public Health England set up in DH
  - Working arrangement with local authorities begin to be set up with matching up of PCT Directors of Public Health to local authority areas
- April 2012
  - Public Health England to take on full responsibilities (including functions of HPA and NTA)
  - Shadow public health ring-fenced allocations to local authorities published
- April 2013
  - Ring fenced allocations and transfer of local health improvement functions granted to local authorities

The process of transition locally is at an early stage

- Co-Directors of Public Health are working with the Director of Adult Health and Wellbeing in Tower Hamlets Council on developing a local transition plan

- At sector level, the Directors of Adult Social Services in the City and Hackney, Tower Hamlets and Newham are in discussion with locality Directors of Public Health and the Sector Director of Public Health to align approaches to transition
- A stakeholder workshop is planned in February across the sector to introduce key partners, including Councillors, GP representatives and others, to the White Paper and to explore its implications locally

## Conclusions

'Healthy Lives, Healthy People' sets out a step change in how public health is delivered in England. The continuity with Marmot's framework, the focus on health inequalities, the commitment to the principle of 'proportionate universalism', the development of Health and Wellbeing Boards (and restatement of the central role of JSNA) and the proposal for a public health outcomes framework are all welcomed. The positioning of public health in the local authority provides new opportunities to address wider determinants of health and integrate health improvement across a broader range of services. However, it will be critical to ensure that in the context of simultaneous restructure of the NHS, economic recession and public sector spending cuts, the fundamental principle of NHS and local authority partners working together to promote health and wellbeing and reduce health inequalities based on a rich insight into the needs of the local population is sustained and strengthened.

This page is intentionally left blank

# Healthy Lives, Healthy People
# What are the key issues?

Somen Banerjee and
Esther Trenchard-Mabere
Co-Directors of Public Health

## Healthy Lives, Healthy People:

- Our strategy for public health in England (30 November 2010)
- Transparency in Outcomes: Proposals for a Public Health Outcomes Framework (20 December 2010)
- Consultation on the funding and commissioning routes for public health (21 December 2010)

# The White Paper sets out to:

- Assess current public health challenges
- Critique the current approach to improving population health
- Set out principles and values underpinning a new approach
- Identify priorities for intervention
- Outline a new structure for public health delivery
- Set out a timeline for transition to the new structure

# “Radical new approach”

- Responsive
  - Owned by communities and shaped by their needs
  - Decreased top down control from Whitehall, increased responsibilities to local authorities
- Resourced
  - Ring-fenced funding with incentives to improve
  - But will face same running cost reductions and efficiency gains as rest of NHS
- Rigorous
  - Professionally-led and focused on evidence
  - Led by Public Health England
- Resilient
  - Strengthening protection against current and future threats to health
  - Led by Public Health England

# Key proposed changes*

- Establishment of Public Health England (PHE) with national responsibility for health protection, research and evidence and commissioning
- Transfer of health improvement and other public health responsibilities to local authorities with a new statutory duty to improve the health of their population
- DsPH to be employed by LAs and lead at a local level but will be jointly appointed by PHE
- Establishment of statutory Health & Wellbeing Boards

*Subject to Parliamentary approval of legislation

# Public health outcomes framework

**Domain 1** **Health protection and resilience**
protecting people from major health emergencies and serious harm to health

**Domain 2** **Tackling the wider determinant of ill health**
addressing factors that affect health and wellbeing

**Domain 3** **Health improvement**
positively promoting the adoption of ‘healthy lifestyles’

**Domain 4** **Prevention of ill health**
reducing the number of people living with preventable ill health

**Domain 5** **Healthy life expectancy and preventable mortality**
preventing people from dying prematurely

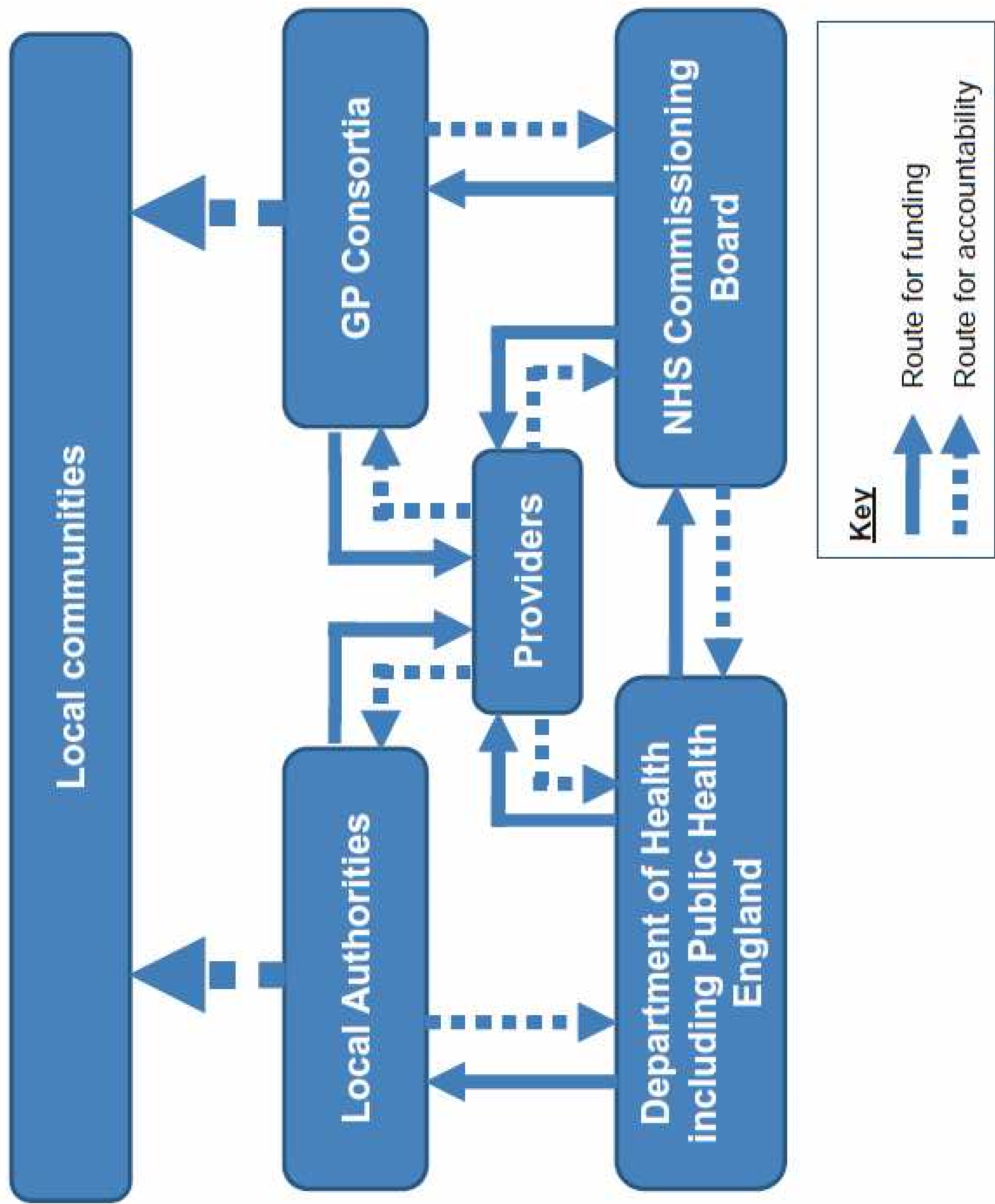
- Focus on addressing health inequalities across the domains, with ‘health premium to incentivise improvement
- Important overlaps with NHS and Adult Social Care outcomes framework

# Public health funding

Public Health England will fund public health activity through three principle routes:

1. Allocating funding to LAs
2. Commissioning services via the NHS Commissioning Board
3. Commissioning or providing services itself

Figure 4.1: Funding and accountability through the public health system



# Health and Wellbeing Boards

- Bring together local elected representatives and commissioners (GP consortia, DsPH, adult social care and children’s services)
- Share local views about community needs (including ‘HealthWatch’)
- Support joint commissioning of NHS, social care and public health services
- LAs and GP consortia will prepare the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy, led by DPH

# Summary timetable*

| Activity | Date |
| --- | --- |
| Consultation | Dec 2010-March 2011 |
| Set up shadow Public Health England<br>Start to set up working arrangements with local authorities | During 2011 |
| Develop public health workforce strategy | Autumn 2011 |
| Public Health England will take on full responsibilities<br>Publish shadow public health ring-fenced allocation to LAs | April 2012 |
| Grant ring-fenced allocations to LAs | April 2013 |

*Subject to Parliamentary approval of legislation

# Local Plans

- Co-Directors of Public Health are working with the Director of Adult Health and Wellbeing in Tower Hamlets Council on developing a local transition plan
- At sector level, the Directors of Adult Social Services in the City and Hackney, Tower Hamlets and Newham are in discussion with locality Directors of Public Health and the Sector Director of Public Health to align approaches to transition
- A sector stakeholder workshop is planned for 9th March to introduce key partners, including Councillors, GP representatives and others, to the White Paper and to explore its implications locally

This page is intentionally left blank

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **25 January 2011** | **Unrestricted** | | **4.5** |
| **Report of:**<br><br>London Borough of Tower Hamlets<br><br>**Presenting Officers:**<br><br>Deborah Cohen – Service Head Commissioning and Strategy, London Borough of Tower Hamlets | | **Title:**<br><br>Transforming Adult Social Care and Personalisation<br><br>**Ward(s) affected:**<br><br>All | | |

**1. Summary**

This paper sets out the work that is currently underway to implement the Transformation of Adult Social Care which provides the overall future direction for Adult Social Care in Tower Hamlets. The Transforming Adult Social Care Programme is the Tower Hamlets response to the national *Putting People First (PPF)* initiative.

**2. Recommendations**

The Health Scrutiny Panel is asked to consider and comment on the information set out in the paper.

## Transforming Adult Social Care and Personalisation

**Introduction**
This report advises Health Scrutiny of the programme of work that is currently underway to implement the Transformation of Adult Social Care which provides the overall future direction for Adult Social Care in Tower Hamlets. This means maximising choice for people with support needs whilst shifting our focus to prevention and early intervention, minimising where possible the need for long term support.

**Putting People First and Personalisation**
The Transforming Adult Social Care Programme is the Tower Hamlets response to the national *Putting People First (PPF)* initiative. This is a cross government concordat launched in December 2007 that set the direction for adult social care over the next ten years. It required the most radical changes to social care since the establishment of the modern welfare state. Traditionally the support provided to people with disabilities and older people through social services nationally has been service led, rather than person centred. The Putting People First Concordat seeks to change this. The origins of this lies within campaigns over many years by the Disability Rights movement and the underlying ethos is that support is a “right” or an “entitlement” that should be under the control of the service user.

The process of change is often referred to as the “personalisation” of adult social services. It is about being led by the needs and aspirations of each individual service user/customer and not shoe-horning service users into existing services regardless of whether these services really are what they want. This means that service users individually and collectively many no longer wish to use existing services and may wish for other services that may not up to now been offered as options.

To achieve this requires a transformational programme of change that impacts on residents of Tower Hamlets, staff, and providers of Adult Social Services. This is considered in more detail below.

**Transforming Adult Social Care Programme (TASC): Stage 1**
The Transforming Adult Social Care (TASC) Programme involves system-wide change to work differently to deliver social care, and wider public support, for vulnerable people in Tower Hamlets. We have thought about this as devising a new “customer journey” which is the term we are using to describe the “pathway” through services from referral through to support/care plan that service users undergo.

The TASC vision for Tower Hamlets is:

*“To shift from a service based approach in the kinds of support people use now towards support that is personalised and community based so that by 2011 everybody will be given the opportunity to meet their needs in a way that is personalised and effective for them.”*

To achieve this vision presents significant change to the people that use our services, our staff, the council itself, our partners and providers.

The Council’s Transforming Adult Social Care Programme seeks to offer greater choice, independence and control to our residents in need of social care information or support. We aim to enable residents to become more independent and make better use of the resources in the community as well as the council's resources. This includes:

a) providing universal services (services that anyone in the community can access) from a range of organisations including: the Local Authority, Primary Care and other public, voluntary and private agencies;
b) focusing on early intervention and prevention to increase independence - such as reablement services;
c) increasing choice and control by enabling and supporting customers eligible for social services support to participate fully in their own assessment and support planning to identify outcomes which are important to their physical and mental well-being;
d) encourage social capital by supporting and stimulating social networks and community-based support groups

**Stage 2 in the Transformation of the Customer Journey**
The Directorate’s work has focussed to date on developing the structures and policies to put in place a new customer journey for social care whereby people are supported to become more adept at self-assessing and self-managing their support.

The Directorate Management Team came together on 10th January 2011 to review progress on the Transformation Programme and to agree the next step by which we can step up the volume of customers (service users) receiving personal budgets.

This next stage focuses on ensuring that as many service users have a personal budget, which means that their choice of supports and services will not be constrained by a menu of pre-purchased services. The only constraints will be that the choice must be lawful and not the formal responsibility of another agency. To get to a personal budget, an individual will be assessed and based on that assessment will be given an indicative budget that people can use as a guide to plan their support to meet their eligible needs – this is called a support plan. After the Support Plan is agreed then the Personal Budget is allocated and confirmed. This is significantly different from the experience of customers currently which involves assessment and care planning led by social workers.

In terms of the structure of the organisation, this next stage sees a move away from "care groups" and instead the current older peoples, physical disabilities and vulnerable adults teams along with the occupational therapy service come together to form a new single adults' service. The new adults' service will be staffed by Social workers, Occupational Therapists and other social care "officers". Teams will reflect the customer pathway or customer journey as follows:

- **First Response and Hospital Service** will have responsibility for receiving all new referrals and enquiries and also to respond to enquiries regarding people that already have support in place but do not currently have an active involvement. It is expected that the First Response Service will resolve 80% of contacts without referring on to other services. It is also expected that the majority of episodes will be concluded within five days. This Service will be a multi-disciplinary team consisting of OT's and Social Workers.

- **Reablement Service** will have responsibility for working with people to maximise their independence. The Service will set goals in the form of an independence plan and will work with people to deliver the elements of the identified outcomes. The Reablement Service will need to link with services outside of AHWB, to ensure that there is a holistic approach to maximising independence. It is expected that the Reablement Service will complete most episodes within 6 weeks and will be involved in determining the appropriate resource allocation, for people eligible for ongoing support.

- **Longer term Support** will work with people to explore choices available to them for how their eligible needs can be supported. The Longer Term Support Service will have a responsibility to ensure that the support people receive is personalised. The Longer Term Support Service will be focussed on delivering personal budgets to all people eligible for support and on maximising the number of people that receive their Personal Budgets as a cash payment.

From June 2011 the above teams should be in place.

In addition to the work we are doing to develop the new adults service we will also be working with both learning disabilities and mental health services, both of which are services integrated with health, to ensure that the customer journey in these service areas has the same type of support and achieves similar outcomes for people.

Safeguarding is an important and critical part of the work of the Adults Health and Wellbeing Directorate. The Safeguarding challenge involved in the Transforming Adult Social Care Programme is to introduce more choice and control without exposing people to serious risk or harm. The aim is to achieve a focus on safeguarding that does not limit people's ability to make real choices. In the new Customer Journey we will be educating people about risk, and working with people to minimise risk. We will aim to manage risk in partnership with people. The Preventative approach that is a key element in personalisation will extend to Safeguarding and we will be investing in empowering organisations and individuals to recognise, prevent, report, avoid and complain about abuse in all its' forms.

**A transformed market place**

To deliver the outcomes of increased choice and control a different marketplace for adult social care is needed. We are ensuring that the market of support options is, on an individual basis, high quality, good value for money and easy to access through good information, advice and brokerage. The Commissioning section of the Directorate is being redesigned to ensure that it can respond to the new requirements.

As highlighted before, the Transforming Adult Social Care programme has a significant impact on our providers and partners. Increasingly people will be able to purchase support themselves that is agreed in the support plan. This means that over time, the Council may reduce the amount of services that are

directly commissioned as people take on this role more and more. The role of the Council with regards to commissioning services will increasingly become one of a market facilitator and developer working with people and providers to understand need, demand and emerging market areas. This will role will include community development within the context of the national agendas of Big Society and Localisation.

For providers this may mean a loss of income from Council block contracts that guaranteed income and minimum levels of business, to having to compete in the market place for the custom of individual service users who can purchase their services using a personal budget.

Tower Hamlets has a well established Voluntary and Community Sector and we are working with this sector to ensure providers can transition into a position whereby they are sustainable without block contracts from the Council.

**Customer engagement**
We have been working with over twenty different customer forums over the last six months on the changes being made to social care[1]. To get more in-depth feedback on particular issues with transformation we have recently set up a customer Reader's Panel to focus on our information and publications; and a Customer Steering Group to focus on the market shaping and commissioning elements of the programme.

To develop the programme we are also working with the Housebound Older People's Reference Group to ensure we are hearing the views of people not able to attend customer forums; as well as enabling people to give feedback via the Tower Hamlets website and in response to the articles we have submitted in a variety of newsletters.

The resulting feedback and views that we hear from customers are compiled and submitted to the programme on a monthly basis to consider and respond to; and in turn, customers are informed as to what difference their feedback has made. For example, the Housebound Older People's Reference Group gave feedback on what makes a good social care professional:

*A good Social Worker is someone who understands a person's needs by listening carefully, is caring, "keeps their eyes open" (doesn't take things on face value), is patient and not rushed*

This is being used to inform the review of staff competencies and the design of future staff learning and development programmes.

We are continuing to work in partnership with THINk to make these changes. The feedback gained through a customer event organised by THINk in March 2010 resulted in five "Customer Engagement Principles" for the programme, which in turn has been used to inform the new organisational values in the Directorate.

Working in partnership with people that use services is also an important element of the programme. As part of work on transformation and engagement, five service users from learning disability services are currently leading on the development and production of a DVD, which is intended to explain Personal Budgets to people with support needs. We are also working with three service user volunteers in new work placements to assist us with communication and engagement work.

**Provider engagement**
Adult social care has a range of existing forums with local service providers to enable good communication and engagement between the Directorate and the third sector. We have set up a Personalisation Provider Network to focus on transformation, which continues to meet on a regular basis. A programme of support and training has also been provided and is ongoing.

**Member engagement**
Post the Mayoral election, plans have been put in place to engage Members in the development and progress of the Adult Social Care Transformation Programme. Short updates have begun to be included into the Member Briefing and these will continue on a regular basis.

Alongside this, Member workshops are being planned. Topics that will be covered will be:

- What adult social care is and does
- Demographic pressure in Tower Hamlets

[1] Groups we have been working with include: the Older People's Reference Group, the Alzheimer's Society Carers Forum, the Tower Hamlets Interfaith Forum and Rainbow Hamlets.

- The transformation of adult social care
- Why we are changing
- The impact on local people - case studies
- Value for money
- Question and Answer Session

The outcome of these events is that Members will feel informed about social care and can influence the changes ahead. Importantly, these workshops will support Members in answering potential queries from constituents that may arise as a result of the changes.

Once the Member workshops have been scheduled we will ensure that members of Health Scrutiny are informed.

**APPENDIX 1 – Case Studies**

**Mr A case study**

**Background**
Mr A is 102 years old, he was born in Cork in Ireland on the 23 November 1907. Mr A has a physical disability and is housebound.

He has been widowed for the last 35 years and has two children. As Britain's oldest carer, Mr A has been the main carer for his daughter, who is a 65-year-old woman with a moderate learning disability, for 35 years. Mr A lives with his daughter in a three bedroom maisonette, which is owned by Tower Hamlets local housing authority.

**Life before personal budgets**

Mr A previously received homecare from the council, but would much rather be taken out and about. He has never attended any of the boroughs day centres and never participated in any of the older people events or celebrations that take place annually. In the past, one of his friends used to visit him to take him to his local pub twice a week.

Even if Mr A could go to the council's day centres for older people, he personally felt that this traditional service was not for him. Given the choice, he would rather visit sites around the borough or enjoy a short break with his daughter.

"It's been about four years since I've been able to get out and about," said Mr A. "I don't want to be housebound anymore because it's boring and quite isolating. I just want the opportunity to go out and pursue my own leisure and recreational interests once a week in the community. Sorry but I'm not really into going to day centres!"

**Life after personal budgets**

Mr A is now in receipt of a personal budget and is no longer housebound. Having gone through the support planning process with social worker and key worker, Mr A was able to plan his support to achieve the outcomes he wanted, to meet his social care needs.

When asked about what the changes mean for him Mr A said: "I'm happy about the changes and being able to go out. More choice is important. It makes me feel young. If you do nothing you become a vegetable!

"It's important to me to be able to make decisions, be independent and do things that I enjoy. It's also important for me to continue to live with and care for my daughter for as long as possible."

Mr A was able to use some of his personal budget to pay for his care and support so that he could enjoy a short break in Eastbourne with his daughter and is already planning another short break next year to Scarborough.

"I am looking forward the most to visiting Mile End Park because I have not been to the park for years. I can wonder around and look at the scenery and there is a restaurant there where I can have a cup of coffee.

Working with his social worker, Mr A has tailored his support in a way that fits with his life, rather than his life fitting in with existing services. His support reflects the outcomes that Mr A feels are important in his life – especially the outcomes in relation to his daughter.

"I am happy to have more control of my money. But that doesn't mean you have to change everything," said Mr A. "I chose to have the same carers that currently support me. I have built up a good rapport with them all because they understand my needs, are patient and kind and another important factor is that they get on well with my daughter."

"My quality of life will improve because my personal carer will take me out for an hour three times a week. I am looking forward to going on the buses because I understand that they can take wheelchairs now!"

**Personal budgets Case Study: Mr Z**

"My name is Mr Z and I was born in Morocco in a town called Wogda on 14 August 1940. I came to the United Kingdom in 1967 and settled in Sheffield. I met my wife at Chase Farm Hospital where she was a

patient. We married in 1976 in a Mosque based at Waltham Forest in London. I moved to Tower Hamlets with my wife, and we are blessed with three wonderful children, two daughters and one son.

“I suffered a brain injury in 1996 in the Canary Wharf bombing. This has resulted in severe cognitive impairment, memory loss, confusion and speech and comprehension difficulties. I also suffer with epilepsy resulting from the accent, and am at risk of fits.

“Prior to my accident, I was a very fit and healthy person and had no major health problems. I am now dependent on others with my daily living activities, because I have little insight and lack capacity to make any informed choices or decisions regarding my care needs due to my medical condition.

“My wife is a strong advocate for me and she ensures that all decisions are made on my behalf thus ensuring my safety and wellbeing. I do not understand basic risk which therefore puts me at risk of wandering.”

**Mr Z’s situation before Personal budgets**

When asked what he wanted to change in his life, Mr Z said:

- To learn to be safe
- My wife has significant health problems, she suffers with high blood pressure, diabetes and depression. I am dependent on my wife with most aspects of my activities of daily living, though the current care package gives her a break from her caring role. However, I could like her to have more support to enable her to have a good quality life as this will ease the every day stress and prevent imminent carer breakdown.

His needs:

- Being unable to undertake aspects of personal care
- Unable to go into the community due to little safety awareness
- A flexible worker for both community-based and home-based activities
- Being unable to cook meals
- “I might choose to stay indoors because I need some form of stimulation as I do not want to attend any day centre. Therefore I will need my PA to stay with me to support me with activities like painting, drawing, gardening, watching other programmes on the television or chatting with me, providing social stimulation and ensuring my safety.”

**With personal budgets, Mr Z chose:**

- **Personal Care:** A Personal Assistant that undertakes any aspects of his personal care
- **Community access and social interaction:** A Personal Assistant to take him to places of interest like the park or seaside, to go to the cinema to watch films and other locations, depending on the weather
- **Choice of assistants:** Mr Z was able to choose Personal Assistants that understand his culture, faith and are sensitive to his complex needs and circumstances
- **Social stimulation at home:** The same Personal Assistant for outdoor activities will also help him with activities at home such as painting, drawing, gardening, watching TV, chatting and social stimulation
- **Continuing support from family:** To continue with his wife supporting him with daily living activities independently such as shopping, housework, laundry and attending healthcare appointments, as well as food and a nutritional balanced diet.
- **Personal safety and supervision:** Mr Z’s support plan is designed and tailored so that he is always has 24 hour supervision whether from a Personal Assistant or his family and unpaid carers.
- **Nominated individual:** Mr Z nominated his wife to manage his Personal budget

**Overall Outcomes**

- Choice and control over a flexible set of Personal Assistants to ensure Mr Z is supported to be safe in both indoor and outdoor environments
- To be clean and smartly dressed, maintaining safety, independence, dignity and personal hygiene
- Supported with all daily activities that aim to ensure his safety, health and wellbeing in the community
- By being part of the support planning process, Mr Z’s wife is able to be involved and ensure that his support is tailored to ensure 24 hour supervision and work for the family.

This page is intentionally left blank

<table>
<tr><td>Committee<br><br>Health Scrutiny Panel</td><td>Date<br><br>25 January 2011</td><td>Classification<br><br>Unrestricted</td><td>Report No.</td><td>Agenda Item No.<br><br>4.6</td></tr>
<tr><td colspan="2">Report of:<br><br>Tower Hamlets Involvement Network<br><br>Presenting Officer:<br>Dianne Barham</td><td colspan="3">Title:<br><br>Response to Tower Hamlets Involvement Network (THINk) Recommendations<br><br>Ward(s) affected:<br><br>All</td></tr>
</table>

**1. Summary**

1.1 At the last Health Scrutiny Panel Members were presented with the recommendations from the THINk patient and user comments. From October 2009 to July 2010 THINk received 172 comments on hospital services. When THINk members were surveyed they indicated that hospital services were the second most important issue for the community behind GP Surgeries. The vast majority of feedback received with regard to hospitals relates to experiences at Royal London Hospital (RLH) and therefore the comments and recommendations are mainly directed to them.

1.2 Appendix 1 summarises the comments and recommendations from THINk and Appendix 2 provides a letter from THINk to the Chair of Barts and London NHS Trust requesting a response from these recommendations. Finally Appendix 3 contains an action plan with Barts and the Royal London NHS Trust's response to the recommendations.

**2. Recommendations**

2.1 The Health Scrutiny Panel is asked to:

a) Note the summary recommendations in Appendix 1
b) Comment on the Action Plan in Appendix 3.

This page is intentionally left blank

# Appendix 1
# Tower Hamlets Involvement Network
# Royal London Hospital
# Comments and Recommendations
# Oct 2009-July 2010

From October 2009 to July 2010 THINk received 172 comments on hospital services. When THINk members were surveyed they indicated that hospital services were the second most important issue for the community behind GP Surgeries. The vast majority of feedback we receive with regard to hospitals relates to experiences at Royal London Hospital (RLH) and therefore our comments and recommendations are mainly directed to them. The analysis has also been informed by a number of Enter and View Visits undertaken by THINk to RLH during September and October 2010.

The hospital topics that we receive feedback on include:

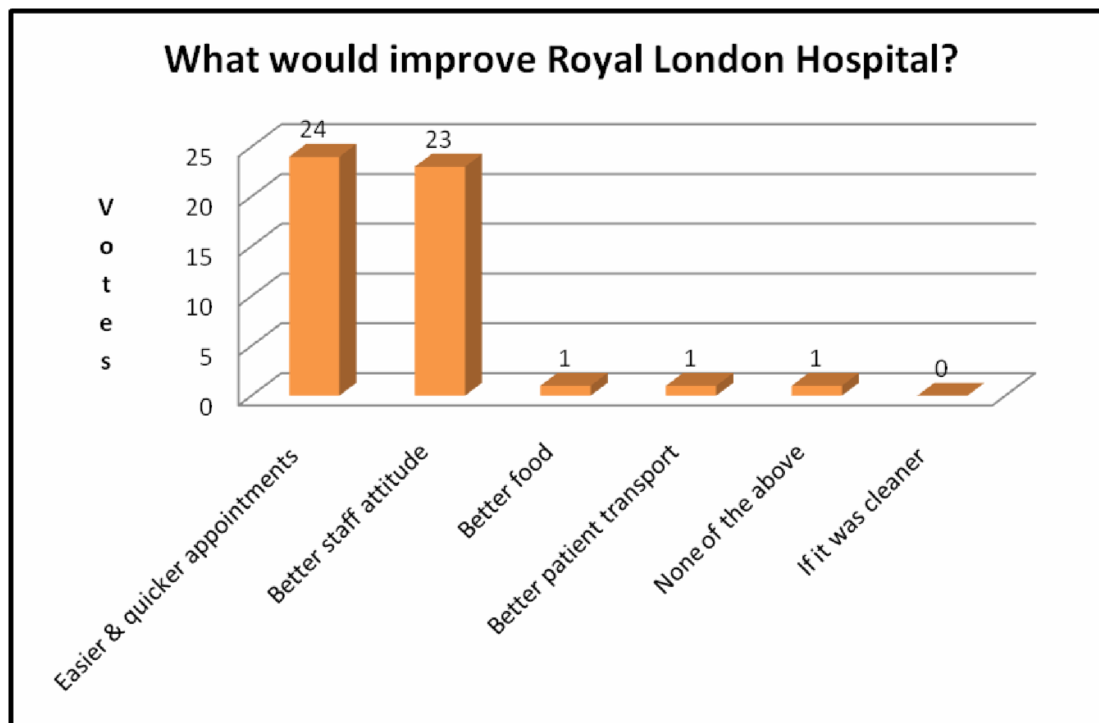
1. Appointments
2. Staffing
3. Physical infrastructure
4. Accident and Emergency (A&E)
5. Communication
6. Maternity services
7. Transportation

This paper addresses each of the above topics but the priority issues of concern for patients are:

- Attitude of staff, especially nurses
- Communication to patients
- Communication between staff
- Choose and Book system
- Maternity services
- Treatment of older people
- Cleanliness of facilities
- A&E experiences

THINk found that although clinical care is good and survival chances are high at the RLH, patients said they could not get appointments as quickly as they would like and they found some staff to be uncaring and abrupt. Figure 4 summarises the opinions of many service users as to what changes patients would most like to see at the hospital. Positively there has been a significant decrease in the number of concerns raised regarding the quality of food at the hospital.

**Figure 1**




**NOTE:** The data in Figure 4 represents the votes of 50 service users from a consultation event that took place on 10 June 2010, where each participant had one vote per question.

One of the underpinning principles of the Health White Paper is to enable patients to drive quality by exercising choice as to where or what treatment they receive and part of THINk's new job as the local HealthWatch will be to provide people with the information to make those choices. It is crucial that Barts and the London Trust (BLT) address these major issues to patient satisfaction if they are to continue to be the community's hospital of first choice.

**1. Appointments**

The two main areas of concern regarding appointments are with the Choose and Book system operation and the length of wait times. The Choose and Book system has been problematic for service users for a number of reasons including a lack of choice of hospitals, incorrect information being sent to patients and difficulty accessing the system, particularly by people with additional support needs.

*"It will take more than 10 months to get an appointment for my back surgery, this is really frustrating....in the meantime I will have to suffer with this pain."*

**2. Staffing**

There are a number of staffing issues presenting and they also link to the issues related to communication and customer care. In addition to complaints about staff shortages and too few staff on hand to deal with patient needs, there is an ongoing issue of the attitude of nurses and their compassionate care skills as well as the communication between staff. These issues combined can lead to patients feeling

like “a nuisance” and lowering the levels of trust and confidence in the care they receive at hospital.

Nearly everyone we speak to can give an example of a person in the hospital who was kind and supportive and who they felt was trying their very best to take care of them. Unfortunately the reverse is also true with patients feeling that some staff are rude, uncaring and insensitive. THINk are strongly advocating for much clearer messages from BLT management that disrespectful, insensitive and uncaring attitudes are not acceptable and will not be tolerated. Where compassionate care standards are not being met by staff they should be immediately addressed and staff dismissed if there is no improvement. Staff who are doing an excellent job with positive and compassionate attitudes should not feel compromised by poor staff or a culture of disrespectful nursing and this should not be allowed to permeate the wider hospital culture as appears to be the case at present. There needs to be a strong focus on quality patient-centred care despite reduced resources and the difficulties of working in an old building which will be relocated in the near future.

We understand that there is a compassionate care project currently being undertaken at RLH but THINk has not been informed about it or asked for input. There should be a focus on working in partnership with patients. Staff should use communication methods that make patients feel comfortable such as through reassurance, friendliness and professionalism and they should receive training in this area. Patients should be supported to feel ‘in control’ by being given explanations and other useful information about their issues and offered choices about their care. Respecting the rights of patients, gaining their consent and promoting their independence should be high priorities for staff. Staff should behave in ways that make patients feel valued; such as by being helpful, courteous, considerate and showing concern for patients as individuals. Experienced staff should role model this kind of behaviour to more junior staff. Patients have said it is important to be involved in decision-making wherever possible and to be treated as an individual; for example by asking them if they prefer a bath or a shower, or if they need assistance washing or if they prefer to be left alone for a while.

Ideally hospitals should get patients involved in staff recruitment and monitoring and there is perhaps something to be learned from East London Foundation Trust’s experience in this area.

**3. Physical Infrastructure**

There have been ongoing complaints related to the condition of the facilities at RLH as well as the cleanliness of the building. While some of this is to be expected from an old building in need of repair and the planned move in 2012, there is still a need to address these issues and to communicate with building users. This is a management and maintenance issue and there should be certain standards that are upheld as well as proper signage throughout the hospital to let people know about the situation (i.e. excuse our mess, we are planning a move shortly and we don’t want to waste precious NHS resources).

**4. Accident and Emergency**

The overall patient experience of A & E has been fairly positive and there has been significant improvement over the past few years . Often the issues are about accessing other facilities at the hospital such as MRI Scans and ultrasound facilities over the weekend. Additionally, the waiting room environment is poor with cramped space, uncomfortable chairs and toilets that are misused. We understand that there is limited capacity for environmental improvements given the imminent move to the new hospital but the continued effort to keep the place clean should be maintained. For example, some form of cushioning should be provided on the seating if people are waiting as much as four hours or more.

THINk believes there is some capacity for frequent users of A & E and the hospital in general to have patient held records. It is frustrating for patients who know where they need to go and who they need to see to have to go through the whole process of explaining this every time. Perhaps a special fast track system for regular patients should be considered.

**5. Communication**

The staff attitude problem seems to be strongly linked to the desire for more information on what is likely to happen to patients, when it is likely to happen, if it is not happening why not and what is the result. The longer people are left without information the more anxious they become and the more they feel they are being ignored or forgotten. This can have a drastic effect on both their physical and mental well being and leads to them becoming agitated, frustrated and sometimes angry.

People who do not have the answers keep asking nurses again and again to find out. If nurses are not communicating with doctors properly and they do not have the answers they get frustrated and irritated and can become abrupt with patients. The George Ward is a good example. Patients have no information on what is likely to happen when they arrive on the ward, they are given no indication of when their surgery is likely to happen or if there are delays. Following surgery they are told the surgeon will give them feedback on their operation but not when this is likely to be. We realise that schedules are not always predictable but uncertainty makes patients anxious and irritable. If people know they are going to be waiting for a long time, they can get on with doing other things or organising their lives accordingly.

Where ever possible patients should be provided with information before they come in to hospital on what is likely to happen. Once in hospital, there should be whiteboards or information letting patients know if things are not happening as normal on that day and why (e.g. there has been a major trauma, one of the consultants is sick, the computer system is down) and the likely impact. This would be an ideal role for non-clinical staff. In general, communication both between staff (such as doctors and nurses) and communication from staff to patients needs improvement.

There appears to be an over-demand for the Somali interpreters/advocate (one part-time person covers all four hospitals in Tower Hamlets). People are waiting six months for an appointment only to find that the interpreter misses the appointment and they have to go back to the GP to re-book and wait again. Perhaps it would make more sense to have a number of sessional interpreters.

## 6. Maternity

THINk recognises that there has been some significant improvements in maternity services however there continues to be a problem with some staff treating patients rudely, abruptly and with an uncaring attitude, making them feel like they are ignorant or an annoyance. There must be more focus on clearly identifying staff that have a problem providing compassionate care in this busy and stressful environment.

*"UCH was totally the opposite of Royal London Hospital. Staff are polite, very caring and very competent. I decided to have my second child there".*

Maternity services need to be honest about the staffing levels on the wards and what parents can realistically expect. There seems to be an issue around adequate information for parents when they come on to the wards. If people are given realistic information they will be more understanding and more likely to try and help themselves where possible. It will also help patients to understand that they are not being ignored intentionally. It was very saddening to hear from mothers that felt it was something personal against them.

Although it may be difficult with current staff levels being given the opportunity to discuss the whole birth experience with somebody, to review what happened, and ask questions would appear to be very beneficial for some parents. Parents that we talked to on our visit to Mary Northcliff (Postnatal) Ward felt that things had gone wrong or they had been ignored when in actual fact what they had experienced was normal in the circumstances.

It does not seem that first time parents are getting enough support and guidance and they would welcome some training in relation to changing nappies, bathing, breast feeding and general care whilst on the postnatal ward. It was felt that parents should get group breast feeding advice so that they might support each other and it would also save the support worker time. There is also a lack of breastfeeding support at night time in the wards which needs to be addressed.

It would obviously be useful if there could be an increase in the number of maternity support workers and funding to take on the trained maternity support workers from South Bank University, freeing up midwife time to provide more care and support.

*"If we had more Somali and Bengali midwives the issue of language and communication would be far less of a barrier in getting a better service from midwifes".*

There also seems to be some specific issues relating to Somali mothers which warrant further investigation (i.e. that some Somali mothers believe it is culturally inappropriate to scream during labour). This is an area that Women's Health and Family Services is looking into further. Somali women are also low attendees of ante natal classes and we would like to see some thought put into how this community could be encouraged to attend or whether classes could be conducted in community settings.

Lastly, there is an important opportunity to change the poor perception of maternity services at RLH when the wards move to the new hospital. It is crucial that the staffing levels and attitude are such at that time that we can make an organisational cultural shift both within the wards and within the community.

**7. Transportation**

Patient transport services to the hospital as well as access to the hospital have been areas of concern for hospital users. Community transport, while being a popular and necessary service, has had a number of complaints due to wait times and mistakes. Car parking and drop off are also areas of concern for patients.

**8. Questions and Recommendations**

The following section has identified a number of questions for Commissioners and also some recommendations for future action.

***Questions***

a) Have patients had any input into Compassionate Care Standards? Are there other ways to input?
b) Are there clear processes for patient feedback to be taken into account in staff appraisals? Do staff reflection sessions happen at the moment?
c) What are the proposed changes in relation to the Choose and Book system? The appointments process still appears to be a major problem and more information is needed on how this is being resolved. When will GPs be able to book at the time of appointment? Why does there seem to be a problem with appointments being cancelled so frequently?
d) Are there best practice hospitals in London where patients have scored highly in relation to staff attitudes? What are they doing differently to BLT?
e) Are there staff competencies in relation to treating patients with respect and dignity?
f) Has the rotation of night duty staff with day staff led to any recognisable improvements in the experience of mothers?
g) Does midwife training include feedback from mothers about what good and poor care entails? Is there information on particular cultural issues regarding giving birth? Could the Maternity Services Liaison Committee feed in to this?
h) Is there any chance of increasing the number of maternity support workers and is there funding to take on the trained maternity support workers from South Bank University funded by NHS London?
i) THINk has asked a number of times over the past two years if there could be a patient representative on the BLT Board. We have still not received a response to this request.
j) How often does the hospital use language line for the Somali community and is this cost effective?

***Recommendations***

Short term

a) Cleanliness standards and schedules should be posted throughout the hospital with specific contact points for complaints on each ward or area.
b) Signage should be developed to inform patients about the ‘untidy state’ of the hospital and the impending move.

c) Where ever possible patients should be provided with information before they enter hospital on what is likely to happen.
d) Look at ways of improving the communication systems between staff, particularly between doctors and nurses on wards. Nurses should be updated regularly and should be able to tell patients when they will receive the next update.
e) The Choose and Book system should be monitored to make sure that users have an actual choice and mistakes and cancellations are minimised.
f) Can we ensure that patient feedback is heard by managers and linked in to the performance management system with a clear action plan implemented to bring about change?
g) Could patients have a small white board at the end of their beds or a card to go with patient notes where they could note down any questions they have for staff or concerns about their treatment?
h) Care for Older People standards should be presented to all nursing and frontline staff and made a performance management priority for supervisions.

Long term
i) Develop a system for patient held records for frequent hospital users.
j) Develop a system for sessional interpreters to be available as needed for appointments.
k) There is a need for increased support and signposting by patient advocates and volunteers. We understand that a Doula volunteer project is commencing with Maternity services and it would be good to see the impact of this. Would it be possible to develop a kind of 'meet and greet' volunteer service on some of the more problematic wards?
l) Nursing staff should be required to attend equalities and diversity training with Compassionate Care standards linked to cultural sensitivity training.
m) Develop an information session for first time parents on the ward.
n) Investigate the need for an organisational culture change around staff attitudes in line with the move and how to best facilitate the change.

THINk has agreed that the monitoring of the quality of RLH services is a priority for this year. We aim to achieve this by:

- Developing and supporting THINk **patient service assessors**. These will be members who are users of hospital services and trained in mystery shopping skills who will be provided with guidance on assessing services from a patient perspective and focusing on the areas above.
- THINk members undertaking **discovery interviews** in key areas of the hospital where patient experience is poor. Information is to be fed back to staff so they understand the impact of their attitude on patients.
- Increasing the number of **Enter and View Visits.**
- Looking at supporting greater use of **volunteers and advocates** within the hospital.
- Ensuring that the THINk **Hospital Task Group** has key input into the transfer of services into the new hospital to ensure that old habits do not relocate with staff.

## Comments received

This report simply combines all of the comments that THINk has gathered from local residents, patients and users on their experience of Royal London Hospital and how they could be improved. Analysis of the information will help inform the recommendations, suggestions and requests for information that THINk will make to commissioners and providers. It will also allow THINk to prioritise its work over the coming 12 months.

Comments were gathered through THINk questionnaires as well as a wide range of outreach and engagement activities the majority of which are listed below.

**Outreach GP Practices**

- Bethnal Green Health Centre
- All Saint's Practice
- Barkantine Health Centre
- Jubilee Practice
- Idea Store Whitechapel
- Idea Store Bow
- St Stephens Health Centre

**Events**

- 6 Lives Big Health Check Up
- Bengali Disability Awareness Day Swanlea School
- Carer's Week Event
- Bow Health Network Public Engagement Event
- Community Options Toynbee Hall
- Health Connex and Health 4 NEL Event-London Muslim Centre
- Health for North East London – Asda Consultation
- Social Action for Health
- Older People's Reference Group: - Health for North East London Consultation
- OSCA Employment Event
- Road Show for Health for North East London Tesco-Bromley by Bow, Asda
- DITTO Event
- Tower Hamlets Maternity Services Liaison Committee
- Watney Market
- Women's Health and Family Services
- Your Heath, Your Say -York Hall

The reference numbers at the end of the comments enable us to track the date and place where the comment was made and in some cases further equalities data.

**Good experience**

1. Hospitals have improved substantially 372
2. Hospital service is good 373
3. It is very good 374
4. Royal London Hospital, I had a very good service. They give me clean sheets and all is good. Hospitals should give notes to the patients or sometimes they lose the notes. 602
5. Royal London is excellent in dealing with my diabetes condition 430
6. Hospitals and GP's are alright. All is good. 603
7. All the services have improved greatly in this hospital over the years 174
8. Heart treatment at RLH – great service 314
9. At RLH received a very good service – no qualms 315
10. No waiting as I was taken to A&E by ambulance. Seen by friendly, understanding staff and doctor. Made to feel comfortable, even though my condition was not! 87
11. Mostly very good, waiting times vastly improved 437
12. Mile End Hospital is good. Staff are friendly and they listen and I am a diabetes sufferer. The service is good. 601

**Staff**

***Nurses***

13. NHS has a lot to deal with but there is a severe shortage off good nurses. Those that understand that these are lives that they are dealing with. The hospital is old and dirty. When I picked up my grandfathers belonging they were shoved in my hands and I waited for a second for someone to talk to me. No one did. I lost my best friend.
14. hospital services were poor: many of the nurses are/were of Nigerian origin and, in general, they are/were lazy, never kept to standards of patient hygiene and were antagonistic and argumentative (THINk Survey, December 2009) 610
15. The oral English used by some of the nurses was not very good & I had difficulty in understanding some of the questions I was being asked. Although persistence paid off in the end and all questions were eventually answered! 87
16. Improve Nursing- the nurses have very poor behaviour ...agency nurses are no good- nurses are cruel 'nurses don't show interest in patient and are dreadful' 345
17. Nurses are neglecting patients...349
18. Would like matrons back on ward...nurses have attitude problems, the matrons can deal with these issues.348
19. Nurses are not informed about patients. They were about to give me an injection, which I was not supposed to get. A doctor came and stopped her as I was not supposed to.565
20. rude staff bad nurses, not very comforting to patients 443
21. nurses unable to find vein for injection – need experience 442
22. Not enough trained staff-nurses 366

23. Nurses should have more training and they should have more skills dealing with patients with mental health problems. 395
24. Staff are not competent. The nurse was not able to get my blood test done. She failed to find my veins and I was left with the needle under my skin while she was looking for her manager to help her out! I had my blood tests in other places without any problems at all. 85
25. Doctors are doing too many hours and they are falling asleep, lacking any break so they tend to avoid patients requirement, nurses are lazy and not determined at all, they here to quickly pass the shifts 28
26. Hospital Transport Service very helpful. 296

***Communication with patients***

27. Hospital provides good service – especially Consultants as they listen to people – they speak to people kindly and sensitively 316
28. Services are improving re patient care and giving more information 440
29. Keeping more connections with patients, like doctors telling patients of the patient's progress. 180
30. Consultant could not explain to patient diagnosis properly and since then going to sue – feels very unhappy about process and not knowing diagnosis 302
31. Taking care of patients first, rather than look at statistics, because patients are important. 181
32. Doctors and nurses could be more welcoming and explain better to the patient 433
33. the way of some doctors deals and handles patients and their needs, listening skills,
34. (my father) was moved onto Cambridge ward, which was OK but the doctors and nurses rarely communicated with us. Same problem when moved onto Mary ward. Not enough info or communication from staff. We were rarely told what was happening with my dad. One or two of the nurses were nice and helpful, unfortunately not around enough, the others were not so great. Nurses were never able to give me info about my dads status, and doctors always seemed unavailable. From the beginning, his medication wasn't given properly, some of his most important ones were missed for a whole week. Its ridiculous. 134

***Communication between staff***

35. Staff must work together as a team. Everybody needs to support each other from experience.439
36. staff working together for the highest care of the patients and this could reduces tensions and stress to both patients and staff but at the moment collaboration is missing big time I've been asking for help and advice to Pals ,unfortunately didn`t do it for me, I felt totally lost and confuse by their advice why are there for??? 113
37. Doctors leave patients in the care of nurses, so they need to communicate with them a lot more in order for them to do their jobs effectively. 134

***Other***

38. Receptionist at Royal London very rude 301
39. RLH staff behave in an uncivil and rude manner 303

40. Physiotherapy at the Royal London Hospital- Need more friendly staff. 172
41. appointments centre staff very helpful and always trying to do their best on giving advice on what should you do next if you kind of stake e.g. needed to see the doctors urgent and the next appointment is January 2011..113

**Appointments**

42. It will take more than 10 months to get an appointment for my back surgery, this is really frustrating, I am angry that I have to wait for so long, in the meantime I will have to suffer with this pain.173
43. Lengthy services at the Royal London Hospital, taking months for transfers, took so long. Waiting for transfering frustrates me so much! 195
44. Hospital appointments need to be sooner- it takes too long. 293
45. They should have a back to back appointment system, if you have to go back to the same hospitals twice in one week. 294
46. Hospitals are ok; however they keep cancelling and delaying my appointments without giving any reasons 422
47. Hospitals keep cancelling appointments ...it's too busy...it happens too much' 428
48. The appointment department sent a wrong appointment. Appointment cancelled without prior notice (April 2010) 432
49. Usually people wait appointment longer than necessary, which could really cause death or other health related problem. Therefore, we need more effort like coordinating system. 434
50. Delays in appointment in rheumatology, and they say they'll send it via address, but when they do they send it to the wrong address. 608
51. Royal London Hospital is really awful. The services is not not good. It's just the waiting time.599

**Choose and book**

52. I wanted to be referred to a specific consultant at a specific hospital. Initially I was given a choose and book form. The hospital I want is in a group and both on line and on the telephone I could not get this hospital but only the main one nor could I book for a specific consultant so I have gone back to my GP and asked for a "Dear Doctor, this pleasant lady etc etc" to be sent (January, 2010) 611
53. My experience of choose and book was disastrous. My doctor gave me a print out with a number to ring and a password. He told me that I needed to see an orthopaedic consultant. I rang the number and entered in the password and I was booked into the Royal London Hospital. There were no choices of where to go at all! 613
54. My role in this choose and book story is as an informal carer for a confused 88 year old, diabetic and virtually housebound, woman. I took her to her appointment with a local GP (East One Practice) who decided to refer her, to follow up her complaints about a very painful knee, to an orthopaedic specialist. She was given several pieces of paper with instructions about how to make an appointment, which we read when I took her home. After the specified waiting time, two days as I recall, I rang the number given using the passwords and reference numbers. She could not have managed this on the telephone herself.

At her specific request an appointment was made at the London Hospital Whitechapel orthopaedic clinic for a time when I was available to drive her to the hospital. When the appointment letter arrived, the appointment was on a different day at Barts. I rang to say that the patient wanted to be seen at Whitechapel because of travel problems (ie parking) at Barts and her unhappiness at using hospital transport with its associated long waits. I was told that she could not be seen at Whitechapel because the consultant she was referred to does not do a clinic there. As she had not requested a referral to a specific consultant, she asked to see any consultant available at the Whitechapel clinic. She was told it was the GP who made the specific referral based on his medical opinion and this could not be changed by the patient or the appointment system.
I then rang PALs and was told that the choice of consultant was up to the GP not the patient, and that I just did not understand that this was entirely up to the GP. The only suggestion was to go back to the GP to get another referral. When I rang the surgery, and after some confusion about what I was requesting, I was given the number of a service that was trying to sort out choose and book problems. I did not take the name of the man who dealt with the request for an appointment at the London Hospital, but he immediately understood the problem, took my name and telephone number and said he would get back to me about an appointment. He did in fact ring back to say another appointment at the London Hospital orthopaedic clinic had been arranged, and an appointment letter would be sent. Impressively, he rang a second time to check if the letter had arrived.
There is no way this patient would be able to manage the choose and book system herself. Who within the workforce would have sorted this? (March 2010) 613

55. I damaged my knee on 16 March in France and saw a French doctor immediately who X-rayed it and provisionally diagnosed damaged ligaments. On return to the UK I saw my GP on Monday 29 March and he ordered an MRI scan which I had on 9 April the results were back at the doctors.
I saw him on 22 April when he did a choose and book referral we looked on his web site and saw that the Royal London had the shortest wait at 19 days and although my preference was for Guys as that was 42 days I picked the London.
When I rang that day they said it had been marked urgent which meant I had to be seen in 20 days but they had no appointments and they would ring me back but if I hadn't heard in 2 weeks to try again.
I rang again on 4 or 5 May and was given the same tale. I contacted PALS to see if they could help to be told that they couldn't help as it was Choose and book. I decided to make a formal complaint. It took me 5 minutes to get the complaints section of the very slow web site where there are 28 options I selected the one headed complaints and after another minutes wait was told about the policy and how everyone but nowhere could I find out how to make a formal complaint - I suppose this lack of openness will help reduce the number of complaints but is not exactly transparent.
I rang again on Monday as I am concerned that the longer I wait the more damage I am doing to my knee - it is now 10 weeks since the initial injury, and was finally told what I should have been at the beginning that they are waiting for someone in orthopaedics to authorise overbooking the clinic.

It seems to me there are several issues here a) if someone has to authorise an overbooking it makes no sense to wait until the last minute. b) The BLT web site is notoriously slow c) it is difficult to find out how to make a complaint from the web site at least for this not very technical person.
I finally made a formal complaint and the chap sorted me out an appointment but because it was choose and book you can't book a specific consultant so almost the first thing the registrar said to me ‘well of course I'm not knees you need Mr. ..... for that’ so he's referring me on !!!! Choose and Book makes no sense when there are sub specialties just delays getting to the right man. 15

56. I had no discussion about choices of hospitals that I want. Homerton is closer to me but I have an appointment at Royal London, when your pregnant journey can be stressful and at difficult to go so for me health professionals need to be more considerate. 295

Cleanliness

57. Domestics have bad personal habits like picking their nose. Domestics refused to clean up after accidents. Didn't mop under the beds properly. Nurses enter and leave the hospital with uniforms or "theatres". So called blocked entrances were used by staff. Spreading infection that was already in three wards in the hospital. Some of the nurses lack of respect and care for it's. elderly patients. 27
58. There was a virus on the ward. They tried preventative measures of it spreading but it really didn't matter if the staff and patients for that matter were not clean, I sincerely understand that there is a shortage of nurses. 28
59. Although the A&E was not busy at the time I was taken in - 0600hrs on a Sunday morning - the cleanliness in the toilets was far from satisfactory. A cleaner was just slopping dirty water from his bucket around the floors with a not very clean mop, leaving puddles everywhere. Very little loo roll on the dispensers. Toilet bowls not very clean. Ideal breeding grounds for many unwanted bugs I reckon!!! 87
60. Cleanliness of hospitals is poor 423
61. Royal London Hospital very unclean...in showers there was a lot of dirty towels on the floor...it never used to be like that...I caught MRS infection in Cambridge Ward...they should have better cleaners...they need to disinfect the lockers, chairs are not clean, toilets are too dirty and too many junkies...food is bad. 429
62. Cleanliness at the Royal London is an issue, the surgical department unclean...I blame it on the privatised cleaning contractors... 431
63. Very happy with the care provided but the wards could be more clean 436

Treatment of Older People

64. They maybe older but they also need to be treated with care and dignity and respect and also to realise just because they are older does not necessarily mean they are dim witted. Transfer of information to the relatives those that are noted as next of kin. Listen to the patients - they have techniques that help deal with their chronic conditions. Change the gowns. Wash the patients properly if they are not able. I didn't mind cleaning my grandfather, he was my responsibility but when I wasn't there gowns were not changed. His teeth was

not brushed. I do not know if he refused but if he did I was only a phone call away. Urine bottles were left on tables that patients ate from. 27

65. Older lady who lives over the otherside of the Motorway by Aberfieldy. She called an ambulance and they said they were going to take her to Newham General and she wanted to go to Royal London because all her care services were in Tower Hamlets. Ambulance said Newham was closer. She spent a couple of weeks in Newham and felt that no one in Tower Hamlets even knew she was there. 1
66. I saw two elderly people put aside for people who had gotten drunk on the mixture of drink and drugs.28
67. Elders not writing negative issues because they might get bad treatment 435
68. Not enough attention is given to the elderly in hospital. It takes a long time for a nurse to see to their needs. May need more nurses.445
69. Elderly people are in hospital nurses behave in a rude way. My mother has spinal tumour and the nurse in the Royal London Hospital behaved very badly towards my mother. She told my mother if she spoke out she'd hurt her. I complained to the head sister. They gave her a cold water shower too. 572

A & E

70. Good experience of A & E. I went in with a sore knee that had been bothering me for about 4 weeks. I went to the Walk in Centre but they said they couldn't do X-Rays so I should go to A & E. The receptionist at A&E said I should really go to my GP as it had been 4 weeks but said they would see me there. I was seen by a doctor within 10 mins who said it was just swollen and if I continued to have problems then go to my GP. The receptionist was friendly and nice and the Doctor was helpful. A & E has improved enormously over the past few years. There's more consultation space, smaller waiting area and things seem to move a lot faster. (White British women over 50, referring to a visit on 22 Oct 2009, spoke to THINk staff on the phone) 609
71. A & E has no access at all for people to be dropped off in an Emergency by car. I was unable to walk and couldn't even get near the department. Old building, very small and dirty waiting room, with an ankle injury and unable to walk I was told by x-ray to find my own porter to wheel me back into the A&E waiting room. When seen by doctor, the cubicle was so cramped and inaccessible I had to leave the wheelchair and attempt to walk on a busted ankle as the space was too small for the wheelchair. Horrible hospital would never return!!! 133
72. My father was taken into A&E. It was horrible. The ambulance staff were great but as soon as we got into the hospital it went from bad to worse. Father was freezing cold, I asked for a blanket a number of times and wasn't given one until the next morning. I had to cover him with mine and my mothers coats. 134
73. The system in A & E is flawed. It took four hours for the Doctor to give the go ahead to the nurse to switch up my son's hand. I went home at 2am; the kids had to go school the next day' 300
74. Royal London – waited 10 hours with 2 needles in hand and no-one attended to them when I was leaving 308
75. Waited in RLH from 1300 –midnight before being told to go to another hospital 312
76. Emergency services are really slow 319

77. Issue of having no A& E at Barts- patients have to go casualty in Royal London and then get transferred to Barts (Cancer Patients) 320
78. Hospital was crap...service was very bad, no follow up information and doctors don't check quick enough (Referring to A+E at Royal London) 392
79. emergency services need to be improved 540
80. A+E is a joke as waiting times are 4-5 hours long' 430
81. I took my wife to the royal London hospital at 3am because she complained of stomach pains; the hospital staff diagnosed kidney stones and said that they operate on her as an emergency. However in the afternoon Royal London staff advised told me that she had to go to St Barts to carry out the operation. We went to Barts, but they did not operate until the next day. After the operation the hospital was suppose to get back to us to follow up progress of my wife, however they did not contact us at all...we had been waiting for 5 months for some contact or appointment to check her progress and to take out the temporary tube they had put inside her ...however when I chased them up to find out why they had not contacted us, they told me they had no record of my wife's operation..I was totally shocked and very unhappy by this treatment; something serious could have happened to my wife" 421

Transport

82. Hospital Transport Service very helpful. 296
83. Ambulance staffs do not allow other people (relatives/family) to go with them in the ambulance (with patient) 347
84. Car parking issue at the Royal London- there should be more pay and display parking closer to the hospital. 370
85. Where do I park – where do my visitors park? 371
86. Ambulances and hospitals should be informed about road works... 368

Information

87. Advocacy service would be good in the hospital 12
88. There are three different x ray places in Royal London but patient gets an invitation to turn up at the Royal London with no idea which one they should be going to. Letter just says XP Knee Rt. Not one of the radiographers washed their hands. 14
89. If they don't ask your details over and over again, perhaps a card that you hand over to them, either an electronic card or a card handing to the receptionist, as its tedious as they always ask for your name." 181

Waiting times

90. My grandfather came in around 10pm was seen by the doctor at 2am. Admitted at 4.30am.28
91. Hospital is very poor... 4-5 hour waiting times when we you go (referring to the Royal London) 393
92. Waiting time in hospital is an issue, getting appointment is difficult, and hospitals keep cancelling appointment i.e. They are on leave etc 298
93. waiting time should be acceptable e.g.I've been booked to see Dr at 3 pm and apparently duo to fire alarm he manage to see me at 6pm

**Maternity**

*Staff*

94. Staff made disparaging comments about me i.e. because I am first time mother. I can't breast feed 'properly' and also negative comments during birth, i.e. not very assuring, by saying 'pain is gonna get worser'.199
95. Aftercare (maternity) at Royal London Hospital was really bad, they are severely understaffed, one sister was running around and dealing with everybody- it took them 3-4 hours to discharge me. 200
96. Staff should communicate with each other, last time whilst I was in maternity ward, one of the nurses did not write on my record that I had a injection, few hours later another nurse tried to give me another injection, which could have been fatal for me...if I did not speak English and could not explain myself I could have been seriously ill...I could imagine this happens to lots of people who don't understand English , they are none the wiser as they think nurses know what they are doing and following correct procedures" 222
97. Attitude of Staffs is poor – they need to be more welcoming and smile. They also need to communicate with people better by letting people know what is happening or explaining things properly. 326
98. When I was giving birth the midwife was rude and she treated me like a case study rather than caring for me as a patient. (Somali) 512
99. the services of the maternity department is very bad as the midwives are rude and they forced me to take pain relief (Somali) 513
100. I refused to take any pain relief because they treated me very bad and no interpreter (Somali) 514
101. The maternity service at Royal London is awful; it was a very upsetting moment. It was our first child being born. The midwifes/nurses spoke really rude to my wife and me. As if we were burdening them. Who employs thee rude and evil people. They have no respect for any of the patients; treat us like we are just numbers. 574
102. After caesarean, the nurses did not support me properly and provide good after care service...she came in once to check me, but when I called her again, said why you calling me so many times, it's your baby.. 578
103. I had bad experience with the Breast Feeding Support Team, I rang them twice to request support and they did not get back to me. 579
104. I went as instructed by an out of hour GP. I am 8 mths pregnant and had a fall. I went to the ward at 8:30 i was hardly spoken to just instructed to sit and wait. I waited till 10:00 when i was given a urine pot then taken to sit further on a bed. After 30mins they stuck a heart monitoring machine and left for another hour! i was so appauled i asked for information the lack of communication was unbelievable. It wasnt even busy. I got no ecouragement, reasurrance or advice, I had to keep asking what am i waiting for. I am dreading having my baby there it seems like a really miserable team. I finally discharged myself thats how dreadful it was. They need to be customer focused. Were not all baby machines and we dont automatically know the procedures in place. There was no care just felt like your tossed aside until they can be bothered to deal with you. hey all seem to walk like snails and fiddle around with papers. I am sorry if i sound rude but it really is that bad! 30
105. When I was giving birth I was in so much pain. I couldn't shout so the midwife left me and the baby was delivered by a student and I lost a lot of blood. Then the midwife said you didn't scream so I thought you are not in pain that's why I left you. (Somali) 516

106. When I was in hospital during labour I saw a midwife shouting at a patient telling her to “shut up” don’t make noise you’ve had a few children you should take the pain. (Somali) 517
107. Patients fear to voice their opinions to avoid bad service from staff. 519
108. I had a miscarriage a few years ago. I was treated absolutely disgracefully. It took 4 scans to determine whether my child was dead or alive... Staff could not diagnose it as it was the weekend and specialist staff was lacking... it’s disgraceful that the hospital did not have the staff to diagnose. Referring to Royal London Hospital 550
109. It’s disgraceful the way I got treated at the Royal London Hospital. Staff are outrageously rude and non-caring. They throw a knife and fork at my bed ad another nurse left water in the corner of the table. I was not able to access it as I just had an operation- how was I suppose to drink it. In contrast UCH is totally the opposite of Royal London Hospital. Staff are polite, very caring and very competent. I decided to have my second child there. 552
110. My wife asked the nurse to help her move, the nurse replied you can move yourself, I asked the nurse to help my wife; again she responded that my wife can move herself. I then had to help my wife. Referring to the Maternity Ward in the Royal London Hospital. 573
111. Waited two days to get discharged as no one was ready to do the paperwork, staff were being lazy and maybe staff shortage, after two day I was going to walk out... (Royal London-Maternity Services) 88

*Equalities*

112. There is no reception staff for Somali speakers, there are lot of Bangladeshi staff...there are no Somali midwifes, no Somali health staff –all services are catered for Bangladeshi’s 267
113. Midwifery training needs to be diverse and reflective of the local community. There needs to be more emphasis on communication skills of midwifes and more cultural awareness training. 322
114. Local community midwifery recruitment campaign – making sure Bengali and Somali people understand about midwifery as a profession and also recruiting more people from the community. One person highlighted...if we had more Somali and Bengali midwifes the issue of language and communication would be far less of a barrier in getting a better service from midwifes. 323
115. Hospitals/PCT should offer an Apprenticeship scheme into midwifery for local residents. 324
116. There is only one Somali interpreter at BLT, and she works at different BLT sites. This is a problem as women who would like access to an interpreter at birth are unable to have one as the interpreting service is not on demand. 329
117. The women highlighted that BLT would claim that they have a language line available at all times –but she questions their response- by saying how is one suppose to use language line at the point of birth. 330
118. In the ethnicity section of the monitoring form there is no box for Somalia (but African) - she thinks BLT should have a tick box for ‘Somalian’ as this will allow them to monitor how many Somali women access maternity service at BLT.331
119. Somali Women tend to get bullied – Somali women are mistreated by midwifes and spoken in a rude manner as they can’t speak English. 332

120. Silent Birth – Somali women have silent births (cultural Tradition). Silent birth implies making no noise whilst giving birth. Because Somali women have silent births she feels midwifes neglect Somali women believing that they are not in pain. A relative told her that her midwife left her alone for 45 minutes in giving birth thinking she was not in pain. She feels that nurses need to monitor the pain threshold on the machines to find out how the patient is doing instead of relying on emotions expressed by women giving birth. 333

***Continuity of care***

121. We have the same midwife on every occasion; this is very useful as it helps us to feel comfortable and free to discuss things. It provides 'continuity of care'.132
122. It would be better to see the same midwife, you feel comfortable to talk to them and there is consistency of care for example you don't have to explain the same thing over and over again...currently I see different midwifes on different occasions 139
123. I see the same midwife all the time; this makes a big difference, as we have a good relationship and understanding of each other, this makes me feel comfortable 140
124. Continuity of care -It would be nice to have the same midwife throughout the pregnancy. With different midwives you have to keep telling them the same information over and over again. 198

***Visiting***

125. Staff do not know regulation of children visiting policy, staff should be consistent ...sometimes they allow children other times they don't 220
126. Visiting policy needs to be reviewed- currently under 18's are not allowed to visit maternity units, this policy is discriminating against people who have children under 18 wanting to make visits to see relatives or sibling giving birth. 327

***What could be improved?***

127. Have another midwife led unit like the Barkantine at the new RLH site. 321
128. midwives trained in customer service – sometimes rude to patients 520
129. people with integrity 521
130. Real, knowledgeable, caring, responsible staff. Not dodgy crooks 522
131. Mental health service for post natal check up. Aftercare re depression. BME friendly 523
132. Keep Children's Centres open in funding cuts. 524

**What would improve the hospital?**

133. hospital staff should be more helpful e.g. helping feed a sick patient 441
134. hospital staff should be more caring 496
135. Specialists to see you thoroughly at hospitals, because they just see you for like 10 minutes, do a small check up and they live it at that. 219
136. Specialists to see you thoroughly at hospitals, because they just see you for like 10 minutes, do a small check up and they live it at that." 196
137. patients must have aftercare when dismissed from hospital 438

138. encourage young people to join to be a nurse 551
139. I guess one way to improve services in hospitals is to have more specialised doctors available, so therefore waiting times are kept to a minimum. 604
140. GP services should do more thorugh assessments so that patients are thoroughly checked and there is no problem, at times assessments and thorough examinations are not met properly and it can be too late. 605
141. Can we change the time on the pedestrian crossing outside Whitechapel Station and across for the Royal London Hospital, doesn't give enough time for those with mobility issues to cross 10

**Other**

142. They do not have a diabetes checking machine at the maternity ward, they asked my husband to get my own one from my home in the middle of the night...it's appalling that the ward does have such equipment 221
143. Women should not feel pressurised into having epidural for pain relief just for midwife convenience. 325
144. I had my baby at the Hommerton. Better than going to RLH 510
145. I had a good experience in Barkantine, the staff are friendly and they give you their full attention (Somali) 511
146. family member was sharing a room with another couple while in labour 515
147. Family member at RLH was examined while in labour in a room where they should not have. 518
148. The doctors and staff in the EGU were lovely - very sympathetic, helpful and kind when explaining that I had miscarried my baby. I was given a side room so that I didn't have the miscarriage on the ward. Follow up care good. Hygiene good - lots of hand gel everywhere. A 6 hour wait to get a bed on a ward to start the treatment for my miscarriage. Lack of communication between medical staff meant that I did not receive the correct medication for 2 days and prolonged what was already a distressing experience. Nursing staff very uncaring and unhelpful, my husband did more of the nursing than they did. I don't want to go back there if I can avoid it. Toilets need cleaning more often in A&E and on the wards. They were unusable on several occasions. 86
149. A man had to go in for a mammogram and felt very, very embarrassed to have wait a very long time in a gown with lots of women. Could they have a male clinic? 4
150. would it be possible to get dongles available for patients to rent or buy so they could use wi-fi in the hospital 8
151. They take for granted you're all right, when you're saying you're ok because you just want to get out of there. 11
152. I don't like going to the reception in the Royal London Hospital purely because everyone in the waiting area can hear what my problem is' – Royal London Hospital. 175
153. It would be good if they can prioritise hospital appointments for children; last time it took me 3 weeks for a hospital appointment for my child, it's too long, as a parent you get concerned. 176
154. I liked the old system, less privatisation- make the health services public." 179
155. Not good service at hospitals. 182
156. Used to be better 5 years ago. But bad now, as the system has gone privatised 183

157. Heart monitor testing specialist based in Hainault- it is a very long way to see a specialist. Don't understand why I couldn't go to Royal London." 297
158. The Royal London is a disgrace – filthy 306
159. Missed monthly blood test at R:H and told to go to a hospital very far away 311
160. Have complained about RLH service to Southwark POWER – 32 Leman St , but there have been delays in process 313
161. Concerns about two acute services under H4NEL proposals- if Royal London is full people feel that they would have to go somewhere else. 328
162. Not happy with the food that we eat at hospital ...this needs to be addressed. 350
163. Royal London food – awful! 304
164. No Neurology consultant at Royal London- they have to come from Barts... 367
165. Information is getting lost in the system i.e. Homerton lost patient biopsy details and failed to send report to GP's and Hospital. 369
166. NHS is not organised properly – money is not used properly by NHS – hospital paid less and work more and local services paid more and work less 376
167. NHS management need to visit services locally to find out how services are run – instead of just meeting up and making decisions – decisions need to be practical 391
168. London Chest Hospital is one of the best...its clean and has good atmosphere 426
169. Everything is no f**cking good (info provided by Sandra Cater) 427
170. Get rid of bureaucracy. There are too many intermediates, and that takes too much time. 607
171. ILF fund should not stop. When a learning difficulties clients goes to hospital, as the client doesn't know anyone they often refuse food or medication (Community Options, Nov 2009) 621
172. Patient had to wait until 11.00 at night for their prescription although they had been told they could be discharged at 11 am. 9

**Appendix 2**

Trust Offices
Mile End Hospital
275 Bancroft Rd
London E1 4DG
T: 020 8223 8933

Stephen O'Brien
Chair
Barts and the London NHS Trust
The Royal London Hospital
Whitechapel
London E1 1BB

11 January 2011

Dear Mr O'Brien

**Re: Tower Hamlets Local Involvement Network (THINk) Comments Report on Royal London Hospital**

At the last Tower Hamlets Health Scrutiny Panel (HSP) on 26 October 2010 THINk presented a report on the comments that we had gathered from local residents over the period October 2009 and July 2010 and suggestions and recommendations for improvements. Members of the Panel felt that this report should be bought directly to the attention of both the Chief Executive and the Chair of Barts and the London Trust. Please find a copy attached.

Since the HSP THINk members have met with Kay Riley (Chief Nurse), Tracy Carter (Deputy Chief Nurse) and Louise Crosby (Divisional Nurse for Acute and Family) and received an initial response to our suggestions and recommendations. Copy attached. THINk appreciates the time and consideration given to the responses provided and will be monitoring progress against some of the actions outlined.

THINk would also like to make a formal request for a patient representative on the Barts and the London Trust Board. We would hope that the representative could be nominated from within the Inner North East London LINks (Tower Hamlets, Hackney, City of London and Newham) as this would give them access to information and evidence on patient views and provide accountability back to LINk members. However it may also be sensible for this representative to come from within the Foundation Trust membership. We look forward to your response to this request.

Yours sincerely

Dianne Barham
THINk Director

cc
Peter Morris (Chief Executive)
Kay Riley (Chief Nurse)

This page is intentionally left blank

Appendix 3

**Barts and the London Trust THINk recommendations and request for information November 2010**

This report contains the recommendations made by THINk that are applicable to the Barts and the London Trust. The recommendations are based on patient and user comments gathered by THINk from local residents, patients and users on their experience of health and social care services between October 2009 and July 2010 and Enter and view visits undertaken in September and October 2010. A full copy of the reports can be found at www.thinknetwork.org.uk .

| Service | Evidence | Recommendation | Response | Date | Further Action |
|---|---|---|---|---|---|
| BLT Board | | 1. THINk would like to formally request that BLT include a patient representative on the BLT Board. | THINk is requested to formally write to the Chairman of Barts and the London NHS Trust with a request. | | |
| Mary Ward | Enter and View Visit October 2010 | 2. The toilet and bathroom facilities in Mary Ward do not enable the hospital to ensure that patient dignity can be maintained. At the very minimum: | There are plans to convert the ablution areas to allow for patients to close the door whilst attending to there personal needs. | | |
| | | 3. The female and male bays should be swapped over (so that the appropriate toilets are available) | The ward has not yet been able to swap the bays so that they to align with the toilets. This is due to high bed occupancy. However, the toilet signage has been changed | | |
| | | 4. The toilets should be thoroughly cleaned and maintenance undertaken to ensure that all mechanisms work effectively. It may be necessary to schedule more regular cleaning given the nature of the ward. | The current cleaning schedules have been in place since July 2010. The schedule is for 3 cleans per day which is the standard for most wards.<br><br>The cleaning standards have improved and in the recent audit the ward received a 100% compliance with the standard | | |
| | | 5. A new shower should be fitted in Mary A. | The bathroom is being assessed and a plan developed to re-design the space into a shower room.<br>The current shower bath area is being refurbished | | |

| | | | | | |
|---|---|---|---|---|---|
| Mary Northcliff Ward | Enter and View Visit October 2010 | 6. Is there a process for clearly identifying the staff that has a problem providing compassionate care in Mary Northcliff. | Yes, all staff receive ongoing review, direct and indirect supervision by their manager and if concerns are raised these are addressed with the individual | | |
| | | 7. Has the rotation of night duty staff with day staff led to any recognisable improvements in the experience of mothers? | Yes all staff now rotate, and there is no permanent night staff. Significant improvements have been made with regards to the quality of care. Staffs have been able to access training during the day and acquire new skills. They have been able to work more in a team during the day, because there is more activity. Everyone has been able share the workload more as a result this change. | | |
| | | 8. Is there any chance of increasing the number of maternity support workers and is there funding to take on the trained maternity support workers from South Bank University funded by NHS London? | There are no plans to increase maternity support workers at present due to budget restrictions. However, their will be development of a transitional care team of support staff in 2011 | | |
| | | 9. Do UCH have the same staffing ratios, if so how are they managing to do it better? | All maternity ratios are assessed using birth-rate + so will be similar throughout maternity units. RLH has the added benefit of breast feeding support workers which many units do not have. The Head of Nursing across London meet and informally share good practices. Recently, NHS Institute for Improvement and Innovation has been looking at improving the number of birth given normally and reducing Caesarean Section. Staff have been sharing and learning via Community of Practice, which is web based tool kit for all clinical staff to share | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | good practice. | | |
| | | 10. Has there been a local community midwifery recruitment campaign. | Yes we have recently taken on 8 new maternity care assistants from the local community. | | |
| | | 11. Does midwife training include feedback from mothers about what good and poor care entails? | Yes the maternity unit use feedback from the birth reflections report/complaints and discussions to inform changes in practice. | | |
| | | 12. Is there information on particular cultural issues regarding giving birth? Could the Maternity Services Liaison Committee feed in to this? | All midwives are given training regarding this – it is possible that more work could be done and we would be interested in the MSLC supporting this | | |
| | | 13. It is crucial that parents are welcomed on to the ward and receive a Welcome Pack explaining what would generally happen between arriving and being discharged. Who does this? How often does it happen? | This is currently part of the MCA or midwifery role – a short leaflet about the ward is available. However, a new brochure is being developed to improve postnatal information given to women. | | |
| | | 14. Could the ward provide education sessions for first time parents? | Yes following feedback an afternoon session is planned daily | | |
| | | 15. How might the issue of lack of breastfeeding support at night time be tackled by the ward? | The breast feeding support workers do not work at night. Information and advice is provided to help support women breast feeding at night. The new maternity unit will also allow partners to stay when requested. | | |
| | | 16. Are there alternatives to using language line | The advocacy service is under review at | | |

| | | | | | |
|---|---|---|---|---|---|
| | | for woman in labour? | present and the maternity unit is also introducing the Doula project | | |
| George Ward | Enter and View Visit October 2010 | 17. Can patients be provided with information before they come in to the hospital on what is likely to happen? | 17. Since THINk visited the ward reconfigurations have taken place and there is now a dedicated day care and same day admission unit on Croft ward. George Ward is now a surgical ward incorporating short stay beds and a surgical assessment unit. Dedicated patient information booklets that detail what patients can expect and how their care and treatment will proceed, are provided from pre-assessment, for all patients. | | |
| | | 18. Once in hospital can whiteboards or information inform patients if things are not happening as normal today and why (e.g there's been a major trauma, or one of the consultants is sick, or they are short staffed) and what the impact is likely to be. | 18. Day care staff have close links with theatre and access the information needed to keep patients informed of changes to schedules. Any changes in planned care, such as list progressions or changes in list order are communicated to staff on Croft so that patients can be kept fully updated and informed. | | |
| | | 19. People should be given information on when they can eat following surgery. Tell people that the surgeons are not going to get around to giving them an update until after they complete all their surgery. | 19. We are in the process of updating and improving our post-operative information leaflets so that patients have written specific and general post op instructions, including eating and drinking following surgery. | | |
| | | 20. How can better communication between doctors and nurses be facilitated to enable more rapid feedback to patients? | 20. We now have dedicated staff for Croft ward who link more closely with the surgical teams looking after the patients. This enables nurse-led discharges following surgery and | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | clear information to patients about follow-up appointments, and further care with their GP. | | |
| A& E | Enter and View Visit October 2010 | 21. Can some form of cushioning be used on the seating in the waiting area if people are waiting up to four hours in A&E? | Infection control considerations prohibit the use of padding on the seats in the department as there is a risk is of body fluids soiling or being absorbed by the cushions. | | |
| | | 22. Can patient feedback screens be more prominently located and patients proactively engaged to record their experience. | The positioning of our feedback screens is being reviewed in all areas to maximise publicity and use. We are designing new posters to encourage people to participate and there is greater engagement of staff teams as they begin to see the results and use the feedback to improve services | | |
| | | 23. Is there the possibility for patient held records to fast track frequent visitors to A&E? | Each attendance at A&E has to be logged in the system to enable test and investigation requests. Each attendance is different and needs to be assessed at the time. Although a patients' history is important it would not necessarily lead to them being fast tracked. Clinicians have access to patient electronic records if the patient is being seen in the Trust. We are using patient held records to enhance care - for example in the care of patient's with learning disabilities the patient passport is used to enable rapid assessment. | | |
| Royal London | THINk Comment Report October 2009 to | 24. Cleanliness standards and schedules should be posted throughout the hospital with specific contact points for complaints on each ward or area. | All wards and departments have cleaning schedules highlighting the service to the area. A blue cleaning schedule should be visual at all times on the patient information board. Information on how to complain is provided | | |

| | | | | | |
|---|---|---|---|---|---|
| | July 2010. | | in leaflets and on posters displayed in patient areas. The supply and display of the posters are reviewed by Matrons and complaints staff | | |
| | | 25. Signage should be developed to inform patients about the ‘untidy state’ of the hospital and the impending move. | Directional signs have been improved and this is an ongoing programme. PEAT inspections along with weekly site visits manage the untidiness which is gradually improving.<br>There are no plans to develop additional signs to inform patients about the move. We have information available about the new building at the main reception area. | | |
| | | 26. Where ever possible patients should be provided with information before they enter hospital on what is likely to happen. | Outpatients<br>All patients referred to the Trust receive information with their appointment letter; this includes a comprehensive leaflet with an insert on text messaging. Patients attending certain clinics e.g. Urology One Stop, receive additional, more service specific information. As part of the work undertaken within the outpatient service transformation, all patient correspondence is being reviewed. This includes the proper use of letter preps which are pieces of information that are automatically inserted into the text of letters and relate specifically to the appointment at hand, in order to give the patients more information. The review is to be completed by March 2011. | | |
| | | 27. What systems are in place to improve communication between staff, particularly between doctors and nurses on wards? | Different wards and departments operate different systems to facilitate good communications. Many areas have multi disciplinary team meetings every week, such as in the Orthopaedics, These meetings will | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | include Doctors, Nurses, Managers and the Physiotherapists and other health professionals.<br><br>When people have complex discharge or continuing care arrangements, case conferences that include the health professionals, carers and patients and/or relatives are arranged to ensure all the parties are informed of the issues and arrangements.<br><br>Day to day communication regarding clinical care is achieved through ward rounds, ward diaries and instructions/entries made in the care records. There are handovers of information and care instructions for nurses at the change of each shift.<br><br>Each Clinical Academic Unit holds monthly meeting to review complaints and serious incidents, decide on actions and next steps and identify points for learning from these.<br><br>All maternity wards have daily multi-disciplinary ward rounds and a midwife is present at the follow up reviews of women. All care plans are communicated verbally between midwife, doctors and other relevant professional and written in the woman's record. | | |
| | | 28. Can we ensure that patient feedback is heard by managers and linked into the performance | Patient complaints are discussed with staff and managers during the course of the | | |

| | | | | | |
|---|---|---|---|---|---|
| | | management system with a clear action plan implemented to bring about change<br><br>29. Are there staff competencies in relation to treating patients with respect and dignity? | investigation. .<br><br>The CAU and Divisional governance teams report monthly to the CAU and Divisional boards. The Boards are made up of senior medical health professional and management staff.<br>The reports include information on patient feedback/complaints and PALS information; Actions plans and changes implemented in response.<br><br>Complains numbers and themes of complaint are presented in report format to the Quality and Safety committee.<br>Results from the real time feedback project will also be presented to these groups with examples of what is being done in response.<br><br>There are core competencies for maintaining respect and dignity for all levels of nursing staff. | | |
| | | 30. Are there clear processes for patient feedback to be taken into account in staff appraisals? Do staff reflection sessions happen at the moment? | If a particular member of staff is named within a complaint or specific feedback about the staff member is received from a patients about their performance it may be recorded as part of a professional portfolio and/or used as part of performance review during appraisal<br><br>Staff reflection and review happens routinely as part of complaint and incident investigations | | . |

| | | | | | |
|---|---|---|---|---|---|
| | | | Reflective practice is undertaken in different ways, by different staff groups throughout the Trust. Clinical and case supervision is used by health professionals. Staff use patient feedback in their portfolios and staff are beginning to use feedback from the RTF to focus improvements in areas that matter to patients | | |
| | | 31. Could patients have a small white board at the end of their beds or a card to go with patient notes where they could note down any questions they have for staff or concerns about their treatment? | Thank you for the suggestion<br>We encourage our patients to write down questions or concerns they have in order to help them remember. However, we do not have plans to issues patients with cards or white boards at this time. | | |
| | | 32. Care for Older People standards should be presented to all nursing and frontline staff and made a performance management priority for supervisions. | Care standards do form the basis for performance management for clinical staff - | | |
| | | 33. Is it possible to look at developing a system for patient held records for frequent hospital users? | We are currently utilising patient held records to enhance care for some groups e.g. in the care of patient's with learning disabilities we utilise the patient passport. Increasing information that patients have to keep as their own record is being implemented gradually through initiatives such as copies of discharge letter sent to the patients. | | |
| | | 34. How often does the hospital use language line for the Somali community and is this cost effective?<br><br>35. Is it possible to develop a system for | In the last quarter the language line was used 8 times for the Somali Community. The total cost to the Trust for this service was £137.50.<br><br>There is an advocacy review underway to further develop the way advocacy is provided | | |

| | | | | | |
|---|---|---|---|---|---|
| | | sessional Somali interpreters to be available as needed for appointments? | in the Trust. We do operate a booking system for appointments and interpreters are booked in advance whenever the need is known. Some of this need is met by the in-house service and some is met by external companies. This includes Somali interpreters. | | |
| | | 36. Are nursing staff required to attend equalities and diversity training with Compassionate Care standards linked to cultural sensitivity training? | Equalities training is now mandatory for nurses | | |
| | | 37. There is a need for increased support and signposting by patient advocates and volunteers. We understand that a Doula volunteer project is commencing with Maternity services and it would be good to see the impact of this. Would it be possible to develop a kind of 'meet and greet' volunteer service on some of the more problematic wards? Can THINk work with BLT staff to further develop the Volunteer Programme? | We have volunteer welcomers based in outpatients and the dental hospital and some that work across the whole site. The Doula project has been organised by Women's Health and Family Services based in The Brady Centre. The initiative will work with women in the community in conjunction with Maternity Services. We have volunteers who befriend patients working on some of the wards. Their role is to keep patients company, shop for them and make drinks and encourage patients to use the real-time feedback touch screen.<br><br>Voluntary Services would be more than happy to discuss with THINk any ideas they may have to improve patient experience in our hospital. | | |
| | | 38. What are the proposed changes in relation to the Choose and Book system? The appointments process still appears to be a major problem and more information is needed on how this is being resolved. When will GPs be able to book at the time of | Many but outpatient services can now be booked direct from the GP surgery, approximately 65% of BLT outpatient services can be booked in this way. There continue to be some issues with using the service for example | | |

| | | | | | |
|---|---|---|---|---|---|
| | | appointment? Why does there seem to be a problem with appointments being cancelled so frequently? | The GP is not aware/chose not to use the CAB system<br>The specialty they needed to be referred to was not available on CAB and so the traditional paper route had to be followed<br>The patient asked to make the booking at a later time<br><br>Plans are in place to have all outpatient services available on Choose and Book for direct booking from GPs by March 2011. Leading up to this there will be a number of communications to GPs to ensure they are aware of the increased service.<br><br>With regard to the clinic cancellations, these do sometimes happen and recently there has been an increase in the number of cancellations. This is due to clinical services rearranging the clinic templates and schedules in order to meet capacity standards. This work is nearing completion and we expect that the number of appointment cancellations will reduce. | | |

THINk has agreed that the monitoring of the quality of RLH services is a priority for this year. We aim to achieve this by:

- Developing and supporting THINk **patient service assessors**. These will be members who are users of hospital services and trained in mystery shopping skills who will be provided with guidance on assessing services from a patient perspective and focusing on the areas above.
- THINk members undertaking **discovery interviews** in key areas of the hospital where patient experience is poor. Information is to be fed back to staff so they understand the impact of their attitude on patients.
- Increasing the number of **Enter and View Visits.**
- Looking at supporting greater use of **volunteers and advocates** within the hospital.
- Ensuring that the THINk **Hospital Task Group** has key input into the transfer of services into the new hospital to ensure that old habits do not relocate with staff.