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Notice of Meeting

Health Scrutiny Committee

Tuesday, 5th April, 2022 at 1.30 pm

in Second Floor Meeting Area Council Offices Market Street Newbury

This meeting can be streamed live here:
https://westberks.gov.uk/hsclive

Date of despatch of Agenda: Monday, 28 March 2022

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Vicky Phoenix on 07500 679060
e-mail: vicky.phoenix1@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Councillors Claire Rowles (Chairman), Alan Macro (Vice-Chairman), Jeff Beck, Tony Linden and Andy Moore

Substitutes: Councillors Jeff Brooks, Gareth Hurley, Thomas Marino and Erik Pattenden

Agenda

Part I

Purpose: Healthwatch West Berkshire to report on views gathered on healthcare services in the district.

10 **Task and Finish Groups** 163 - 166

Purpose: To agree the Terms of Reference and Membership for any Task and Finish Group that the Health Scrutiny Committee might wish to appoint in-depth scrutiny reviews:

1) Continuing Health Care: To look at CHC assessments and awards locally compared to other areas and to consider the review made by the CCG.

11 **Health Scrutiny Committee Work Programme** 167 - 168

Purpose: To receive new items and agree and prioritise the work programme of the Commission.

Sarah Clarke
Service Director (Strategy and Governance)

If you require this information in a different format or translation, please contact Stephen Chard on telephone (01635) 519462.

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Health Scrutiny Committee – 5 April 2022

Item 1 – Apologies

Verbal Item

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DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD ON WEDNESDAY, 10 NOVEMBER 2021

Councillors Present: Tony Linden, Alan Macro (Vice-Chairman), Andy Moore and Claire Rowles (Chairman)

Also Present: Andy Sharp (Executive Director (People)), Gordon Oliver (Principal Policy Officer), Andrew Sharp (Chief Officer, Healthwatch), Katie Summers (Berkshire West CCG), and Lesley Wyman (Healthwatch).

Apologies for inability to attend the meeting: Councillor Jeff Beck

PART I

10 Minutes

The minutes of the meeting on 11 August 2021 were accepted as a true and correct record.

11 Declarations of Interest

There were no declarations of interest.

12 Petitions

There were no petitions received.

13 Health Scrutiny Committee Prioritisation Methodology

Gordon Oliver presented the report on the Health Scrutiny Committee Prioritisation Methodology (Agenda Item 5). He explained that this was a tool designed to help Members prioritise topics for future scrutiny, and was encouraged in the Government's Statutory Guidance. In developing the methodology, reference had been made to guidance produced by the Local Government Association and the Centre for Governance and Scrutiny, as well as similar tools produced by other local authorities. The proposed methodology adopted criteria using the PAPER acronym: public interest, area affected, performance and priority; effectiveness; and resources available. An optional scoring system was also proposed for each of the criteria.

Councillor Andy Moore sought confirmation that each topic would be assessed in this way so they could get an idea as to which should be prioritised. He considered that it had picked up all relevant considerations and was a good starting point.

The Chairman expressed her thanks for the work undertaken in preparing the methodology and suggested that it set a good model for other areas of the Council.

Resolved that: the Health Scrutiny Committee adopt the PAPER criteria (Public interest, Area affected, Performance/Priority, Effectiveness, Resources) and associated scoring system to help prioritise its work programme.

14 Protocol between the West Berkshire Health Scrutiny Committee and local health bodies

Gordon Oliver presented the report on the protocol between the West Berkshire Health Scrutiny Committee and local health bodies (Agenda Item 6). He explained that the need for a protocol was identified within the Terms of Reference for the Committee. The aim of the protocol was to encourage improved engagement and communication between the Committee and local health bodies. It also set clear standards for working together and would give confidence in planning for service change. The protocol included a series of seven working principles. It also set out the factors that would be considered when determining whether a proposed variation in health services was considered 'substantial' and therefore requiring formal consultation with the Health Scrutiny Committee. The protocol proposed that initial consultation on proposed changes in health services would take place with the Chairman and Vice Chairman of the Health Scrutiny Committee, who would make a recommendation to the rest of the committee as to whether the proposed change was considered to be 'substantial'. It was explained that the protocol was closely modelled on that used by Oxfordshire Joint Health Scrutiny Committee.

Councillor Andy Moore felt it was a sensible approach. He noted that it was an agreement between the Committee and health bodies and asked if all partners would be required to sign the document and how many protocols would be needed. The Chairman noted that the recommendation sought to authorise consultation with local health bodies with a view to bringing a final version back for sign-off. This would give partners a chance to have their say on the draft protocol.

Councillor Tony Linden noted that a Joint Health Overview and Scrutiny Committee (JHOSC) had been set up to scrutinise the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS). He asked if any meetings were planned. Gordon Oliver indicated that no meetings were planned yet, but officers at Oxfordshire County Council were drafting a protocol to be adopted by the JHOSC and were liaising on the need for future meetings.

Councillor Alan Macro asked if the fact that the proposed protocol was based on that used by Oxfordshire meant that it was more likely to be accepted by health partners. Gordon Oliver confirmed that there were some common health partners and the move towards the BOB ICS meant that it made sense to model the scrutiny protocol on the Oxfordshire model.

Councillor Graham Bridgman asked what would happen if one of the health bodies objected to a particular aspect of the protocol. He suggested that it would be good to try to have a common protocol across the BOB ICS area, since it would be easier for health partners. The Chairman agreed with Councillor Bridgman and suggested that protocols were only as good as the engagement from all partners.

Councillor Moore suggested including the list of bodies consulted in the protocol and that there should be some reference to their agreement or response to the consultation. The Chairman agreed and expressed her thanks for the work undertaken in developing the draft protocol.

Action: Gordon Oliver to include a list of bodies consulted in the Protocol.

Resolved that the committee:

1. Endorse the draft protocol and the process for dealing with proposed substantial developments of variations to health services.

2. Authorise consultation with local health partners on the above, with a view to bringing a final version back to Health Scrutiny Committee for approval.

15 NHS Dentistry

Hugh O'Keefe gave a presentation on NHS Dentistry Services (Agenda Item 7). The key points from the presentation were as follows:

- Dental services were running at 65% of capacity due to Covid safety requirements.
- Patients were prioritised according to need using criteria set at the national level.
- Capacity allocated to NHS treatment was determined by each practice, resulting in variations in availability of appointments.
- Action was being taken locally, with additional sessions offered to practices for patients who didn't visit a dentist on a regular basis.
- NHS patients were not 'registered' with a particular dentist.
- Around 50% of the population attended an NHS dentist regularly, with the remainder going private or attending when they had a problem.
- A pilot programme was being run for looked after children.
- Significant investment was being made in community based referrals for out-of-hospital specialist oral surgery for the period to 31 March 2023.
- The additional investment was intended to keep the system as open as possible, or at least stabilise waiting times for treatment, but while dentists continued to operate at reduced capacity, there would continue to be a backlog.
- Feedback from dentists suggested that some patients failed to attend booked appointments, which was causing issues, since dentists had to set aside long time slots to allow for disinfection between patients.
- There were some challenges with the workforce – the pandemic had resulted in challenging working conditions, and more dentists wanted to work part-time on the NHS – this meant that more dentists were required to keep up with demand.
- The 65% capacity limit was scheduled to be reviewed in January 2022.
- There would also be a national review in April 2022 to see what incentives and systems should be incorporated into contracts.
- It was anticipated that there would be issues with availability of NHS dentistry appointments for some time.

Councillor Tony Linden asked if the dentistry workforce was facing similar issues to GPs with significant numbers due to retire in the near future. Mr O'Keefe suggested that this was less of an issue with dentists. Contracts for dental services were instigated in 2006, which were accompanied by significant national investment. As a result of this additional capacity, there had been a 30% growth in patients attending the dentist across the Buckinghamshire, Oxfordshire and Berkshire West area. Mr O'Keefe confirmed that the workforce was relatively young and suggested that the issue was more related to the heavier case mix, making it a tougher environment – this was prompting some dentists to move to the private sector. However, this was more of an issue in other areas.

Council Alan Macro noted that a high proportion of children treated in hospital were there for dental problems. He suggested that many of these issues could have been identified earlier by a dentist and asked how this could be addressed. Mr O'Keefe highlighted the strong correlation between socio-economic factors and dental extractions in hospitals for children, with 40% of the community dental extractions in Berkshire coming from four postcodes. He highlighted the 'starting well' initiative to promote oral health within local communities. He suggested that prototype contracts had been trialled for about 10 years, which had a greater focus on preventative measures, but there were challenges in terms of striking a balance between access and prevention. He suggested that there would be more opportunity to engage in preventative work once the peak of the pandemic had passed.

The Chairman asked about the role of dental hygienists. Mr O'Keefe noted that those involved in preventative work may not need the same level of qualifications as dentists and so resources could be targeted appropriately. He highlighted work being done on training pathways (e.g. dental nurses training to become hygienists and eventually dentists). He also highlighted a new course run by Health Education England on oral health promotion, which could be done outside the dental surgery. He noted that community dental services had done much of this work to date and suggested that more needed to be done through high street dentists.

The Committee agreed to suspend standing orders to allow Andrew Sharp to speak on this issue. Andrew Sharp stated that NHS dentistry was the issue that the public most contacted Healthwatch about. He suggested that waiting lists would continue to increase while restrictions remained in force to limit capacity to 65%. He noted that acute hospital services were now working to 110% of capacity to address backlogs, and asked when normal access to dentistry would return. To illustrate the point, he highlighted a recent letter from a patient who was unable to get an appointment until March 2022. He also asked about NHS resources for emergency dental treatment in West Berkshire. Finally, he asked if the integration of NHS dentistry within the ICS would be a positive development. Mr O'Keefe indicated that NHS dentistry would be a high profile issue for the ICS and discussions had already started. He indicated that there would be investment to address the issues mentioned, and highlighted success in community dental and referral services, with good take-up by providers to address waiting lists. He highlighted that if dentists hit the 65% threshold, then they would retain 100% of their funding. This represented additional investment into the system.

Councillor Andy Moore sought confirmation that all dental practices offering NHS treatment also offered private treatment. Mr O'Keefe indicated that some practices were 100% private, while some only offered NHS treatment to children and exempt patients. Even practices that had substantial contracts with the NHS also offered private treatments.

Councillor Moore asked what measures were in place to prevent dentists from offering NHS patients private appointments. Mr O'Keefe stressed that it was important for the patient to make an informed decision, with options clearly explained to them. Instances of patients being pushed towards private treatment when they had a clear preference for NHS treatment would be reviewed and followed up. He explained that practices set aside a particular amount of time for NHS work and if that was full, then patients may be offered private appointments, but they would need to ensure that patients were making informed choices.

The Chairman thanked Mr O'Keefe for attending and for his presentation.

16 Healthwatch Report

As part of the Healthwatch Update (Agenda Item 10), Lesley Wyman presented the report on Children's and Adolescents' Mental Health Services (CAMHS).

She explained that Healthwatch had surveyed the parents / guardians of current and former CAMHS users living in West Berkshire and the survey attracted 128 responses.

The survey report referenced a national report by the Children's Commissioner on the state of CAMHS in 2021. This revealed a big increase in referrals, in part due to the Covid pandemic, and that this increase in need was expected to continue. However, capacity was not keeping pace with the increase in demand.

Berkshire West CCG had experienced one of the largest increases in waiting times in the country between 2017/18 and 2019/20, although this appeared have reduced slightly

since 2018/19. A positive point was that Berkshire West CCG had one of the largest reductions in the number of referrals to CAMHS being closed. Figures were not available on CAMHS spend for Berkshire West relative to other areas.

The Healthwatch West Berkshire survey showed that one of the main issues was the very long waiting times, with 50% of respondents waiting between 1-3 years for a diagnosis or to access CAMHS. Families felt that there had been impacts on their children's education and other family members had also been affected.

Three quarters of respondents felt the service had note made a difference to their child, 7 out of 10 had been unhappy with the information they got on discharge and 8 out of 10 wanted more information about where to go for help. There were many comments asking for waiting times to be decreased, and for better communication throughout the journey.

The report made a series of recommendations related to the above points (i.e. decreasing wait times, improving communications, and improving prevention / early intervention to reduce the need for CAMHS referrals).

It was noted that the CCG had recently published a refreshed version of the Local Transformation Plan (LTP). The Healthwatch recommendations had been linked to the previous version. The LTP detailed progress that had been made and outlined the Children and Young People's Mental Health and Emotional Wellbeing Review. The LTP included a refreshed set of priorities and indicated how these would be met.

Lesley Wyman stated that the revised LTP gave a lot of reassurance that commissioners were focusing on and continuing to improve CAMHS locally.

Councillor Tony Linden was struck by the level of dissatisfaction with the service and the waiting times. He noted that the survey had attracted a small response and asked if those responding were more likely to have experienced problems. Lesley Wyman explained that some respondents had been satisfied with the service, but the number was relatively small compared to those who were dissatisfied. She suggested that this was to be expected from this type of survey.

Andrew Sharp stated that there were around 1,500 CAMHS referrals per year across Berkshire West, so the number of survey responses was significant. He indicated that Healthwatch England research had shown that for every person who complained, there were 100 people who had not bothered to do so. He suggested that long wait times may be the critical issue, since patient's conditions may deteriorate in that time. The focus groups had shown that nothing much happened until a diagnosis was made and there may be unrealistic expectations of what would happen once treatment commenced. He suggested that the pandemic had made things worse and stressed the need for a continued focus on CAMHS. He thanked Lesley Wyman for her work on the report.

Councillor Alan Macro expressed shock at the length of waiting times and the level of dissatisfaction with treatments. He noted that there would be significant impacts on families of patients. He asked about levels of confidence in the ability of the LTP to address the issues raised. Katie Summers indicated that the CAMHS Team were aware of the problems caused by the long waiting times and were working very hard to address this. She also highlighted that the NHS had given additional funding to Integrated Care Systems to address existing problems. However, demand for CAMHS had risen as a result of lockdown. She indicated that a focus on preventative services was needed to address low level issues and prevent them from escalating. She noted that a update would be given to the next meeting of Health and Wellbeing Board.

Councillor Andy Moore noted that the survey had identified issues around communication and asked how these would be addressed. Andrew Sharp indicated that the survey provided a snapshot while transformation work was underway. He accepted that the LTP

had changed substantially and commended the CCG. He noted that the report had gone to the Mental Health Board and they had been given the chance to respond. He suggested that children's mental health and wellbeing should not just be for the Health Service to address, but it needed all relevant parties to be involved to look at causes and mitigations. He noted that GP practices would get support from mental health professionals over the next couple of years. He also suggested that there was a need to manage the expectations of families regarding the effectiveness of treatment and that when they left CAMHS, they were given adequate support and information. He highlighted that there were major workforce issues with mental health professionals.

The Chairman thanked Lesley Wyman and Andrew Sharp for their presentation. She stressed that this was an enormously important and ongoing issue. She asked Healthwatch if it would be appropriate for the Health Scrutiny Committee to include this on their work programme to check how things were progressing at a future date. Councillor Graham Bridgman indicated that it should be assessed using the protocol to confirm if it was a priority. Councillor Moore was encouraged by the interventions being made, but felt that the process would be a long one and supported a future item on CAMHS.

Councillor Linden asked about timescales for a follow up. Andy Sharp noted that the Integrated Care Partnership was looking at Mental Health (including CAMHS) as a joint project. Underpinning work was due to be completed by March with delivery rolled out in the following months. He suggested that a good update could be provided within 2-3 months. Katie Summers confirmed that there had been additional investment within the last few months and suggested looking at CAMHS again in March, by which time there should be some improvements in waiting lists. She suggested that a further update could be given around 6 months after that. She highlighted that this related to Priority 4 of the new Health and Wellbeing Strategy and that work would be done through CAMHS and through wider partnerships to support this priority.

The Chairman then invited Andrew Sharp to present the Healthwatch West Berkshire Covid-19 First Wave Survey Report.

Andrew Sharp stated that the report had already been presented to Health and Wellbeing Board. He indicated that the country had not been prepared for Covid and stressed that it was important to have formal learning about lessons from this pandemic, so they could be applied to the next one. He also stressed that the workforce needed to be looked after, since they were exhausted after the first wave, but there had been another wave since then, and it was looking like there would be a third wave over the winter.

The Chairman thanked Healthwatch for the report. She noted that there had been around 300 respondents to the Healthwatch survey, compared to 3,395 who had responded to the Council's survey. She acknowledged that while there were undoubtedly lessons to be learned, the Council's survey had painted a more positive picture on aspects of the response such as the Community Hub and communications.

17 Access to GPs and the Impact of Covid-19 on Primary Care

Katie Summers was invited to give a presentation on Access to GPs (Agenda Item 8). It was noted that the report had already been presented to Health and Wellbeing Board. Key points from the presentation were as follows:

- Due to pressures in Primary Care, the CCG had been unable to get a GP to attend the meeting.
- Around 50% of appointments were being carried out face-to-face, which was the preferred format for GPs.

- Most practices had moved to a hybrid model, with telephone / video consultations used to triage patients and identify those who needed a face-to-face appointment.
- Demand for appointments had increased considerably compared with the pre-Covid situation.
- Many people had experienced delays in elective appointments, so there was a backlog of re-referrals to secondary care services.
- Across Berkshire West, there had been a 76% increase in consultation activity, while some Primary Care Networks had experienced increases of up to 155%.
- Face-to-face / telephone consultations had increased in some PCNs and decreased in others, but overall, there had been a 5% increase.
- Each GP surgery recorded its activity slightly differently, but NHS England had recently established the General Practice Data Audit, which set out standard parameters for recording all GP activity.
- Responding to online requests was a big challenge for most GP practices.
- Face-to-face consultations were taking longer due to Covid infection control measures (14-16 minutes vs 8-10 minutes pre-Covid).
- Housebound patients / those with transport difficulties had better access to GPs than before, which was a benefit of the new hybrid model.
- The Respiratory Hub arrangements had been stepped down, with all patients managed within practices – patients were given pulse oximeters to monitor the oxygen in their blood.
- There was a local campaign to inform patients about when to contact their GP or when to call 111 or 999.
- Plans were underway for the next phase of the Covid vaccination programme.
- A workshop had been held in May to agree remedial actions for primary care – a key outcome was that the CCG had commissioned 170 additional appointments per day to increase capacity up to March 2022.
- The Government had launched a new Winter Access Fund for General Practice, with £74 million allocated to Buckinghamshire, Oxfordshire and Berkshire West.
- Workforce challenges remained – there had been a 6.8% reduction in the number of salaried GPs in the 5 years to March 2021.
- Efforts were being made to promote General Practice as a career for new doctors.
- The Additional Roles Reimbursement Scheme was being used to create multi-disciplinary teams to support GPs (e.g. paramedics, pharmacists, mental health specialists, nurses and care navigators).

The Chairman asked if additional roles were being used to support GPs across all GP surgeries in West Berkshire. Katie Summers explained that the clinical director and partners for each Primary Care Network (PCN) made decisions about staffing. In some cases staff would be shared across surgeries within a PCN, while in other cases each surgery might have a dedicated resource.

Councillor Alan Macro expressed concern about the emphasis on non-face-to-face consultations and suggested that GPs could tell a lot about a patient by their demeanour and how they were walking. Also, telephone conversations did not allow GPs to observe body language to confirm patients' understanding of what they were being told. He highlighted potential issues with online consultations for patients with hearing difficulties, people without technology, poor broadband, etc. He also suggested that phone consultations were not saving time for patients who then had to book a face-to-face consultation. Katie Summers agreed about the points in relation to body language. However, GPs had received special training to listen for particular clues. She noted that the triage system was still 'work in progress' and that triage calls would not be appropriate for high-risk individuals with long-term conditions. She stressed that the focus

was on quality of care and safety. She noted that most practices had a hearing loop system and all practices were able to automatically flag individuals with hearing difficulties.

Councillor Tony Linden raised issues around: training for receptionists; emails not being seen by GPs prior to making calls to a patient; defined time slots for a calls to avoid patients having to wait around needlessly; and ensuring that the appropriate communications tool was used for each patient (e.g. elderly patients may only have a landline). Katie Summers noted that there was a digital inclusion programme being run with Age UK aimed at patients aged 65+, providing iPads and training. She noted that patients could use Footfall to leave messages for GPs via their websites and responses were generally provided within two hours.

Cllr Linden He also indicated that he had sent a picture to his practice to clarify a previous discussion, but it had been sent to a different doctor and he had been forced to start the consultation afresh. He also observed that some people under the age of 65 had issues with IT.

Action: Katie Summers undertook to try and resolve any email issues with Cllr Linden outside the meeting.

The Chairman agreed about the need for time slots for telephone calls rather than having patients waiting for a whole morning. She also asked if enough was being done to communicate with the public and what the Committee / Council could do to help. Katie Summers agreed that Members could help to disseminate messages about the pressures and demands on GPs, and use the poster that the CCG had produced when talking to constituents. She also offered to discuss the issue of timed slots for calls with colleagues and get an audit of waiting times.

Action: Katie Summers to review the potential for timed slots for telephone calls and to undertake an audit of waiting times.

Councillor Andy Moore asked to what extent individual practices were developing their own hybrid models and whether there were any plans to achieve a consistent approach and to communicate to the public which aspect of the new approach they would be likely to encounter in particular situations. Katie Summers noted that there were 13 GP practices which were independent businesses, but there were 4 PCNs and each had a memorandum of understanding about the business models to be used. Also, the PCNs were sharing information across Berkshire West, which would help to work towards a standardised model. However, she noted that some flexibility was needed to tailor the approach to the local population.

The Chairman asked what was being done to support the mental health needs of health professionals during this challenging time. Also, she asked what the Committee could do to help. Katie Summers noted that there were national initiatives such as advice lines, counselling and support. She suggested that Members could help by promoting the poster to patients. She indicated that she would provide contact details for practice managers to allow Members to direct complaints for them to respond.

Action: Katie Summers to provide Health Scrutiny Committee Members with details of Practice Managers in West Berkshire.

18 Berkshire West Clinical Commissioning Group Update

Katie Summers was invited to give a presentation on the work of the Clinical Commissioning Group (Agenda Item 9). Key points from the presentation included:

- The CCG would no longer exist as of April 2022, but would be integrated into an Integrated Care Board (ICB) for Buckinghamshire, Oxfordshire and Berkshire West (BOB).
- An Integrated Care Partnership (ICP) would be set up at the BOB 'system' level and discussions were ongoing regarding membership.
- Place Based Partnerships (PBPs) would be created, including one for the Berkshire West 'place' to support the population health needs of local residents, with representation from West Berkshire, Reading and Wokingham.
- Functions currently discharged by the CCG would transition to the ICB. These were being reviewed to see what could be delegated to PBPs.
- An announcement regarding the appointment for the new ICB chief executive was expected shortly.
- Javed Khan had been appointed as Chairman.
- The non-executive directors would be recruited within the coming weeks.

Action: Councillor Graham Bridgman undertook to share the slide showing the ICS terminology with Health Scrutiny Committee Members.

It was noted that the terminology and acronyms were confusing, particularly with regards to the Integrated Care Partnership (ICP), which was currently operating at 'place' level, but would operate at 'system' level in future.

It was also noted that changes to legislation would be required, since Health and Wellbeing Boards were required to have CCG representatives as a matter of statute. Memberships would need to take account of the new structures.

The Chairman sought clarification about how the Health Scrutiny Committee would interface with the Integrated Care Board. It was confirmed that there would be no representation from the Health Scrutiny Committee, but a Joint Health Overview and Scrutiny Committee had been set up to undertake scrutiny at the 'system' level. There would be one local authority representative on the ICB and there would also be local authority representation on the ICP.

Katie Summers stressed that it was important to agree what would be delegated to 'place' level and it was critical to have the right form and governance for the PBP, including reporting to Health Scrutiny.

Councillor Andy Moore noted that the proposed changes were significant and asked if there was a parallel assessment to ensure that everything was being picked up by the new bodies. Katie Summers confirmed that NHS England was undertaking a review of all the individual functions, statutory roles and work programmes. However, she acknowledged that it would be appropriate for the Joint Health Scrutiny Committee to check that everything was being picked up.

19 Work Programme

The Chairman invited Members to put forward items for consideration – all proposed items would be subject to the agreed prioritisation methodology and would then be reviewed by the Chairman and Vice Chairman.

It was highlighted that there was a form on the website to allow members of the public to nominate topics for health scrutiny, which could be accessed via the following link:

https://www.westberks.gov.uk/article/37170/Suggest-a-Topic-for-Scrutiny

(The meeting commenced at Time Not Specified and closed at Time Not Specified)

CHAIRMAN ……

Date of Signature ……

Health Scrutiny Committee – 5 April 2022

Item 3 – Declarations of Interest

Verbal Item

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Health Scrutiny Committee – 5 April 2022

Item 4 – Petitions

Verbal Item

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NHS
Berkshire Healthcare
NHS Foundation Trust

CAMHS T4 New Service Model

Louise Noble, Head of CAMHS & BEDS

Thames Valley CAMHS Tier 4 Network

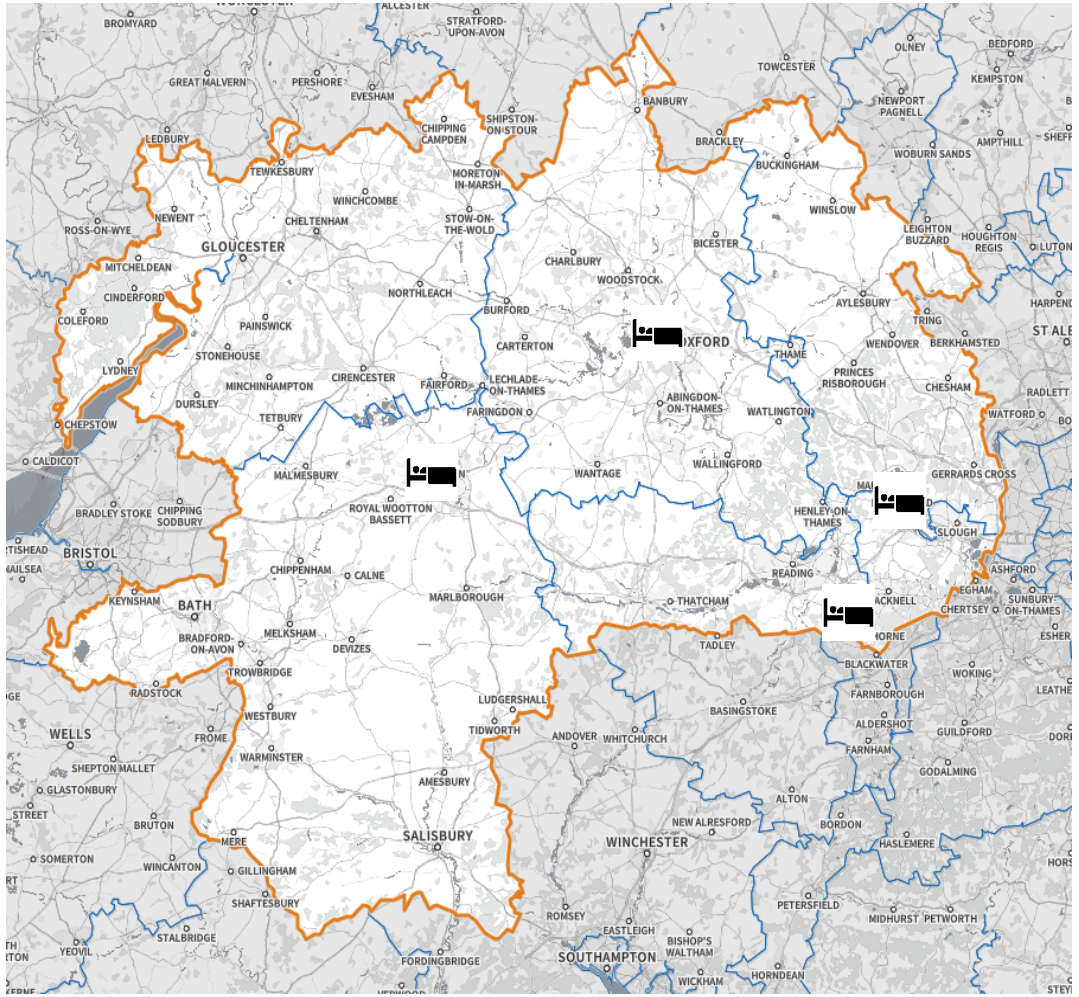
Provider Collaborative Objectives:

- Care closer to home is maximised
- Out of Area Beds are minimised
- Patient experience and quality is improved whilst sharing best practice and innovation.
- Any savings are to be reinvested to aid further improvements

Bed Stock and Services:

- Highfield Unit: 18 GAU beds
- Huntercombe Maidenhead: 60 beds (29 PICU, 11 GAU, 20 ED)
- Marlborough House: 12 GAU beds
- Phoenix Unit: Day patient unit & intensive home treatment
- ED Hospital at Home: PC wide
- OHFT PICU: opening late 2022

Please note: not all Huntercombe beds are aligned to the Network



What is Phoenix Unit?

- Day hospital and home treatment service for young people aged 12-18 years of age with acute moderate/severe and complex mental health disorders whose needs can not be adequately met within community and outpatients settings (“tier 4 CAMHS”).

- New service developed in collaboration with NHS England and Oxford Health NHS Foundation Trust in line with national evidence of hospital at home and intensive community treatment models.

- Designed to meet the needs of young people who would meet criteria for Tier 4 GAU or specialist EDU services.

- Capacity for up to 16 young people, with an expectation that approx. 50% will need ED care and 50% GAU.

- Core hours are 8am-8pm Monday-Friday; 9am-5pm Saturday, Sunday & Bank Holidays. Support out of hours is provided via an on-call rota and the crisis service.

- Opened 1st May 2021.

What do we offer?

Assessment and care in line with the national specification for CAMHS Tier 4 care and relevant NICE clinical guidance

- Multidisciplinary assessment, formulation of difficulties and diagnosis
- Evidence-based individual, group and family therapies
- Medication initiation and monitoring
- Nursing support
- Meal planning, meal supervision, dietetic advice
- Social care advice, support and liaison
- Education support and onsite school
- Joint work and liaison with other professionals, including community CAMHS care teams, acute health colleagues, CAMHS inpatient provision, social care, education etc.

Average length of stay is 12 weeks

The multidisciplinary team

- Service manager
- Consultant psychiatrists
- Clinical psychologists and assistant psychologists
- Family and systemic psychotherapist
- Occupational therapist
- Social worker
- Dietician
- Nursing team (qualified nurses and clinical support workers)
- Activities co-ordinator
- Teachers and education staff
- Administrative staff

Patient Timetable CAMHS Tier 4 Hospital at Home Service – Aug 2021

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	ARRIVAL 08:15	ARRIVAL 08:15	ARRIVAL 08:15	ARRIVAL 08:15	ARRIVAL 08:15
	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15
	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30
	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30
	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00
	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15
	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30
	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15
	POST MEAL SUPPORT / 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT / 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT/ 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT/ 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT/ 1-2-1 SESSIONS SLOTS 13:15- 14:00
	SCHOOL 14:00 – 15:00	MANAGING MOODS (10.08.2021) 14:00 – 15:00	SCHOOL 14:00 – 15:00	MANAGING MOODS 14:00 – 15:00	Wellbeing Activity 14:00 – 15:00
	BREAK /SNACK 15:00-15:30	BREAK /SNACK 15:00-15:30	BREAK / SNACK 15:00-15:30	BREAK /SNACK 15:00-15:30	BREAK /SNACK 15:00-15:30
	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45
	Motivation and Resilience Group (Start: 16/09/2021) 15:45-17:00	Food and Nutrition Group (ED)/ other (Start 10.08.2021) 15:45-17:00 1-2-1 SESSIONS SLOTS	Parents Group Non-ED / OT Related Group (TBC mid sept) 15:45-17:00	Advocacy/ Community Meeting (Alternate Fortnightly) 15:45-17:00 1-2-1 SESSIONS SLOTS	The Weekend Group 15:45-17:00
	Wellbeing Activity 17:00 -18:00	Wellbeing Activity 17:00 -18:00	Wellbeing Activity 17:00 -18:00	Wellbeing Activity 17:00 – 18:00	Wellbeing Activity 17:00 – 18:00
	1-2-1 FT SESSIONS SLOTS	Parents Group ED 18:00-19:30 (07/09/2021)	1-2-1 FT SESSIONS SLOTS	1-2-1 FT SESSIONS SLOTS	
	DINNER 18:00- 17:00	DINNER 18:00- 17:00	DINNER 18:00- 17:00	DINNER 18:00- 17:00	DINNER 18:00- 17:00
18:45	POST MEAL SUPPORT	POST MEAL SUPPORT	POST MEAL SUPPORT	POST MEAL SUPPORT	POST MEAL SUPPORT

WEEKEND	SUPPORT-	HOME/DIGITAL
	BREAKFAST 09:15-09:45	BREAKFAST 09:15-09:45
	POST MEAL SUPPORT/ 1-2-1 09:45-10:15	POST MEAL SUPPORT/ 1-2-1 09:45-10:15
	WELLBEING ACTIVITY / COPING SKILLS & STRATERGIES 10:15 – 12:30	WELLBEING ACTIVITY/ COPING SKILLS & STRATERGIES 10:15 – 12:30
	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15
	POST MEAL SUPPORT/ 1-2-1 13:15 – 14:00	POST MEAL SUPPORT/ 1-2-1 13:15 – 14:00
	WELLBEING ACTIVITY 14:00 -15:00	WELLBEING ACTIVITY 14:00 – 15:00
	BREAK / SNACK 15:00-15:30	BREAK / SNACK 15:00-15:30
	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45
	COPING STRATERGIES & EVENING MEAL PREP 15:45 – 16:45	COPING STRATERGIES & EVENING MEAL 15:45 – 17:00
	HOME 16:45	HOME 16:45

Key: Groups highlighted in yellow

1-2-1 SLOTS ARE Bookable For Nursing / Psychology/ OT / FT/ Doctor via the 1-2-1 booking sheet

Examples of young people attending

- Young person with anorexia, significantly underweight and losing weight in the community despite regular support
- Young person with severe emetophobia (vomit phobia) and obsessive-compulsive disorder whose life became so restrictive that they were not able to leave the house
- Young person with high levels of anxiety, perceptual disturbances (seeing figures, hearing voices), strong suicidal thoughts and impulses, struggling to maintain adequate functioning in the community; diagnosis unclear
- Young person with severe depression, spending all of their time in their bedroom, not socialising or attending school, possible autism

Such young people would previously have been admitted to an inpatient unit.
Now we are able to offer a less restrictive option that provides the same intensity of therapeutic support but enables them to stay at home and connected with friends and family.

Progress to date

Berkshire CAMHS Tier 4 Alternative Model Development - Information for Transition Modelling													
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
Expected Admissions to New Model	2	2	2	2	2	2	2	4	4	4	4	4	34
Actual Admissions to New Model	1	3	6	1	2	3	3	1	3	1	3	5	33

- ✓ The service has accepted the expected number of YP for treatment in the transition year.
- ✓ Fewer young people have needed an inpatient admission as a result of the change in service model than anticipated.
- ✓ There have been a higher number of referrals for YP needing intensive treatment of an eating disorder than expected. This is in line with the continued increase in referrals to the specialist ED service (national and regional trend).
- ✓ Several young people have escalated to need acute paediatric admission for re-feeding and then needed transition to inpatient care. The YP have remained under the care of the Willow House team while at the Royal Berkshire Hospital, with good joint working across the teams and positive feedback from acute colleagues.
- ✓ The number of young people/families needing to access crisis support outside of core service hours has been very low.
- ✓ The number of incidents of self-harm has been significantly lower with this service model.
- ✓ There have been no serious incidents during the transition year.
- ✓ Service user feedback is positive.

Feedback from young people

When I first arrived at CAMHS Phoenix, I was very anxious and scared. Though it was a lot to get used to, the staff and patients were really friendly and supportive. The more I spent time at CAMHS Phoenix, the easier it was for me to fit in and feel safe. Since coming to CAMHS Phoenix, I have learnt to grow in myself and look past my anxiety. The group sessions and activities have really helped me know how to use strategies that can be life changing. Overall, my experience here has given me hope and a fulfilling future.

*Safia, age 17y
*pseudonym

Feedback from young people

Before I arrived at Willow House, I was really nervous, with no idea of what to expect and I was dreading coming. My first day was pretty daunting, it was a bit like being at a new school, but I was surprised how quickly I made friends.

The best thing about Willow House is the staff. From the nurses to the psychologists to the therapists, they are all so kind and do everything they can to help you settle in.

Whilst I miss my normal school and friends, I know I'm in the right place to help me get better.

*Emma, aged 15y

*pseudonym

Hampshire Hospitals NHS Foundation Trust

Basingstoke and North Hampshire Hospital

Inspection report

Aldermaston Road
Basingstoke
RG24 9NA
Tel: 01256473202
www.northhampshire.nhs.uk

Date of inspection visit: 16 November 2021
Date of publication: 28/01/2022

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Basingstoke and North Hampshire Hospital

Inspected but not rated

We carried out this unannounced focused inspection of maternity services because we received information giving us concerns about the safety and quality of the service.

Information of concern had been received from several sources about the maternity services across the trust. This included staff whistleblowing, patient complaints and information from other regulatory bodies.

Hampshire Hospitals NHS Foundation Trust provides maternity services at Basingstoke and North Hampshire Hospital, Royal Hampshire County Hospital and Andover War Memorial Hospital. This report focuses on our findings at Basingstoke and North Hampshire Hospital.

This inspection has not changed the rating of the location overall. However, our rating of maternity went down because our ratings limiters were applied due to enforcement action.

We did not change the rating of the hospital. Our rating of maternity safe and well led went down. We rated them as requires improvement because:

- We found breaches of regulations reducing the quality of care or people's experience and have taken enforcement action under regulations for safety, safeguarding and governance. Our ratings rules say that in these circumstances the rating will normally be limited to requires improvement.

How we carried out the inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities in maternity services. We carried out a focused inspection related to the concerns raised. This did not include all of our key lines of enquiry (KLOEs). We looked at KLOEs specific to the domains: safe, effective and well-led.

We visited clinical areas including the delivery suite, the postnatal and antenatal ward and the maternity day assessment unit (MDAU).

We spoke with 20 staff, including service leads, midwives (bands 5-7), obstetric staff, consultant anaesthetists, obstetric theatre staff, maternity care support workers, student midwives and the patient safety lead.

We observed the morning multidisciplinary handover on the delivery suite and the morning handover on the postnatal and antenatal ward.

We reviewed four sets of maternity records and prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

Our findings

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- The service did not have enough staff to care for women and keep them safe and staff did not always have time to complete training in key skills. Staff did not always identify and act on risks to women in a timely manner. The service did not manage safety incidents well and ensure changes in practice were shared widely. The service did not ensure essential equipment checks were completed and the environment did not meet national guidelines.
- Leaders did not have reliable, up to date information and understanding to ensure risks and priorities in the service were managed. Senior leaders were not always visible and approachable in the service. Some staff felt respected and valued, but senior staff did not always create a culture which supported individuals and responded to concerns.

However:

- Staff understood how to protect women from abuse and worked well with other agencies to do so.
- Multidisciplinary worked well together for the benefit of women.
- The service managed medicines well.
- The service had identified concerns with the culture of the service and had started a culture change programme.
- Staff felt there was a no blame culture across the service.
- The service had an inclusive culture which ensured family or partners could support women throughout their pregnancy journey.
- Staff adhered to personal infection control procedures and the service ensured measures to reduce transmission of COVID-19 were implemented across maternity services.
- The service had implemented the A-EQUIP model to empower and develop staff to bring improvements to the quality of care into all staff's everyday role.
- The service had achieved 100% compliance with Practical Obstetric Multi-Professional Training (PROMPT) for midwives and maternity support workers and 89% compliance for medical staff.

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement

Mandatory training

The service provided mandatory training in key skills to all, but leaders did not always ensure staff had time to complete it.

Staff were not always able to keep up to date with their mandatory training. The trust used an online platform to deliver and record training. Some staff told us that, although annual mandatory training was provided by the trust, they could not attend because they were needed to work in clinical areas of the department. The service identified 13 core

statutory modules, seven of these such as basic life support, infection control, manual handling and information governance had compliance below the trust target of 90%. The remaining six modules achieved compliance above 90%. The trust told us that one of these trainings changed on 1 July 2021 and the compliance reflects the need for staff to complete revised training.

The mandatory training provided was comprehensive and met the needs of women and staff. The mandatory training programme met the standards required to meet Health and Patient Safety standards for clinical and non-clinical staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff could monitor their own progress and compliance against training targets by using the online platform. Staff told us they would receive an email to notify them when they needed to attend mandatory training.

Safeguarding

Staff understood how to protect women from abuse and worked well with other agencies to do so. However, staff were not always given time to complete safeguarding training and did not always ensure women had the opportunity to disclose abuse.

Staff did not carry out domestic violence screening at every contact with pregnant women. Three members of staff told us they would not carry out domestic violence screening with a pregnant women if their partner was present, two members of staff working with pregnant women told us that it was the role of the community midwives to screen for domestic violence. We reviewed four maternity records and only one woman had been asked domestic violence screening questions.

We reviewed the maternity safeguarding children guideline policy and found it did not meet National Institute for Health and Care Excellence guideline NG201 Antenatal Care which recommends women are given an opportunity at every antenatal appointment to discuss concerns such as domestic violence. This posed a risk that women in abusive relationships would not be given the opportunity to disclose abuse. Senior staff told us there was a function in the new electronic records system which would allow notifications to be sent directly to women asking if they felt at risk of domestic violence, but this had not been widely implemented yet.

The trust had a guideline for managing missing babies, children and young people which outlined the key principles of security and action to be taken in the event of a missing baby, child or young person. However, whilst the guideline outlined security arrangements for the children's unit in detail, it did not specify security arrangements for the maternity service. The service did not carry out any baby abduction drills from October 2020 to November 2021. Although there had been no reported incidents, there was a risk staff may not be aware of the procedure.

Staff did not always complete safeguarding training. The trust submitted data showing that by October 2021 only 74% of eligible midwifery staff had completed safeguarding children level 3, this was below the trust target of 90% and posed a risk that staff were not up to date on current procedures to safeguard children. The trust also submitted data showing that only 29% of staff had completed safeguarding adults training by October 2021. However, the trust had changed the training in July 2021 to meet national guidelines and the low compliance reflected this. In June 2021, the compliance rate had been above the trust target at 92%.

Maternity

Midwifery staff knew how to recognise and report abuse. Staff we spoke with understood and could describe their responsibilities in relation to reporting safeguarding. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Guidance was readily available and contained contact numbers of the relevant authorities, alongside an easy to follow flow chart of actions. They maternity service described strong links with the children's safeguarding team and felt able to contact them for advice if needed.

Cleanliness, infection control and hygiene

Whilst staff adhered to personal infection control procedures, we were not assured that regular cleaning and infection control measures across the service were being carried out. Some equipment was visibly dusty.

Cleaning records were not always completed up-to-date and therefore there was no assurance that ward areas were cleaned regularly. Whilst the environment looked generally clean, we found that domestic cleaning schedules on the antenatal and postnatal ward were not always completed. We also found some equipment which had not been cleaned, for example a resuscitaire on the labour ward used to provide emergency resuscitation to newborn babies was visibly dusty.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff were bare below the elbows, decontaminated their hands after each patient contact and used personal protective equipment (PPE) such as gloves and aprons when performing clinical duties. Staff wore masks to comply with measures to reduce transmission of COVID-19 and we observed that they had changed some of their practices such as limiting the number of people in offices and patient bays to ensure social distancing was maintained.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Staff did not always carry out daily safety checks of essential equipment. We reviewed two emergency trolleys and the emergency bag in the maternity day assessment unit, none of which had all the daily checks completed. The emergency trolley on the postnatal ward had not been checked seven times in September 2021, six times in October 2021 and four times from 1 November 2021 to 16 November 2021. We found two sodium bicarbonate vials out of date on postnatal emergency trolley despite two full checks of the trolley since the medicine expired. This posed a risk patients could be given expired medicine in an emergency. The maternity day assessment unit emergency bag had not been checked 15 times in September 2021, 14 times in October 2021 and seven times from 1 November 2021 to 16 November 2021, this means on average it was only being checked approximately half the times it should have been checked. We found nine pairs of sterile gloves which had expired in June, July and August 2021. Whilst this was not an immediate patient safety issue, it did demonstrate essential equipment was not being checked regularly. We raised both these issues immediately with clinical staff who replaced the expired stock.

The emergency trolley in the antenatal ward had not been checked four times from 1 to 16 November 2021 but we did not find any expired stock on this trolley. However, one check on the defibrillator in September 2021 was recorded as 'failed'. Senior staff told us there should have been a printout of the defibrillator check but it was not present. There was no record of the fault or any action to resolve it and the next test was three days later. There was no incident report completed for this so it was not possible to track the actions. This posed a risk that faults for essential equipment were not being reported or actioned, or that staff would not know if they were actioned.

We reviewed the daily equipment checklists and found there were 40 gaps in checking the resuscitaires across the unit between 1 and 16 November 2021. There were 11 occasions where oxygen and suction had not been checked in all eight rooms and the observation bay, three days where the blood gas machine had not been checked and five days where the anaphylaxis box had not been checked. This posed a risk that essential equipment would not be in good working order if required in an emergency.

The environment was not always well maintained to ensure the safety of women and babies. In labour ward we observed four holes in the floor and staff told us rooms we could not access also had poor flooring. This posed a health a safety risk to women and newborn babies. Following our inspection, the trust told us they would replace the flooring.

The service did not always have enough suitable equipment to help them to safely care for women and babies. We observed staff did not have enough equipment to carry out basic observations on women. In one case equipment had to be shared by two patients while midwifery staff tried to find additional equipment. Staff told us there should be enough equipment for broken equipment to be removed and fixed when needed but this was not always the case.

The design of the environment did not always ensure the security of women and babies. Whilst, there was secure access to the antenatal ward, postnatal ward and delivery suite via swipe card for staff or intercom for visitors, we were able to access the unit on the morning of our inspection without using the intercom as a member of staff allowed us to enter as they left the unit. The staff member did not ask for identification or our purpose to be on the unit. A member of staff also allowed us to enter the building where maternity services are located via a staff entrance without asking for identification. This posed a security risk for women and babies that unauthorised visitors could access the maternity unit.

The maternity theatre changing rooms were located through double doors from the postnatal ward. Although there was a ‘staff only’ sign, there was no security system such as swipe card or door code access and we were able to access the female changing rooms without seeing a member of staff on three separate occasions. This posed a risk that unauthorised visitors could access the changing area and theatre scrubs without staff being aware. This was included on the maternity risk register in February 2021, the actions included the current signage advising patients that the area is for staff only.

The service had suitable facilities to meet the needs of women's families. Partners were welcomed to stay with women throughout their stay in the maternity service, at antenatal appointments and in the maternity day assessment unit. The service also had a bereavement suite for families who had suffered a loss. The suite was in use on the day of our inspection and therefore we were unable to inspect this area.

Staff disposed of clinical waste safely. All clinical areas had sharps bin and clinical waste facilities. Clinical waste was separated and placed in the correct bins.

Assessing and responding to patient risk

The service had a comprehensive risk assessment system, but staff did not always identify and act on women at risk of deterioration quickly.

Staff did not always identify and treat sepsis in line with national guidance. We observed that a woman on the labour ward recorded two separate temperatures, but this did not trigger the sepsis protocol despite staff handing over that the patient had commenced antibiotics when they had not. The service had also had a recent serious incident where sepsis screening and treatment did not follow trust policy. NICE guideline (QS192) Intrapartum care: existing medical

conditions and obstetric complications (February 2020) quality statement 4 states, “pregnant women in labour with sepsis have an immediate review by a senior clinician decision maker and antibiotics are given within 1 hour if indicated. This is also reflected in the Trust policy for the management of sepsis. We raised this issue as an immediate area of concern to the trust and they developed an action plan to address these concerns.

The maternity service had reported six pressure area injury incidents since between January and July 2021. The service had recognised this as a concern and were reviewing their local policy for risk assessing skin integrity.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used the Birmingham symptom-specific obstetric triage system (BSOTS) to ensure pregnant women received a standardised initial assessment and was prioritised in order of clinical need in line with the Royal Society of Obstetricians and Gynaecology guidelines. We observed staff using this system in the maternity day assessment unit.

The service aimed to triage women within 15 minutes of arrival. The service submitted an audit of triage times carried out from February to April 2021 which showed the service achieved the 15 minute triage time for 60-90% of patients. However, when we visited the unit staff were extremely busy and out of 12 patients seen that morning only one had the time of arrival and time of triage recorded on their records. There was a whiteboard in the maternity day assessment unit office with details of all women who were in the unit. When we visited there were six women listed on the whiteboard, all had times of arrival, but none had a triage time. Therefore, we could not be assured that staff consistently triaged women within 15 minutes.

Staff communicated key information during handover to keep women and babies safe. We observed handovers on the antenatal, postnatal and labour ward and although key information was shared, this was not always in a structured way. On some wards, we found staff needing to ask additional questions for clarification and the plan from the medical team was not always clear. Staff did not always identify risk factors in handover, for example a woman who had just given birth was in pain and not mobilising, there was no discussion or handover about how to manage her pain and ensure pressure areas remained intact.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff told us they used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed four MEOWS charts during the inspection and found them to be correctly completed.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman’s mental health. We saw contact details for these teams displayed in staff offices. One junior staff member told us they had concerns about a woman’s mental health and when they escalated this, it was taken seriously, and specialist mental health support was sought for the patient.

The service had not successfully implemented the four recommendations from the Chief Midwifery Officer for England to reduce the additional risk of COVID-19 for women from black, Asian and minority ethnic (BAME) groups. Whilst senior staff told us posters had been displayed and community staff had checklists to identify women at increased risk, no members of staff we spoke to knew about additional measures to protect this group of women.

Maternity staffing

There were not always enough staff with the right qualifications, skills, training and experience to meet the needs of women and babies in the maternity service. Managers systematically reviewed staffing but were not always able to deploy staff to meet the needs of women on the unit.

Maternity

There were not enough staff to keep babies and women safe. The service used a recognised acuity tool to calculate the number of midwives required to staff the antenatal, postnatal and labour ward, this showed that nine midwives were required. However, on the morning of our inspection, there were only five registered midwives on duty at the start of the shift, due to staff illness. Further information provided after inspection reflected that by 11:15 am nine midwives were on shift to fill the rota.

There was only one midwife allocated to the antenatal ward which meant when the midwife needed to carry out procedures or treatment such as an induction of labour, there was no registered midwife for the rest of the ward. During our inspection there was an emergency call on the labour ward which the antenatal midwife attended. Therefore, a student midwife was left alone and in charge of six patients. This posed a risk of safety to women.

There was one midwife, one registered nurse and a midwifery support worker allocated to the postnatal ward at Basingstoke and North Hampshire Hospital. The rota reflected that two nursery nurses should have also been allocated to the ward. The registered nurse was new in post and had not completed all her competencies which meant one midwife was responsible for the care of 11 women and 12 babies. This posed a risk that deterioration of women and babies may not be recognised and placed additional pressure on one midwife.

Since our inspection the trust have increased the number of midwives required for each shift to 10 so two midwives can be on the antenatal and postnatal ward. However, this would only possible if staff were available.

The service used national guidance from the Royal College of Obstetricians and Gynaecologists / Royal College of Midwives (2007) to inform safe care midwife to birth ratios. Guidance stated these should be 1 midwife to 30 births. Data from the trust showed for the four months prior to the inspection ratios were worse than recommendations; July 2021 1:33, August 2021 1:35, September 2021 1:35 and October 2021 1:33.

The labour ward coordinator role was supernumerary to ensure a senior midwife had oversight of the service and to provide support and clinical advice to staff. However, staff told us that they were regularly not supernumerary due to staff shortages

The vacancy rate for registered midwives was increasing. The service reported the vacancy rate for registered midwives was 8.68% in September 2021, this had risen from 6.6% in August 2021 and was 11% at the time of our inspection. Staffing within maternity services is a nationally recognised concern. This also reflected recommendations in the National Ockenden report for additional maternity staffing investment. However, the vacancy rate for midwifery support workers had reduced from 1.28% in August 2021 to 0.91% in September 2021. Senior staff told us they had recruited staff including newly qualified midwives and international candidates to help with the staffing gap.

Women experienced delays (over four hours) to elective caesarean sections. Data from the Trust's maternity dashboard showed the service delayed 18 caesarean sections in August 2021, 16 in September 2021 and 12 in October 2021. The staff we spoke with confirmed this and told us the service frequently delayed caesarean sections.

There were also delays (over four hours) to inductions of labour. Data from the Trust's maternity dashboard showed the service delayed 48 inductions of labour in August 2021, and 27 in both September and October 2021. Staff told us it was common for women to have their induction of labour delayed for two days. Delay in induction by over two hours is a midwifery red flag event which is defined by the National Institute for Health and Care Excellence (NICE) Safer Midwifery Staffing for Maternity Settings as a warning sign that something may be wrong with midwifery staffing.

Managers tried to get enough staff to staff the unit in line with the rota but did not use an acuity tool to assess changing patient acuity and staffing requirements. On the day of our inspection, the shift started with a gap of three midwives across the antenatal, postnatal and labour ward. Whilst senior staff did source additional staff by using specialist midwives clinically and asking staff to work additional hours, we did not see the use of a recognised acuity tool to ensure staff were deployed to meet the needs of women and babies. Staff confirmed to us they did not use a recognised acuity tool to assess staffing requirements on the ward on a day to day basis.

The service had high sickness rates. Data supplied by the trust in the October safer staffing report showed the sickness rate for registered midwives had increased from 10.33% in August 2021 to 10.5% in September 2021. Of this, 3.43% was reported as COVID-19 related sickness and 7.07% was reported as other sickness. This was above the trust target of 3% and significantly higher than the sickness rate for registered nurses in the trust.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. Consultants were on site from 8am to 5pm, Monday to Friday. There was a night handover at 7pm for midwives and 8pm for consultants, which ensured a continuity of care.

The service always had a consultant on call during evenings and weekends. Consultants said they stayed on if there was high acuity on the delivery suite. Junior doctors who are speciality trainees with four and five years training could call consultants for support with any cases going to theatre. The trust advised they had online guidance for what on call consultants are expected to attend to in person. However, medical staff told us there were informal arrangements for attending out of hours. All staff confirmed these arrangements worked well and consultants were responsive to requests for support from colleagues.

Doctors completed ward rounds during the day, one in the morning, one in the afternoon and one in the evening. Staff told us that medical staff were responsive when calling them in. Staff told us they had good communications with doctors and felt confident to escalate any concerns to them.

Records

Whilst staff kept comprehensive records, they were not always easy to follow or easily accessible to all staff providing care.

Women's records were completed but staff could not always access them easily. The service had implemented a new electronic record system in May 2021 but still used some paper records. During our inspection there was a national outage of the electronic records system which meant staff were not able to access women's records. We observed a member of staff stayed 90 minutes after their shift had finished to recreate notes that appeared to have been lost, three babies could not be registered, and staff told us some babies had been given two NHS numbers. This meant there was potential for inaccurate record keeping and errors which may put women and babies at risk.

The service had two midwives to help implement and support the new digital system. They also provided training and troubleshooting advice to staff. Staff told us they did not have access to enough digital support at night, there was a helpline available, however staff reported they did not find it helpful.

Access to the electronic records system was via secure login details, personalised for each member of staff.

Maternity

We reviewed four sets of records and found that although records had been completed, staff could not easily locate clinical information as some was stored in electronic records and some in paper records. The midwife assisting us with our review had to cross reference between the notes several times to provide information, this posed a risk that essential information would not be available to staff.

Medicines

The service stored medicines safely and securely. There were multiple systems for recording medicine administration which posed a risk of inaccuracies in administration.

The trust had implemented a new electronic prescribing and medicines administration (EPMA) system at the beginning of November 2021. However, staff told us that medicines were also recorded in women's paper notes and on the electronic records system. This meant staff had to check three different places before administrating medicines. A senior member of staff told us there had been an incident where an overdose of paracetamol had been administered as staff did not have time to check all three areas. This was not included on the maternity risk register.

Medicines were stored securely in line with national guidance. Medical gases were stored safely and securely in an upright position. They were stored in well ventilated areas away from heat, light sources and other flammable materials.

Incidents

The service did not manage safety incidents well. Whilst staff reported incidents, they did not consistently get feedback and lessons learned were not shared effectively with the whole team and wider service. Serious incidents were investigated but often did not identify effective immediate and long term actions to prevent them reoccurring.

The trust used an electronic incident reporting system which all staff had access to. Staff knew how to report concerns and could share examples of when they had done so but did not always receive feedback. Staff consistently told us they did not always get feedback from incidents or concerns raised, even when these were serious issues, such as no one responding to an emergency call or staffing concerns.

Incidents at ward level were reported via the electronic reporting system. Incidents were then reviewed and escalated to the clinical governance lead.

Following the incident review meeting, any incident rated as moderate harm or above was prepared as a 72-hour briefing and submitted to a 48-hour panel via Central Governance Department. The incidents were then declared as a Serious Incidents or allocated for local RCA investigation.

After completion of the investigation the findings of the reports were shared with the staff, the woman, the Maternity Safety Champions, presented at Maternity Clinical Governance Committee and summarised for the Quality and Performance Report.

Where feedback was received, this was not always helpful or meaningful. We reviewed a maternity red flag incident from September 2021 where one to one care could not be provided on the delivery suite. The feedback from this incident was that maternity staffing remained under review, acknowledged it was stressful for staff, thanked them for their continued hard work and asked them to keep reporting staffing concerns. The feedback did not highlight any immediate actions senior staff were taking to address this concern to ensure it did not reoccur. This could potentially discourage staff from reporting incidents.

Maternity

Managers did not share lessons learned effectively. Staff we spoke with during our inspection could not tell us any learning from recent incidents. Senior staff told us that they communicated learning through several channels such as emails, message groups, posters and videos but these were not effective. During our inspection, staff raised a never event which occurred in August 2020 on the Winchester site, where a procedure was carried out without consent. Midwifery and medical staff across the service told us the only learning shared was the termination of the staff member's employment with the trust.

The service held a weekly meeting to discuss incidents. Senior staff told us that all grades of staff were invited but only senior staff usually attended as junior medical and midwifery staff were working clinically on the wards.

The service reported 13 serious incidents across from October 2020 to September 2021, this included one maternal death. Eight of these incidents had been reported to the Maternity Healthcare Safety Investigation Branch. We reviewed the initial incident reports for some of these incidents and found they did not identify any immediate actions to reduce the risk of these incidents reoccurring.

Managers debriefed and supported staff after any serious incident. The trust had a 'hot debrief' process whereby staff were supported following any traumatic incidents within their specific shift. Staff were also supported by trauma trained professional Midwifery Advocates via virtual meeting sessions. Educational feedback was given to any medical staff who required it.

Is the service effective?

Insufficient evidence to rate 

Our rating of effective stayed the same.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice, however we noted the absence of some guidelines.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

The service had 67 guidelines and policies and 10 standard operating policies (SOP's), 87% of these were in date, the service recognised some policies and guidelines required review and had a plan to complete this. Clear indications at the start of the document referenced recent changes. Policies were dated when reviewed and there was an indication of the next review date.

There were no specific guidelines for reduced fetal movements, out of hours attendance for consultants and the Birmingham Obstetric Triage System (BSOTS). Staff told us that there were informal arrangements for out of hours consultant cover, and these arrangements worked well. We saw BSOTS being used but the absence of a formal guideline meant the service could not be assured that staff were applying the principles correctly.

Staff completed mental health training as part of their mandatory training.

Maternity

The service was functioning in line with current government guidance in relation to COVID- 19. We saw signage relating to the numbers of people allowed in each area and we saw signage to advise on COVID-19 procedures.

Patient outcomes

Staff monitored the effectiveness of care and treatment but information was not always up to date and therefore could not always be used to make improvements and achieve good outcomes for women.

The maternity service had defined performance measures and key performance indicators (KPIs), which were recorded and monitored using the maternity dashboard. The maternity dashboard parameters were presented in a structured format. The parameters had been set in agreement with local and national thresholds which allowed the service to benchmark themselves against other NHS acute trusts.

It was unclear how the service used monitoring results to improve safety. On day of our inspection the maternity dashboard was not up to date and some elements of the data were not immediately available to us. Which meant they were also not available to the service to inform them of their own position.

The service participated in relevant national clinical audits. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

The rates of third and fourth degree tears was above (worse than) the national average. In June 2021 the trust reported 43 third and fourth degree tears per 1,000 births compared to 25 per 1,000 births nationally. In August 2021, data submitted by the trust showed incidents had risen to a rate of approximately 4%. This was significantly higher than at the trust's other maternity site in Winchester.

In June 2021, the trust was above the national average for the number of babies born with an APGAR score of between 0 and six. An APGAR score is a measure for professionals to assess the health of newborns at one and five minutes after birth. The score is determined through the evaluation of five criteria; appearance, pulse, grimace, activity and respiration. Scores of seven and above are classed as normal, scores of four to six are fairly low and a score of three or below is classed as critically low.

The service met the national target of 5% for avoiding term admissions into the neonatal unit (ATTAIN). The admission rate for the hospital was 4.5%.

Competent staff

The service provided support to make sure staff were competent for their roles, but staff did not always have time to access it.

There were concerns that staff were sometimes allocated tasks beyond their competency level.

Some staff raised concerns that student midwives or registered nurses without midwifery competencies were given inappropriate tasks for their level of training or experience. The service had recently held a band 5 listening event where staff had highlighted they sometimes felt "out of their depth" with high risk cases and unable to say no. During our inspection we observed a member of staff in the wrong uniform. This posed a risk that other staff or patients may expect the member of staff to be able to carry out tasks above their competency level based on their uniform. We raised this to senior staff immediately and the member of staff changed their uniform.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Data submitted by the trust showed 84% of medical staff and 65% of midwives and other clinical staff had received an appraisal. Senior staff told us completion of appraisals was challenging and they aware staff were not receiving appraisals or not receiving the full time for their appraisal. The trust told us the senior management team were monitoring the appraisal process. However, this posed a risk that staff were not receiving support and constructive review of their work to aid performance and development.

Managers gave all new staff a full induction tailored to their role before they started work. Staff worked through a competency booklet and worked supernumerary for a period of time until they felt confident and were assessed as competent in their roles. The midwife care assistants had undertaken training to ensure they were competent to undertake observations and maintain the MEOWs charts. New staff we spoke with staff confirmed this was the case.

Clinical educators supported the learning and development needs of staff but their ability to deliver the role was constrained by staffing issues. Practice development midwives were passionate and delivery high quality training and support for staff. A clinical educator met with all band 5 and 6 staff once to year to ensure they had completed mandatory training and any targets set at their appraisals. The team had recently implemented a rotational preceptorship programme which included a week supernumerary on each ward to allow newly qualified midwives to build skills in different clinical areas. Student midwives also received study days such as fetal monitoring whilst completing placements on the wards. The practice development team were experiencing staff shortages and were also frequently asked to cover clinical staffing gaps which limited their ability to focus on clinical education. In August 2021, no skills workshops were held as the practice development team worked at least 75% of their hours clinically.

The trust had implemented the advocating for education and quality improvement (A-EQUIP) model. A-EQUIP is a continuous improvement process designed to empower and develop staff so that action to improve quality of care becomes a part of everyone's job.

There was a professional midwifery advocate (PMA) team and staff had specific support following traumatic events. The PMA role is a recognised means of supporting midwives, through restorative clinical supervision, now formal supervision had been discontinued. There were five PMA's in post. All maternity staff, including midwives, had access to well-being services provided by the trust.

The service had introduced a fetal monitoring study day which included cardiotocography (CTG) training and drills. Trust data showed that fetal monitoring training for doctors and midwives showed had a compliance of 43% for doctors and 26% for midwives. There was also a weekly multidisciplinary CTG meeting where case studies were discussed and staff were expected to attend three sessions a year to maintain their competency. Some staff told us it was not possible to attend these meetings because of staff shortages.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Most staff we spoke with told us that there were good working relationships between medical and midwifery staff. Staff described there was good teamwork and midwifery staff felt consultants had the same common goal to provide a high quality of care to women.

We also observed good team working across the different maternity wards and positive interactions between midwives, registered nurses and midwifery support workers.

Maternity

Obstetricians were on the hospital site until 8.30 pm on weekdays. After that time there was an on-call rota and clinical advice could be sought over the telephone or the obstetrician would come to the hospital in person.

We could not be assured ward rounds were always multidisciplinary on the weekend. Discussions with staff and audit information were inconsistent on this matter.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills and abilities to run the service. They were not always able to understand and manage the priorities and issues the service faced. Senior leaders were not visible and approachable in the service for patients and staff.

Maternity was part of the Family and Clinical Support Services Division across Hampshire Hospitals NHS Trust. The head of midwifery and clinical director was cross-site and covered both the Winchester site and the Basingstoke site. To support the associate director of midwifery, there was a deputy head of midwifery based at each site.

At the Basingstoke site there was a community matron and a governance and safety lead who reported to the deputy head of midwifery. There was a vacancy for an inpatient matron which staff told us put additional pressure on the labour ward coordinator.

Staff did not always have confidence in the senior leadership team. During our inspection there was an outage of the electronic records system. The service had a contingency plan, however, staff told us they received conflicting messages from managers and did not have confidence the electronic system would update information.

Local senior leaders in the unit tried to manage the staffing levels and frequently worked clinically, undertaking many front-line roles. This showed support for staff but it meant they were unable to undertake their leadership roles and safety oversight of the unit.

Staff told us some senior leaders were not always visible in the service. The leadership team did not successfully engage with all staff. Whilst the service had several communication strategies such as emails, social media, newsletters and message groups, staff repeatedly told us they did not always receive key messages. We observed staff did not always know key information for example, when the electronic records system failed, senior staff told us they sent out emails and screen sprinkles to give guidance to staff but these were not read by staff. Senior staff told us they expected all staff to read emails but they did not assess whether this was effective or met the needs of everyone, particularly junior staff.

Culture

Staff were focused on the needs of patients receiving care. They generally felt respected and valued, but senior staff did not always create a culture which supported individuals and although staff raised concerns these were not always acted upon. However, the service had identified some culture concerns and had taken steps to address these.

Maternity

Staff we met during our inspection were welcoming, friendly and helpful. They felt pride in the support they provided each other and having worked together to provide the best service they could to patients in their care.

Staff felt able to speak up but their concerns were not always acted upon. Staff across the service and at varying levels of seniority told us that they had raised concerns about issues such as staffing and equipment but had not received a response.

The most common reason for sickness in the maternity service was anxiety, stress, depression and other psychiatric illness. This accounted for 22.7% of the maternity service sickness.

The service had recently held a virtual pizza evening with junior midwives to obtain their views on working in the service. Staff highlighted concerns such as difficulty transitioning to become one of the team and conflicts between staff grades, for instance, more senior staff being disrespectful about junior staff on shift which lowered confidence and morale and junior staff being sent to another ward when more senior staff were available but refused to go. Staff also raised they didn't always feel empowered to refuse tasks they felt out of their competency level such as looking after multiple women in labour, caring for high dependency patients and being allocated students. The service outlined action that band five staff would not be allocated students in the future.

Culture concerns had been identified as a key concern across the maternity service by staff and the leadership team. The service had a maternity culture change project in pilot stage. This project included work development opportunities, culture workshops and introducing a new communications strategy.

The service had identified a high turnover rate for midwifery staff and had carried out retrospective exit interviews with all staff who had left within the last 12 months. This highlighted behaviour and communication concerns with a key group of senior staff. The service has implemented targeted training and feedback opportunities for this group of staff. Whilst this was only a recent development, staff reported they could see improvements in the behaviour of staff.

The service ran a 'civility saves lives' campaign across the services highlighting the impact positive interactions between staff have on reducing errors and stress. Staff told us respect and working relationships between staff, particularly medical and midwifery colleagues had improved.

Medical and midwifery staff across the service told us there was a no blame culture and they could raise concerns with senior staff. The service held a wellbeing every two months for medical staff and staff told us they received wellbeing support after a serious incident had occurred.

Management of governance, risk, issues and performance

Leaders and teams used systems to manage performance, but this was not always effective. When they identified and escalated relevant risks and issues they were not always actively managed to reduce their impact. They had plans to cope with unexpected events which were not always adhered to.

Leaders felt there was a good risk structure in place and good management support of risk. They described the process of reviewing incidents within the trust used a framework and standard operating procedure to grade levels of harm which then informed judgements about appropriate care in line with guidelines. This also informed the escalation of serious cases. The risk lead sat on the open incidents review 48 hours panel so had oversight of current issues and risks. Within the panel were midwives, obstetricians and, when required, specialists such as radiographers.

When incidents occurred, a case review was done within 48 hours by a multidisciplinary panel, followed by a full root cause analysis within national incident investigation timescales'. Feedback was shared following the analysis, identifying outcomes and reviews and includes addressing duty of candour, feedback to the trust, patients, families and staff including any educational needs. The midwifery risk management team dealt with external reporting to the Health Safety Investigation Board and educational practice midwives provided feedback to specific midwife related issues.

Leaders identified risks but did not always manage them well. There was a maternity risk register which included a description of each risk, control measures including any gaps in control measures and a summary of actions taken. The risk rating, status and any updates were also included. However, we were not assured that all risks were rated correctly. Maternity staffing was added to the risk register initially in November 2012 and most recently updated in October 2021 rated as amber with a risk score of 12. However, during our inspection we saw staffing had a significant impact on the safety and quality of services provided to women and babies. For example, delays in elective caesarean sections and inductions of labour, gaps in checking essential equipment and potentially unsafe levels of staffing on wards. These risks had not been identified and highlighted on the risk register. The control measures documented staffing levels required and a business case for June 2014, meaning it had not been updated to identify current control measures.

The service collected data but it was not always managed so that up-to-date, accurate information was available to understand performance and make decisions and improvements. Data and information was not always used and analysed effectively to assess and improve performance. The maternity dashboard was not always kept up to date or shared with staff. This meant leaders and staff did not always have timely and reliable date to inform them what was happening within their service.

On three occasions in the process of our inspection, the service provided information which was either incorrect or not up to date.

The trust submitted a midwifery red flag audit which showed only one midwifery red flag had been reported between August and October 2021. However, the trust also submitted their maternity dashboard which showed the service delayed (by over four hours) 48 inductions of labour in August 2021, and 27 in both September and October 2021. A midwifery red flag should be reported when there is a delay of more than two hours between admission for induction and beginning the process. We saw staffing had an impact in several areas including checking of equipment, safety of women and babies and delays in care. The incorrect reporting of red flags meant the extent of level of concern for midwifery staffing may not have been visible to the trust.

Information Management

The service did not always collect reliable data analysis. However, information systems were integrated and secure.

The service had electronic systems for collecting and analysing data. However, data and information was not always kept up to date and used effectively.

Data stored by the trust remained confidential and was stored securely. All areas had password protected computer terminals for staff to access information. All computer terminals were password protected when not in use. The service had not reported any data breaches and systems were secure. Patient identifiable information was handled correctly, and patient names were not visible from the ward areas which ensured privacy.

The trust operated an electronic and paper-based records systems for clinical records.

Maternity

The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, the service did not always effectively engage with staff.

Outside of the pandemic leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services. However, this level of engagement was affected by the pandemic and the current staffing shortage.

The service collaborated with partner organisations to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership (MVP).

The trust used a range of communication tools to aid learning and development. This included newsletters, emails, hot topics. However, staff did not always have time to read or engage in these methods of communication because they were prioritising clinical care. This meant during busy times the usual communications tools used to share learning and key messages were having little impact.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure all staff identify and treat sepsis in a timely way according to trust policy and national guidelines. (Regulation 12(1)).
- The trust must ensure the environment meets national guidance and is able to be cleaned effectively to maintain infection control standards. (Regulation 12 (1)).
- The service must ensure regular checks on emergency and essential equipment are carried out. (Regulation 12 (1)).
- The trust must ensure the security arrangements for the maternity unit and staff only areas of the maternity unit keep women and babies safe. (Regulation 12 (1)).
- The trust must ensure national guidelines are followed when screening women for a risk of domestic violence and trust policy reflects this. (Regulation 13(1) & 13(2)).
- The trust must ensure data is managed so it is up to date, reliable and can aid decisions about risk and performance in the service. Midwifery red flag reporting must accurately reflects risk. Regulation 17(1).
- The trust must ensure that they gather and share learning from incidents to evaluate and improve the service (Regulation 17).

Maternity

- The trust must ensure that staffing levels are managed across the midwifery service to ensure the safety of women and babies. (Regulation 18(1).

Action the trust SHOULD take to improve:

- The trust should ensure there are clinical guidelines for reduced fetal movements, out of hours attendance and the triage system. (Regulation 12).
- The trust should ensure staff do not undertake roles outside of their competency level (Regulation 12).
- The trust should ensure all staff receive an appraisal (Regulation 12).
- The service should ensure the four recommendations to reduce the risk of COVID-19 for women from a BAME background are implemented. (Regulation 12).
- The trust should ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18).

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC lead inspector and two specialist advisors. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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Protocol between the West Berkshire Health Scrutiny Committee and local health bodies

Committee considering report:	Health Scrutiny Committee
Date of Committee:	5 April 2022
Portfolio Member:	Councillor Howard Woollaston
Date Head of Service agreed report: *(for Corporate Board)*	
Date Portfolio Member agreed report:	10 March 2022
Report Author:	Gordon Oliver / Vicky Phoenix
Forward Plan Ref:	OSMC/HSC

1 Purpose of the Report

The report presents a final protocol that sets out how the West Berkshire Health Scrutiny Committee will work together with bodies who commission or provide health and wellbeing services to residents of West Berkshire.

2 Recommendation(s)

The Committee is recommended to:

1. Endorse the final protocol and the process for dealing with proposed substantial developments of variations to health services.
2. Recommend the protocol for approval by the Health Scrutiny Committee.

3 Implications and Impact Assessment

Implication	Commentary
Financial:	There are no financial implications arising from this report.
Human Resource:	There are no HR implications arising from this report.

Legal:	There are no Legal implications arising from this report. The protocol sets out an approach to working with health partners, which is consistent with current legislation.			
Risk Management:	There are no risks arising from the report. The protocol should actually reduce risks by providing clarity on what constitutes substantial variations or developments in delivery of health services and ensuring that proper scrutiny of such proposals takes place.			
Property:	There are no property implications associated with the report.			
Policy:	The report is consistent with national guidance on health scrutiny. The proposed protocol will help to achieve effective health scrutiny, which in turn will help to ensure that the priorities and objectives of the Berkshire West Joint Health and Wellbeing Strategy are delivered.			
	Positive	**Neutral**	**Negative**	**Commentary**
Equalities Impact:				
A Are there any aspects of the proposed decision, including how it is delivered or accessed, that could impact on inequality?		✓		The protocol will help to ensure that the needs of all service users are taken into account when variations or developments in health services are proposed.
B Will the proposed decision have an impact upon the lives of people with protected characteristics, including employees and service users?		✓		
Environmental Impact:		✓		There are no environmental impacts arising from this report.

Health Impact:	✓			The protocol will help to ensure effective health scrutiny of proposed variations and developments in health services that are considered likely to have substantial impacts for residents of West Berkshire.
ICT Impact:		✓		There are no ICT impacts arising from this report.
Digital Services Impact:		✓		There are no digital services impacts arising from this report.
Council Strategy Priorities:	✓			The protocol will help to ensure effective health scrutiny of proposed variations and developments in health services that are considered likely to have substantial impacts for residents of West Berkshire. This in turn will support the Council Strategy priority to 'support everyone to reach their full potential'. In particular, it will help with the following areas: - improve the health and wellbeing of our residents - improve mental health and wellbeing
Core Business:		✓		There are no core business impacts arising from this report.
Data Impact:		✓		There are no data impacts arising from this report.
Consultation and Engagement:	Health partners were consulted on the draft Health Scrutiny Protocol.			

4 Executive Summary

4.1 The consultation on the draft protocol has now taken place. No objections or suggested amendments were received and so it is proposed for the protocol to be approved.

5 Supporting Information

Background

5.2 The draft protocol was approved for consultation at the Health Scrutiny Committee on 10 November 2021.

5.3 The draft protocol was sent to all relevant health bodies on 19 November 2021 with a request for responses by 7 January 2022.

5.4 The draft protocol was sent to West Berkshire Primary Care Networks, Berkshire Healthcare NHS Foundation Trust, NHS Berkshire West Clinical Commissioning Group (CCG), NHS England and NHS Improvement South East, Royal Berkshire NHS Foundation Trust and South Central Ambulance Service.

5.5 A joint response was received from Berkshire Healthcare NHS Foundation Trust and Royal Berkshire NHS Foundation Trust. They were supportive of the protocol with no amendments sought.

5.6 Responses were not received from the other health bodies by the 7 January 2022 deadline.

Proposals

5.7 The protocol is included in Appendix A. The aim of this protocol is to provide:

- Improved engagement and communication across all parties;
- Clear standards which set out how all parties will work together;
- Greater confidence in the planning for service change, to secure improved outcomes for health services and communities across West Berkshire.

5.8 It is proposed that the protocol be approved with no further amendments.

6 Other options considered

6.1 The requirement to develop a protocol is set out in the HSC Terms of Reference, so to 'do nothing' is not considered to be an option.

6.2 The Committee could re-consult with those health bodies that did not respond to the consultation. However this is not considered necessary, particularly in light of the fact that no proposed changes have been requested by those who have responded.

7 Conclusion

7.1 Creation of a Health Scrutiny Protocol would be a positive step in terms of improving communication between the HSC and local health bodies and having agreed actions and processes to be followed whenever a change in local health services is proposed.

8 Appendices

Appendix A – Draft Protocol between the West Berkshire Health Scrutiny Committee and commissioners and providers of health and wellbeing services to the population of West Berkshire.

Appendix B – Consultation response from Berkshire Healthcare NHS Foundation Trust and the Royal Berkshire NHS Foundation Trust

Corporate Board's recommendation

*(add text)

Background Papers:

Health Scrutiny Committee papers from 10 November 2021

Subject to Call-In:

Yes: ☐ No: ☒

The item is due to be referred to Council for final approval	☐
Delays in implementation could have serious financial implications for the Council	☐
Delays in implementation could compromise the Council's position	☐
Considered or reviewed by Overview and Scrutiny Management Committee or associated Task Groups within preceding six months	☐
Item is Urgent Key Decision	☐
Report is to note only	☐

Wards affected: All wards

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Document Control

Document Ref:		**Date Created:**	
Version:		**Date Modified:**	
Author:			
Owning Service			

Change History

Version	Date	Description	Change ID
1			
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Protocol between the Health Scrutiny Committee and commissioners and providers of health and wellbeing services to citizens of West Berkshire

(November 2021)

1 Introduction

1.1 This Protocol describes how the Council's Health Scrutiny Committee (HSC) will work together with the bodies that commission or provide health and wellbeing services for citizens of West Berkshire.

1.2 The Protocol defines some working principles to guide and support the relationship between the HSC and local health bodies.

1.3 It sets out the processes that will be followed when substantial variations or developments to health and wellbeing services are proposed that require formal consultation and engagement, as required by legislation. The Protocol also specifies how smaller variations and developments to health and wellbeing services will be handled.

2 Purpose of the protocol

2.1 The aim of this protocol is to provide:

- Improved engagement and communication across all parties;
- Clear standards about how all parties will work together;
- Greater confidence in the planning for service change, to secure improved outcomes for health services and citizens of West Berkshire.

3 Aims and responsibilities of health scrutiny

3.1 Guidance on health scrutiny, published by the Department of Health in June 2014, states that:

> *"the primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe."*

3.2 West Berkshire Council has delegated responsibility for scrutiny of health matters to the Health Scrutiny Committee (HSC). Its terms of reference state that it will:

> *'undertake scrutiny of the planning, development and operation of Public Health and NHS services for citizens of West Berkshire, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'*

3.3 The HSC is responsible for reviewing or scrutinising services commissioned and provided by all relevant NHS bodies and health service providers. This includes GP practices and other primary care providers such as pharmacists, opticians and dentists, and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority, including Public Health services. References to

'health and wellbeing commissioners or providers' in the remainder of this document is used as a term to include all public, private or voluntary organisations.

4 Understanding of the role of the scrutiny relationship

4.1 All parties recognise the role of West Berkshire HSC in reviewing or scrutinising any issues relating to the commissioning and provision of health and wellbeing services to citizens of West Berkshire.

4.2 The bodies involved acknowledge the role of scrutiny in giving the public confidence of effective oversight of their health and wellbeing services. They also recognise the challenges facing the health and wellbeing system and that no single organisation can solve these alone.

4.3 HSC provides health and wellbeing commissioners and providers with a clear governance framework, transparency and a critical friend to help develop integrated solutions.

5 Application of the Protocol:

5.1 This Protocol is an agreement between West Berkshire's HSC (which represents the interests of West Berkshire Council and its citizens), and those bodies who commission and provide health and wellbeing services for the local population.

5.2 It covers health and wellbeing commissioners and providers under the Care Quality Commission (CQC) regulation, including:

- Treatment, care and support provided by hospitals, GPs dentists, ambulances and mental health services; and
- Services for people whose rights are restricted under the Mental Health Act.

5.3 Scrutiny of activities relating to the treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care) is the responsibility of the Overview and Scrutiny Management Commission.

5.4 The Protocol is a living document so can include those commissioners or providers who may be involved, now or in the future, in the planning, provision, or operation of health and wellbeing services. It applies to the resident population of West Berkshire and therefore accordingly where commissioners and providers are serving West Berkshire residents across the district boundary.

5.5 Where necessary, joint health scrutiny committees may be formed across a different geography where a relevant body or service provider is required to consult more than one local authority's health scrutiny function about substantial reconfiguration proposals. West Berkshire has delegated powers for the scrutiny of the Integrated Care System to the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee.

5.6 This Protocol applies specifically to West Berkshire HSC activities, but it could be used as a good practice example around ways of working for any other committees discharging the functions of health scrutiny.

6 Shared goals and working principles:

6.1 Table 6.1 describes the shared goals and working principles by which all organisations covered by this Protocol agree to work.

Table 6.1: Shared Goals and Principles

Shared Goals • Deliver high quality, sustainable health and wellbeing services that meet the needs of the West Berkshire population. • Improve the health and wellbeing outcomes for local people, including ensuring activity addresses health inequalities and aligns with the Berkshire West Health and Wellbeing Strategy.
Working principles 1. There is a "no surprises" approach between the organisations concerned. This builds collaboration whilst also allowing HSC to constructively challenge strategic decisions. 2. There is a climate of mutual respect and courtesy, noting one another's independence and autonomy. 3. Proposals and recommendations are based on appropriately sourced, recognised and clearly presented evidence. This includes relevant clinical evidence. 4. The views and priorities of local people should be gathered and considered in the development of proposals, in scrutiny and in decision making. 5. The overview and scrutiny approach is transparent, collaborative, constructive and non-confrontational. It is based on asking challenging questions and considering evidence. 6. There is recognition and respect for the difference which may arise around what constitutes 'best outcomes' for the local population. 7. Feedback from HSC to health and wellbeing organisations is documented and well communicated.

7 The 'no surprises' approach

7.1 In support of the first working principle, to have a 'no surprises' approach. The HSC forward plan is informed by and developed through regular dialogue with

commissioners and providers. Involving HSC in discussions about proposed changes at an early stage will allow them to plan and scope their scrutiny reviews.

8 Service variations and assessing change

8.1 In circumstances where there are planned variations or developments to health and care services, relevant organisations will undertake to work in accordance with the working principles above to assess how significant the variation is.

8.2 The threshold at which a proposed variation or development is deemed 'substantial' is not precisely defined and an element of judgement is required. The impact of the change on patients, carers and the public is the key concern. The following factors should be taken into account:

- Changes in accessibility of services.
- Changes to methods of service delivery.
- Impacts on service users and their families / carers.
- Impacts on health and social inequalities.
- Implications for service quality, deliverability and risk.
- The effects on other health services and the wider community

8.3 Table 8.1 describes and gives examples of the levels of change, variation or development which may occur in in health and wellbeing service for West Berkshire:

Table 8.1: Levels of change

Level	Category	Description	Example(s)	Action Required
1	Minor	When the proposed change would have a **minor** impact	A minor change in clinic times, the skill mix of particular teams, or small changes in operational policies.	The Committee would not routinely be notified or become involved.
2	Moderate	Where the proposed change would have a **moderate** impact, or where consultation has already taken place on a national basis	Rationalising or reconfiguring Community Health Teams. Policies that will have a direct impact on service users and carers. Changes that include the following may be considered substantial rather than moderate: • A reduction in service • A change to local access to service • Large numbers of patients being affected	The responsible commissioner notifies the Principal Policy Officer at an early stage. The Principal Policy Officer will liaise with the HSC Chairman and Vice Chairman to determine whether a fuller briefing is required in accordance with the Committee's stage one assessment process described below. The Committee will wish to ensure that the Healthwatch and other appropriate organisations are notified by the responsible commissioner or service provider concerned.
3	Substantial	Where the proposal has **substantial** impact and is likely to lead to: • A reduction or cessation of service • Relocation of service	Reconfiguration of GP Practices leading to practice closures. Centralisation of services, leading to closure of local clinics / treatment centres. Redevelopment / relocation of acute hospitals as part of HIP2 programme.	• The responsible commissioner(s) notify the Committee and formally consult the Committee. The Committee will expect to see formal consultation plans. The Local Ward Councillors concerned will be informed of the proposal. • The responsible commissioner(s) notify and discuss with the appropriate local authorities on service developments.

		• Changes in accessibility criteria • Local debate and concern		• The Committee consider the proposal formally at one of their meetings. • Officers of the responsible commissioners and service providers work closely with the Committee during the formal consultation period. • The Committee responds within the time-scale specified by the responsible commissioners. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence.

Stage One

At the earliest possible stage, the health organisation responsible for the proposed change initiates dialogue with the HSC through the Principal Policy Officer.

The HSC Chairman and Vice Chairman are briefed on the proposed change.

The Chairman and Vice Chairman assess and determine the level of change using information gathered at the briefing and advice from officers. A recommendation and rationale is reported alongside the content of the briefing at the next formal HSC meeting for decision.

Stage Two

The organisation responsible completes the substantial variation assessment **(see Appendix A)**, gathering and presenting the relevant evidence.

The organisation responsible contacts the Principal Policy Officer to arrange an informal briefing with the HSC.

All HSC members should be sent detailed information regarding the proposals, including the completed 'substantial variation assessment'.

The organisation responsible should go through the assessment with HSC at the meeting and discuss whether they believe the proposed service variation or development is 'substantial'. A recommendation and rationale will be reported alongside the content of the briefing at the next HSC meeting for decision.

All HSC members and the health organisation responsible should be informed of the outcome of the meeting and given a record of the meeting.

Final Say

8.6 Should there still be disagreement over whether a service change or variation is substantial at the end of a stage two assessment; it is the view of HSC which prevails. The HSC view therefore determines whether a service variation is substantial and requires commissioners to consult.

Exemptions

8.7 The following are circumstances where the HSC will not need to be consulted:

- Proposals to establish or dissolve an NHS trust or CCG if this does not represent a substantial development or variation to the provision of health services.

- Proposals for pilot schemes within the meaning of section 4 of the NHS (Primary Care) Act 1997, as these are the subject of separate legislation.

- Where a decision has to be taken immediately because of a risk to the safety or welfare of patients or staff. These circumstances should be anticipated and reported in advance, making unanticipated situations the absolute exception. The Committee will be notified immediately of the decision taken and the reason why no consultation has taken place. The notification will include information about how patients and carers have been informed about the change and what alternative arrangements have been put in place to meet the needs of patients and carers.

9. Consulting with the Committee

9.1 As identified in the table above, where a 'Level 3' or substantial service variation is identified, the responsible commissioner(s) will notify the Committee and formally consult the HSC. This is in addition to discussions between the responsible commissioner(s) and the appropriate local authorities or Health and Wellbeing Boards on service developments. It is also additional to the NHS duty to consult patients and the public.

9.2 The HSC has the responsibility to consider and comment on:

- Whether as a statutory body the HSC has been properly consulted (in addition to the public consultation process).

- The adequacy of the consultation undertaken with patients and the public.

- Whether the proposal is in the interests of health services in the area.

9.3 The HSC may refer proposals for substantial service developments or variations to the Secretary of State where it is not satisfied that:

- Consultation on any proposal for a substantial change or development has been adequate in relation to content or time allowed.

- The proposal would be in the interests of the health service in West Berkshire.

- A decision has been taken without consultation and it is not satisfied that the reasons given for not carrying out consultation are adequate.

Appendix A:
Substantial Change Assessment Form

NAME OF RESPONSIBLE BODY:

CONTACT INFORMATION:	
Name: **Job Title:** **Address:** **Email:** **Telephone**:	

SECTION A: BACKGROUND INFORMATION
Proposed service change: Brief description of the proposal, including whether it involves: an increase / decrease / introduction / withdrawal of service; changes to hours of operation; relocation; changes to methods of service delivery. Also indicate if the proposed change will be permanent or temporary.
Rationale for the proposed change: All key drivers for the proposal.
Strategic fit of proposal: Consider this at national, system and place level.
Date by which final decision is expected to be taken:

SECTION B: CONSULTATION / STAKEHOLDER ENGAGEMENT
Legal Obligations: Have the legal obligations set out under Section 242 of the consolidated NHS Act 2006 to 'involve and consult' been fully complied with?
Yes / No (delete as applicable) **Commentary:**
Stakeholder Engagement: Have initial responses from service users, their carers / families / advocates, and from Healthwatch indicated whether the impact of the proposed change is substantial?
Yes / No (delete as applicable) **Commentary:**
Stakeholder Support: Is there any aspect of the proposal that is contested by key stakeholders? If so what action has been taken to resolve this?
Yes / No (delete as applicable) **Commentary:**
Staff Engagement: Have staff delivering the service been fully involved and consulted during preparations of the proposals? If so how?
Yes / No (delete as applicable) **Commentary:**
Staff Support: Is there any aspect of the proposal that is contested by the clinicians / other staff? If so what action has been taken to resolve this?
Yes / No (delete as applicable) **Commentary:**

SECTION C: PATIENT IMPACT
Improvement: How will the proposed change deliver improved clinical and social outcomes for patients and improved patient experiences?
Commentary:
Service Users: How many people are likely to be affected by the proposal and which areas are the affected people from?
Commentary:
Inequalities: Does the proposed change of service have a differential impact that could create new / widen existing inequalities (geographical, health, social, etc)?
Yes / No (delete as applicable) **Commentary:**
Patient Access: Will the proposed change affect patient access in terms of location, transport access (public and private), travel time, etc?
Yes / No (delete as applicable) **Commentary:**
Incremental Impact: Does the proposal appear as one of a series of small, incremental changes that when viewed cumulatively could be regarded as substantial?
Yes / No (delete as applicable) **Commentary:**

SECTION D: SERVICE QUALITY, DELIVERABILITY AND RISK
Proven Practice: What is the strength of evidence about the clinical performance of the proposed change?
Commentary:
Service Capacity: Will the proposal result in sufficient capacity to meet demand, taking account of aspects such as demographic changes, changes in morbidity / incidence of relevant conditions, or reductions in care needs due to improved screening?
Yes / No (delete as applicable) **Commentary:**
Workforce implications: Have the workforce implications associated with the proposal been assessed?
Yes / No (delete as applicable) **Commentary:**
Financial Implications: Have the financial implications of the change been assessed in terms of capital and revenue and overall financial sustainability?
Yes / No (delete as applicable) **Commentary:**
Risk: What are the key risks associated with the proposal and how will these be managed?
Commentary:

SECTION E: WIDER IMPACTS

Community Impacts: What are the wider impacts on affected communities (e.g. environmental, transport, housing, employment, etc)?

Commentary:

Service Impacts: Will the proposed changes affect: a) services elsewhere in the NHS; b) services provided by local authorities; c) services provided by the voluntary sector?

Yes / No (delete as applicable)

Commentary:

OUTCOME / DECISION

Is this considered to be a substantial service change or development by the commissioner / provider?

Yes / No (delete as applicable)

Commentary:

Is this considered to be a substantial service change or development by the Health Scrutiny Committee?

Yes / No (delete as applicable)

Commentary:

Possible Outcomes

Consultation is required

- If the health organisation and the Health Scrutiny Committee representatives agree that the proposal does represent a substantial service change or development, the formal consultation with the Health Scrutiny Committee will commence.
- The Health Scrutiny Committee must be provided with:
    - The date by which the responsible organisation intends to decide whether to take the proposal forward.
    - The date by which the responsible organisation requires the Health Scrutiny Committee to provide any comments. (It is expected that any formal consultation would be undertaken by the commissioner of the service.)

Consultation is not required:

- If the health organisation and the Health Scrutiny Committee representatives agree that the proposal does not represent a substantial service change or development, then formal consultation with the Health Scrutiny Committee is not required.
- Best practice is that the health organisation should continue to engage scrutiny and the public in the development of the proposal and onwards to public consultation in accordance with Section 242 requirements.

Agreement cannot be reached:

- If agreement cannot be reached between the health organisation and the Health Scrutiny Committee representatives, then all reasonable, practicable steps should be taken towards local resolution.
- Further meetings may be conducted with the wider Health Scrutiny Committee members and other stakeholders such as Healthwatch, carer/user groups, and the voluntary sector.
- If it continues to be impossible to reach agreement, both sides may jointly or independently pursue the options open to them under their respective statutory instruments, such as escalation to the Secretary of State or to the provider's Board.

NB: Health Scrutiny Committee representatives may prefer not to make a final decision about whether formal consultation is required at the meeting and choose to notify the organisations involved once a decision is made.

Note on Consultation Processes

The Department of Health's (DH) Local Authority Scrutiny Guidance (2014) states the following in relation to consultation processes:

> *"The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS*

should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed."

It is therefore understood that the process of assessing substantial change should take place as part of broader meaningful engagement with local communities.

The relevant health organisation is responsible for engaging and consulting all relevant local people. It is expected that this will include locally elected representatives where the service change will have an impact (parish / town council, district council and MPs).

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Royal Berkshire NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust
Fitzwilliam House
2nd / 3rd Floors
Skimped Hill Lane
Bracknell
Berkshire
RG12 1BQ
Tel: 01344 415600
Fax: 01344 415666
http://www.berkshirehealthcare.nhs.uk/

5th January 2022

Gordon Oliver
Principal Policy Officer
Democratic services
Strategic Support
West Berkshire District Council
Council Offices
Market Street
Newbury RG14 5LD
Executivecycle@westberks.gov.uk

Dear Gordon

Thank you for consulting Berkshire Healthcare NHS Foundation Trust and Royal Berkshire NHS Foundation Trust on the proposed West Berkshire Health Scrutiny protocol.

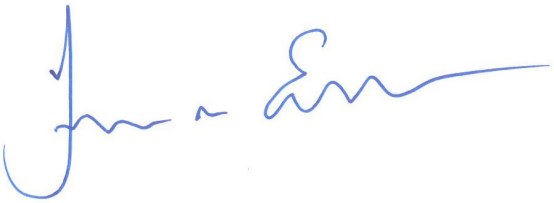
We find the protocol to be clear and framed by helpful partnership working principles, supporting the two Health and Wellbeing goals that we would all support.

The definition of a “substantial” development/change in NHS service provision is the key element of the protocol in terms of when the NHS (responsible commissioner) formally consults with the Health Scrutiny Committee (HSC). Whilst noting that there is no legislative definition for a “substantial” change we recognise the examples used to guide in the protocol.

The success of this protocol will be driven by the opportunity for NHS partners to engage the HSC in forward planning discussion so that there is joint understanding of proposed services changes, well in advance of them happening.

We would ask that the HSC continues to develop partnership connections to the wider Buckinghamshire, Oxfordshire and Berkshire West ICS scrutiny processes, to ensure linkage and avoid duplication.

Yours sincerely,



Julian Emms
Chief Executive
Berkshire Healthcare NHS Foundation Trust

Steve McManus
Chief Executive
Royal Berkshire NHS Foundation Trust

Health Scrutiny Committee – 5 April 2022

Item 9 – CCG Update

Verbal Item

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Health Scrutiny Committee – 5 April 2022

Item 10 – Healthwatch Update

Verbal Item

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healthwatch Swindon

healthwatch Wiltshire

healthwatch West Berkshire

Experiences of patients at Great Western Hospital

July 2021

Contents

Report summary

What is this report about?

In July 2021, Healthwatch Swindon, Wiltshire and West Berkshire carried out a piece of engagement work to hear the experiences of patients that had used the Great Western Hospital (GWH) in Swindon. This work was planned jointly with Great Western Hospitals NHS Foundation Trust, and we heard the experiences of patients that had used the Emergency Department and Urgent Care, and four inpatient wards.

What did we do?

- We devised two surveys – one for the Emergency Department (ED) and Urgent Care and one for inpatient wards at GWH.
- We carried out both face to face and virtual visits to these areas.
- We ran the two surveys online for one month. These were shared widely with our partners.
- We made telephone calls to patients that had been discharged.

What were the key findings?

- Most people said they had first sought help from other services before attending ED or Urgent Care.
- Many people had contacted several services before ED or Urgent Care, and had managed to speak to someone for advice.
- Comments around treatment and quality of care were broadly positive.
- A small number of people did not feel they had been treated with dignity and respect, didn't feel involved in their care, or felt safe.
- Staffing pressures and shortages were widely recognised by patients and the impact that this had on care.
- Food was seen as an area that could be improved.
- While the discharge process worked for some, for many there were delays and communication was raised as an issue.
- Carers reported a worse experience generally than patients themselves.

Conclusions and recommendations

The majority of findings from this review were positive, for which the Trust should be applauded. However, there were also some areas where change is needed.

The report makes several recommendations for consideration based on what people told us.

Introduction and background

About us

Healthwatch is your local health and social care champion. We're here to listen to the issues that really matter to people and to hear about your experiences of using local health and social care services. We're entirely independent and impartial, and anything you share with us is confidential. There is a local Healthwatch in every local authority area of England.

Healthwatch uses your feedback to better understand the challenges facing the NHS and other care providers and we make sure your experiences improve health and care for everyone — locally and nationally. We can also help you to get the information and advice you need to make the right decisions for you and to get the support you deserve.

This collaborative project was produced by Healthwatch Swindon, Healthwatch Wiltshire and Healthwatch West Berkshire to represent the catchment area of patients who may use Great Western Hospital (GWH) in Swindon.

healthwatchswindon.org.uk
healthwatchwiltshire.co.uk
healthwatchwestberks.org.uk

About Great Western Hospital

Great Western Hospital (GWH) is run by Great Western Hospitals NHS Foundation Trust. They provide healthcare to the people of Swindon and surrounding areas, offering treatment and care in hospital, in the local community and in people's own homes.

The hospital has around 480 beds, and includes numerous outpatient clinics, specialist scanners, maternity services, an Intensive Care Unit, an Urgent Care Centre and a 24/7 Emergency Department.

The Care Quality Commission (CQC) monitor, inspect and regulate services to ensure that they are safe and provide good quality care. In February 2020, the CQC undertook an announced inspection of four key services at GWH:

- Urgent and emergency care.
- Medical care.
- Surgery.
- Maternity.

While several areas of outstanding practice were identified, the Trust's overall rating was 'requires improvement'

Healthwatch Swindon, Wiltshire and West Berkshire regularly meet with representatives from GWH to share insight and we discussed the potential benefits of undertaking an Enter and View visit to the areas identified within the CQC report to hear patient experiences.

As a result, a collaborative piece of work was designed by Healthwatch Swindon, Wiltshire, West Berkshire and GWH. Due to the coronavirus pandemic, this work was paused several times and the methodology was adapted in line with the restrictions at the time of our visits.

About Enter and View

Healthwatch has a statutory right to carry out Enter and View visits in health and social care premises to observe the nature and quality of services, as set out in the Local Government and Public Involvement in Health Act 2007.

Enter and View visits are not inspections but aim to offer a layperson's perspective.

What did we do?

Healthwatch Swindon, Wiltshire, West Berkshire and GWH worked together to co-design this project.

It was decided that we should focus on visiting the Emergency department (ED) and Urgent Care, and four inpatient wards — two medical wards (Jupiter and Saturn, where patients are admitted due to illness for treatment) and two surgical wards, (Aldbourne and Meldon, where patients are admitted for surgery).

Together we devised two surveys, one for ED and Urgent Care and one for the inpatient wards. These asked a variety of questions to hear the experiences of people who had used services at GWH from 1 March 2021 onwards.

Due to the pandemic, our initial plan was to carry out virtual visits only, however as this work was delayed and restrictions eased, we felt it would be beneficial to also include face to face visits. These were carried out under a comprehensive risk assessment, and in line with the Covid restrictions and GWH visiting protocols at that time.

We undertook our engagement in July 2021, and this consisted of:

- Face to face Enter and View visits to ED, Urgent Care and four wards to hear the experiences of patients. These took place over one week at the beginning of July.
- Virtual interviews with patients in three wards at the hospital using hospital-based volunteers.
- An online survey that was available throughout July and shared widely by our partner agencies.
- Telephone calls to patients that had been discharged.

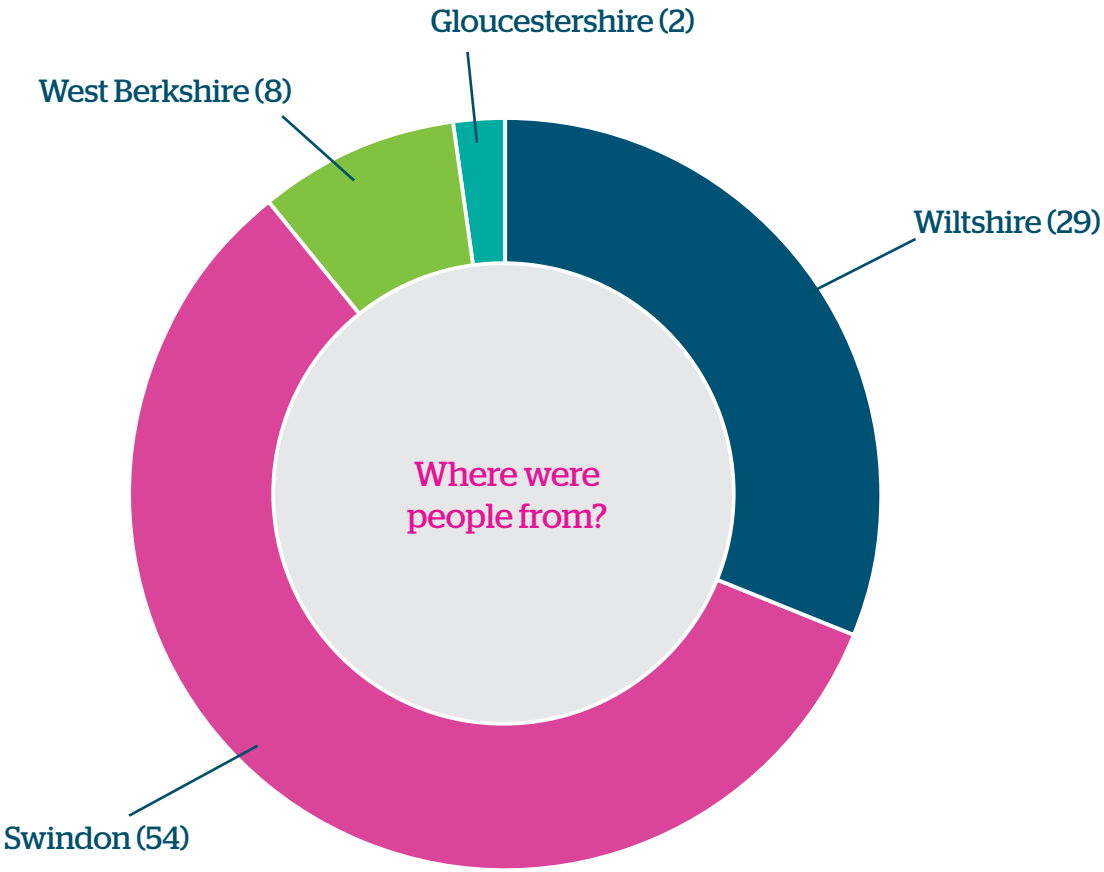
In total we heard the experiences of:

112 people that had used ED or Urgent Care.
84 people who had been inpatients at the hospital.

Who did we hear from?

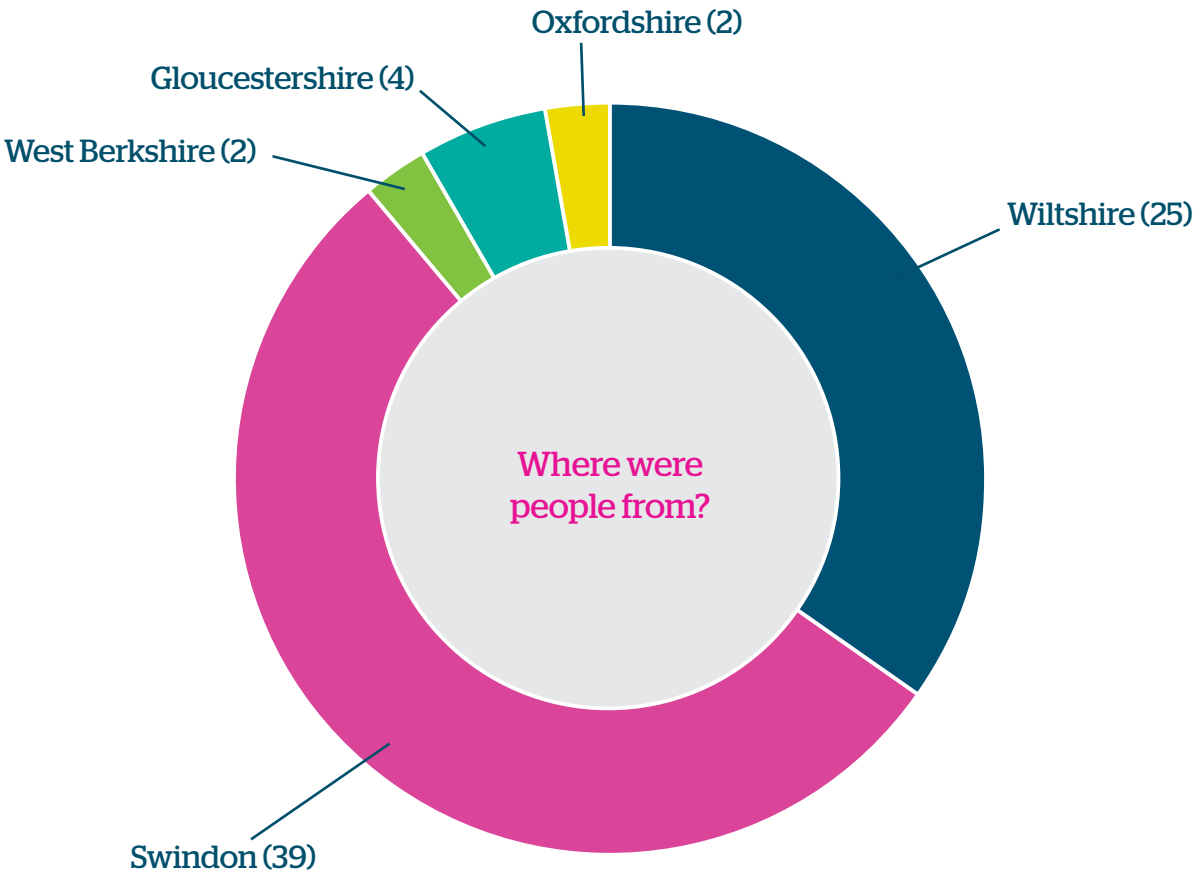
We used a variety of ways to gather feedback in order to hear from a wide range of people that had used GWH services.

ED and Urgent Care



- 60% of those we spoke to were female, with 38% male and the remainder either wishing to self-identify or not wishing to disclose.
- We spoke to people who were a range of ages, from under 18 up to over 85.
- 37% of the people we spoke to considered themselves to have a health condition or disability.
- 77% identified as White British.

Inpatients



- 69% were female and 28% male, with the remainder preferring not to say.
- Most of those we spoke to were between the ages of 55 and 84, although we did hear from people across all age ranges.
- 44% of people considered themselves to have a health condition or disability.
- 89% identified their ethnicity as White British, others identified as Indian, White other or other.

The full breakdown of the demographics can be found in the Appendix (page 46).

Observations from our visits

We visited the Emergency Department, Urgent Care and four inpatient wards to hear the views of patients. While visiting, we also made observations of the surroundings.

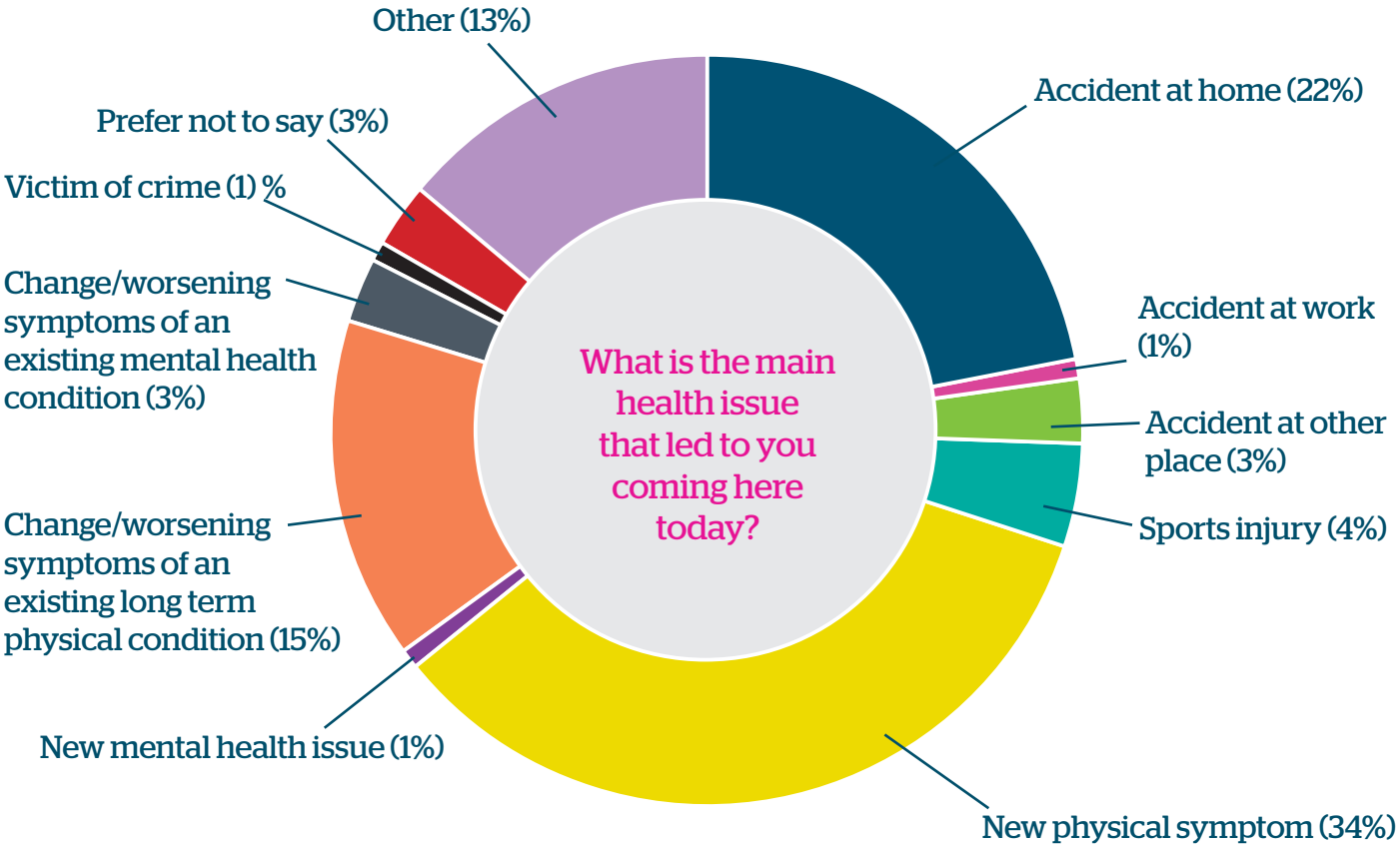
Urgent Care is currently housed in a temporary building, but this was light, clean and spacious. The staff were welcoming and friendly and gave us a tour of the building. There was hand sanitiser at the entrance and at a number of other locations. Their were two waiting areas, with one specifically for those with children. This waiting area could have been more young people friendly and was a little bare. There was a vending machine available for refreshments. Chairs were spread out (or marked with a cross) with some additional screens to aid social distancing. We saw patients being signed in at reception and called through to appointments and observed that staff were polite and pleasant in their manner towards patients.

The **Emergency Department** by comparison was smaller and seemed darker. The staff were friendly and gave us a tour, identifying areas where we could talk to patients and areas to avoid. There was hand sanitiser at the entrance and face masks at the front desk. We observed reception staff checking in patients, clinical staff working on the unit and catering staff who were serving lunch to some of the patients in the bays. All staff were courteous and appeared welcoming of our visit. We saw that staff members were courteous, patient and caring in their manner toward patients. We observed patients being offered a choice of meals for their lunch. All the areas we visited in the Emergency Department were clean and tidy.

The wards we visited were clean and the staff on the whole were expecting us. They were friendly and able to identify patients for us to speak to. We noticed that posters were on display with the details of our visits. There were some wards where the corridors were a little cluttered with wheelchairs and other equipment.

Findings: Emergency Department and Urgent Care survey

The first part of our survey was to identify why people were using the ED, how long they had been experiencing the problems that led them there and whether they had been discharged from the hospital recently. We asked them what the main health issue that led to them visiting. A breakdown of responses can be seen below.

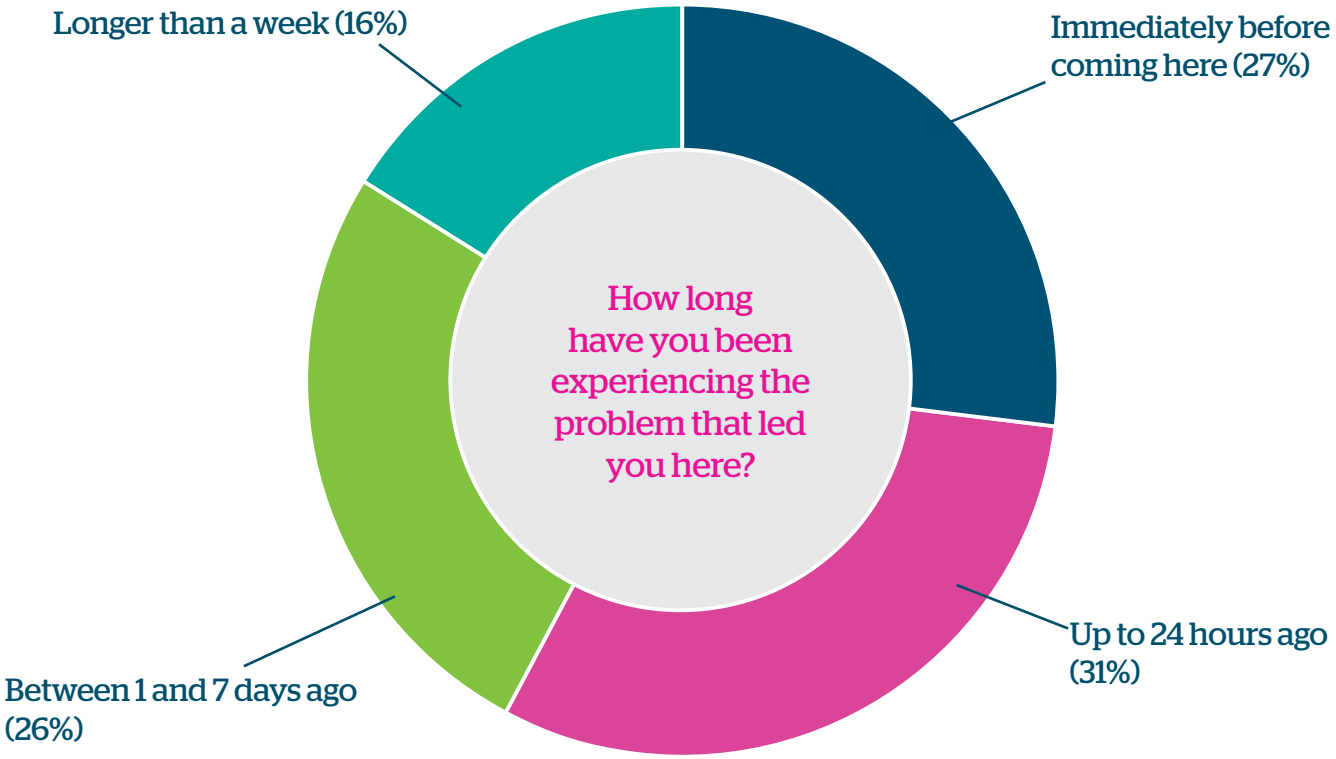


The majority of the respondents reported that acute symptoms had taken them to ED. Just over a quarter (27%) said they began experiencing symptoms immediately and 31% said they had been experiencing symptoms for up to 24 hours before coming to ED. Together this represents 58% of the total 109 people taking the survey. Another quarter (26%) had experienced the problem for up to seven days and 16.5% had been experiencing the problem for longer than a week.

> Bleeding from blood thinning injections that wouldn't stop.

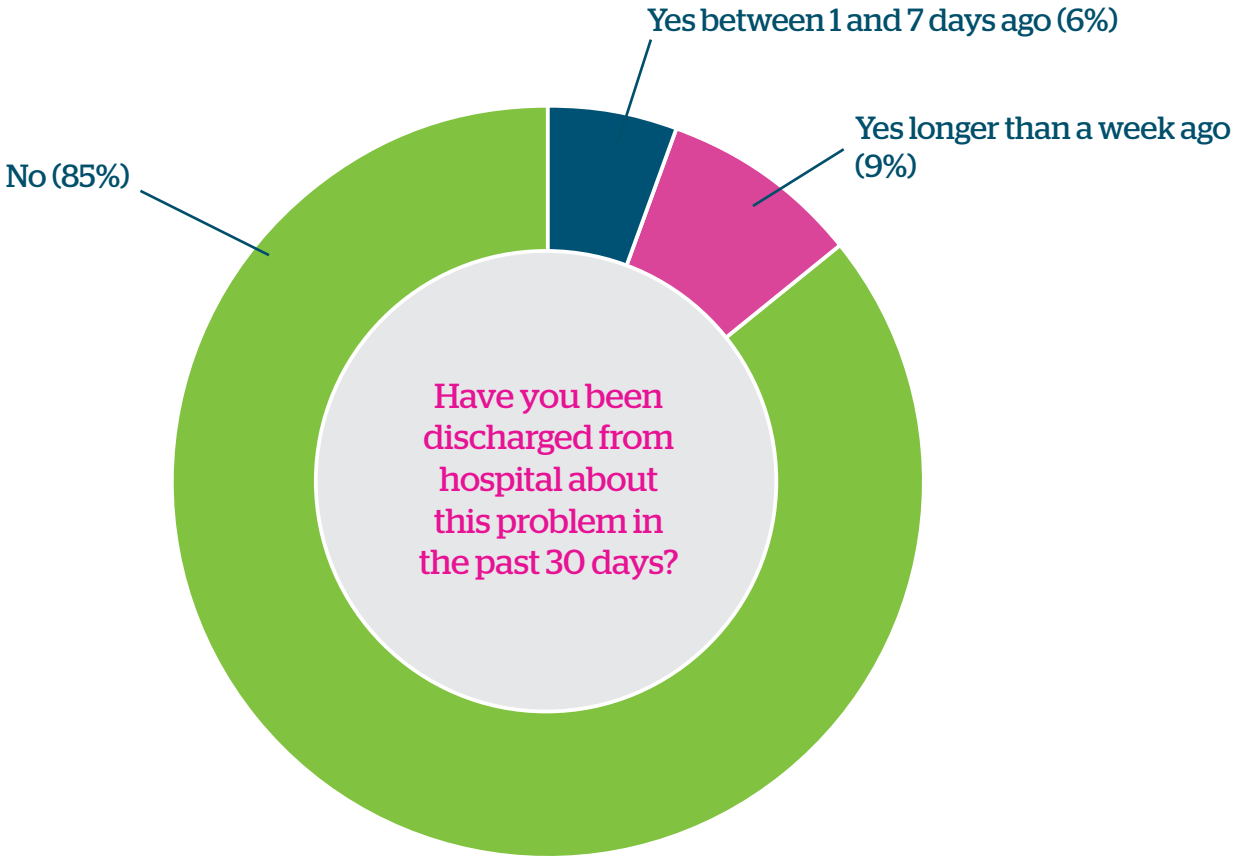
> GP sent me with suspected heart attack.

> Ambulance crew said better I went into hospital – although I felt it unnecessary.



When asked if they had been discharged from hospital with the same problem in the past 30 days, most people (86%) said they hadn't.

Of those 15 who had been in hospital within the last 30 days, 9 people, had been discharged more than a week before going back to the ED. Six people had returned to ED within a week of being discharged.

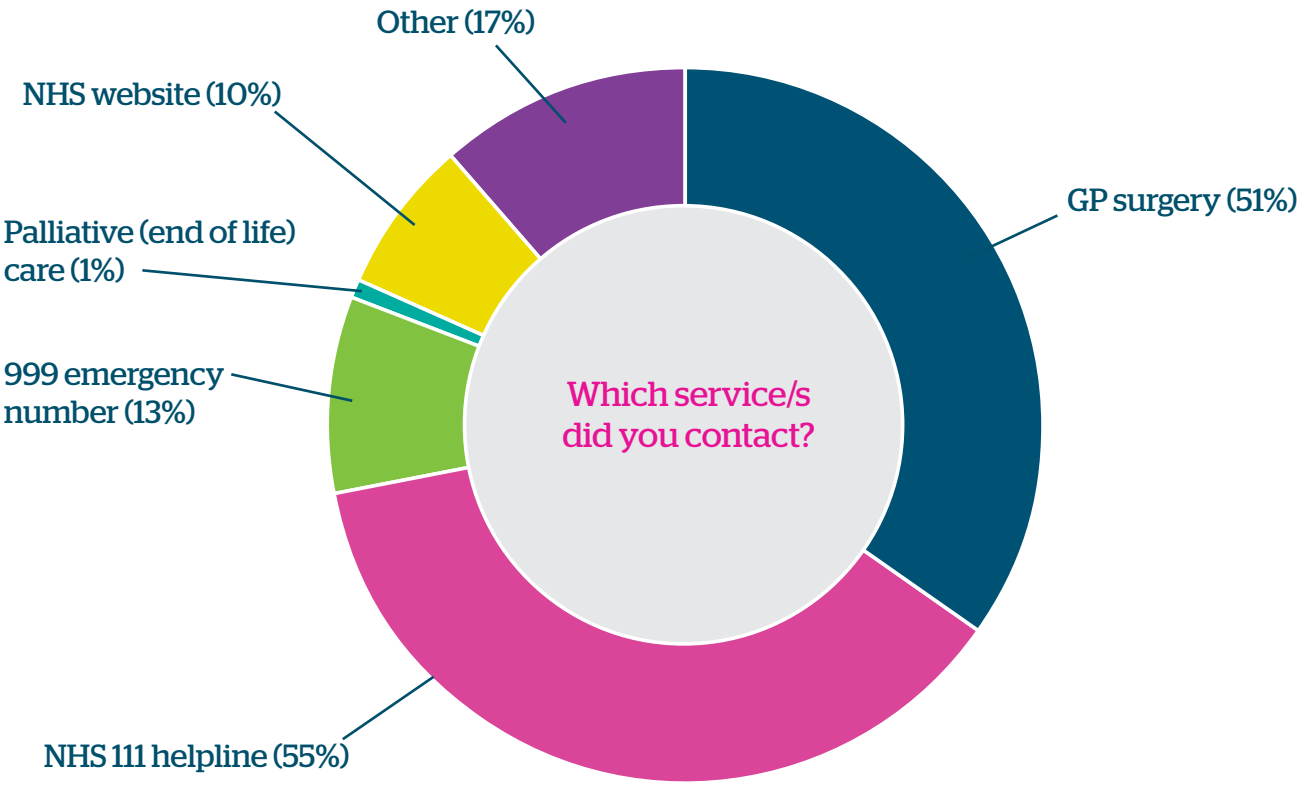


Routes into ED

Our next questions focused on how people had arrived at ED; which services had they contacted, whether they had been able to get advice and if they had been advised to go there by other healthcare professionals.

The majority of people we asked – 69 (68% of 101 who answered) – said they had initially sought help elsewhere while 32 (32%) had used ED as their first port of call. Of those who had sought help from other services, a large number had initially contacted NHS 111 (55%) or a GP surgery (51%).

The chart below shows which services people contacted first.



> Specialist chemotherapy helpline number.

> NHS 111 said to come here.

> Attended Urgent Care Centre – sent me straight to A&E.

> GP and triage busy, NHS 111 sent a taxi to take me to A&E.

> Mental Health rehab service for substance use.

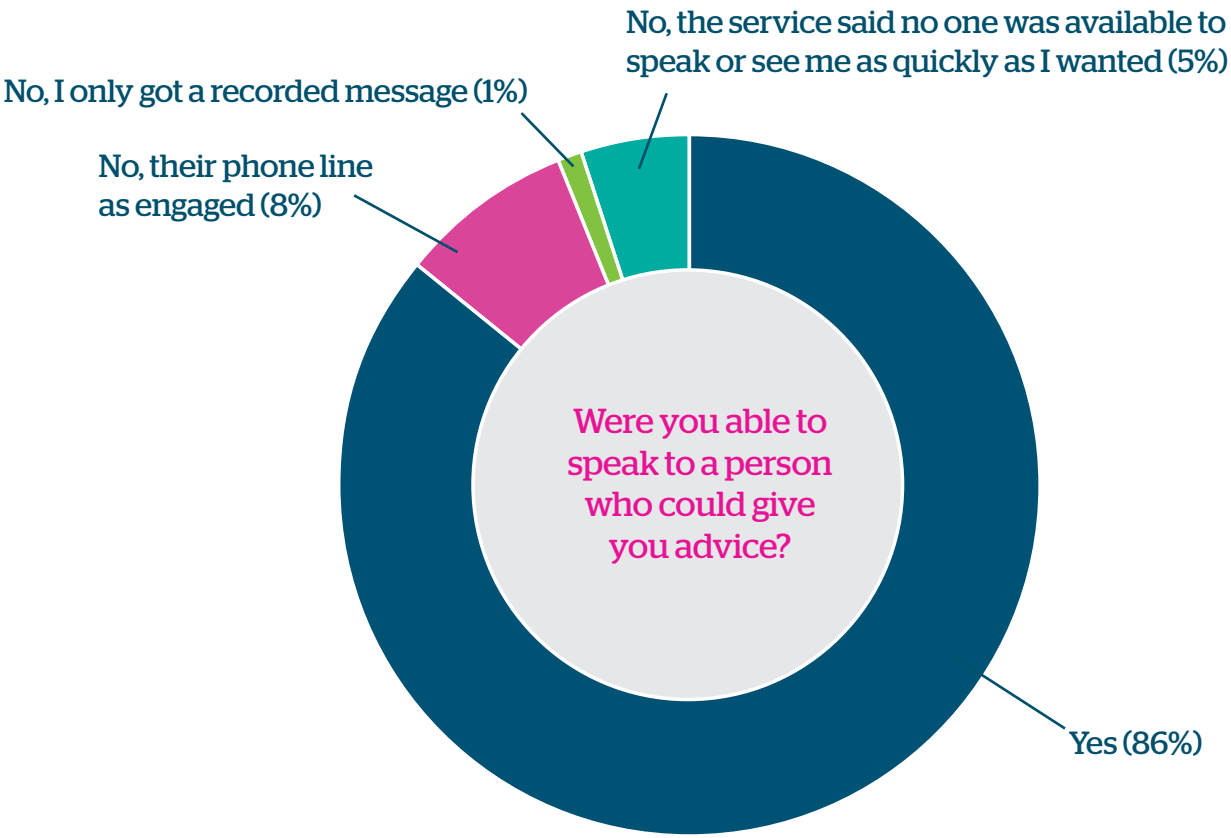
> Community COPD [Chronic Obstructive Pulmonary Disease] team.

> School.

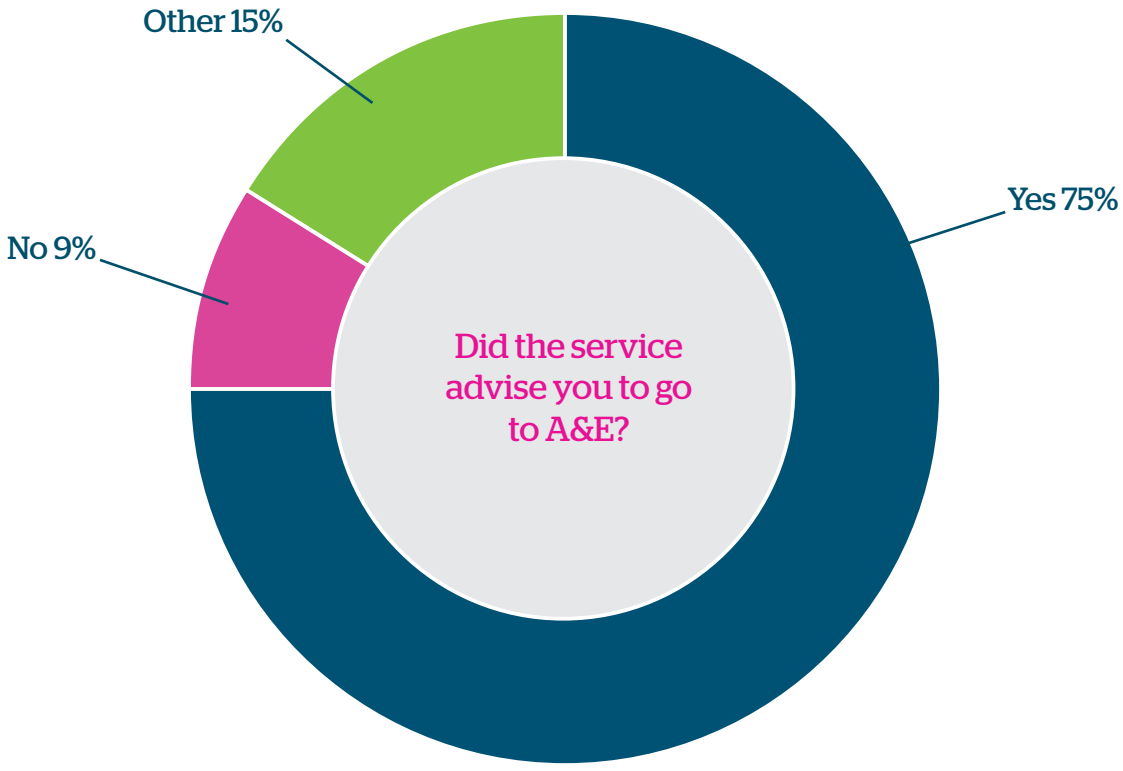
The Which service/s did you contact? question also enabled people to show all the services they had contacted and the following shows the breakdown of the combinations.

Option	Combination count
NHS 111	23
GP	16
NHS 111, GP	13
999	7
GP, NHS 111, 999	3
GP, NHS 111, NHS website	3
GP, NHS website	2
NHS website	1
NHS 111, NHS website	1

Most people told us that they were able to speak to someone for advice from the other services that they contacted, however a small number did not manage to speak to someone.



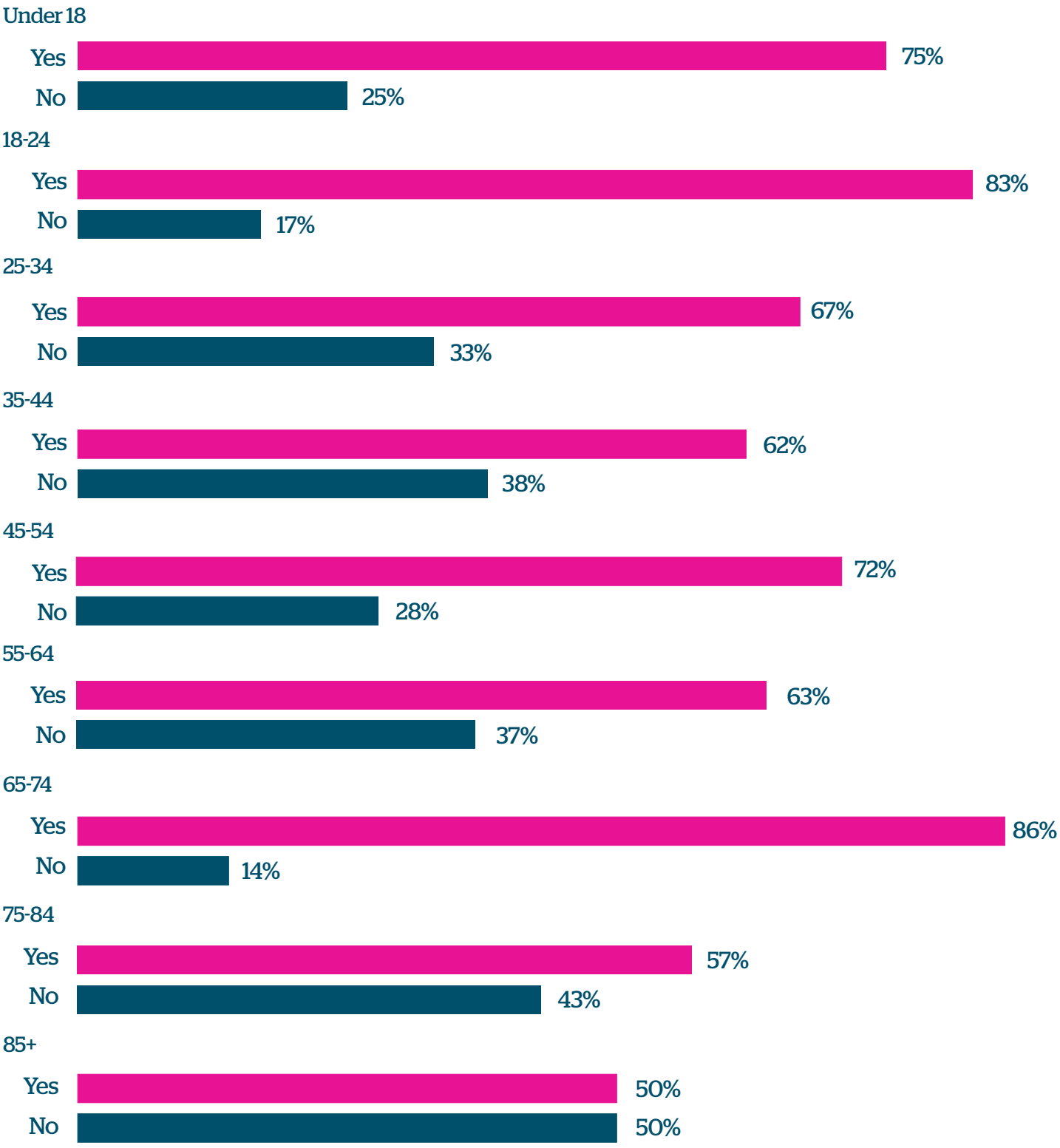
64 people answered the question Did the service advise you to go to A&E? and the majority (75%) reported yes. Of those who selected Other, three were sent an ambulance and another was advised by a paramedic to attend A&E. One reported the GP sent them due to the need for specialist equipment available at the hospital. Another was unhappy with being told they had anxiety, and another said they didn't get the call they were waiting for from the GP.



Age differences

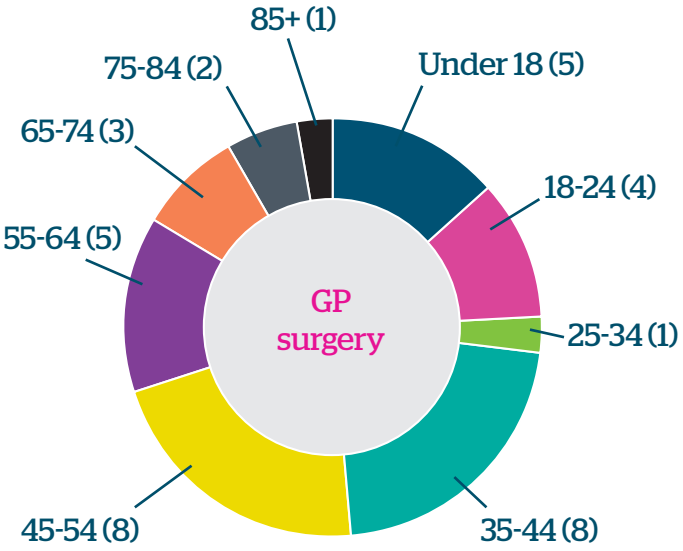
We broke down the results to see if there were any differences in routes to ED and urgent care for people of different ages. As the chart below shows, across all age ranges, more people had tried to seek help from other services before attending than hadn't.

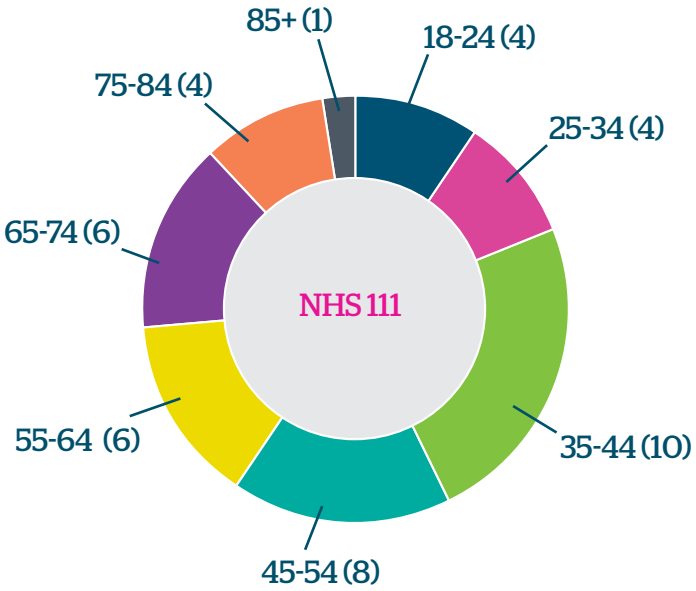
Did you try and seek help from any other services before coming here today?

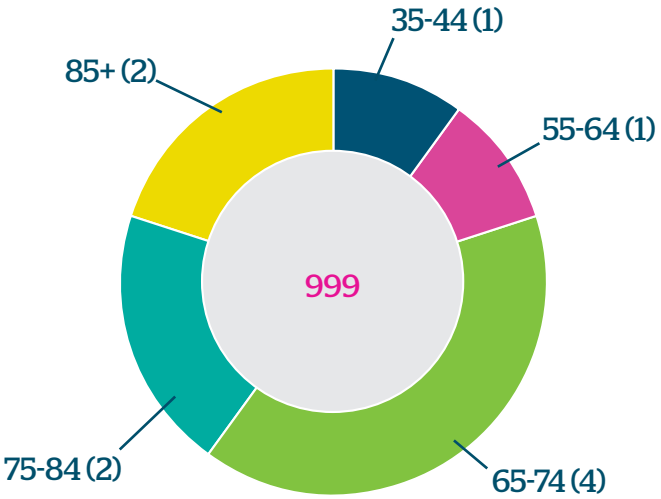


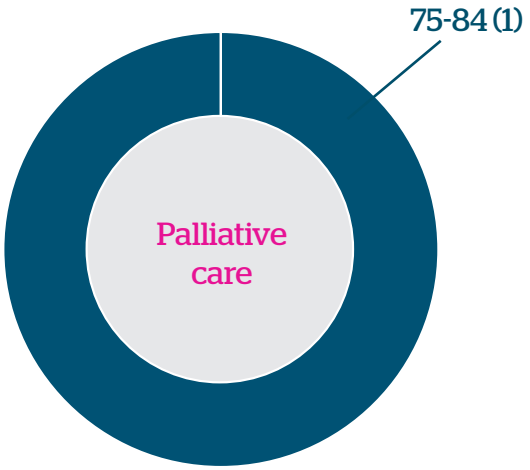
Which services did people contact?

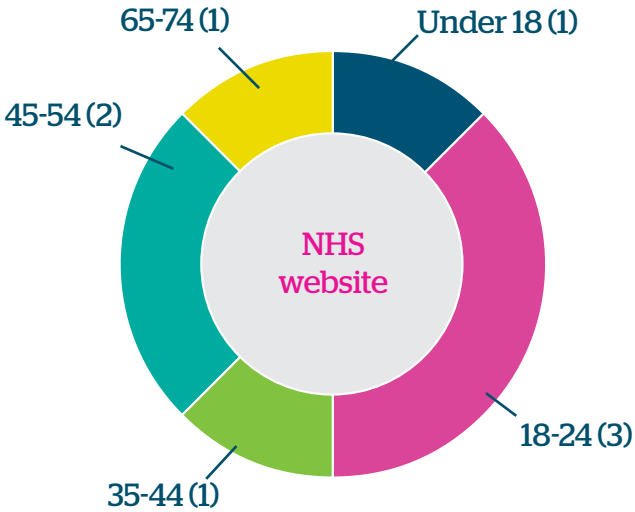
Most people had contacted either their GP, NHS 111 or both before going to ED or Urgent Care. More people in the older age groups had called 999 and the NHS website was used more by those under 54. Those who chose Other mentioned school, the mental health team and community teams.

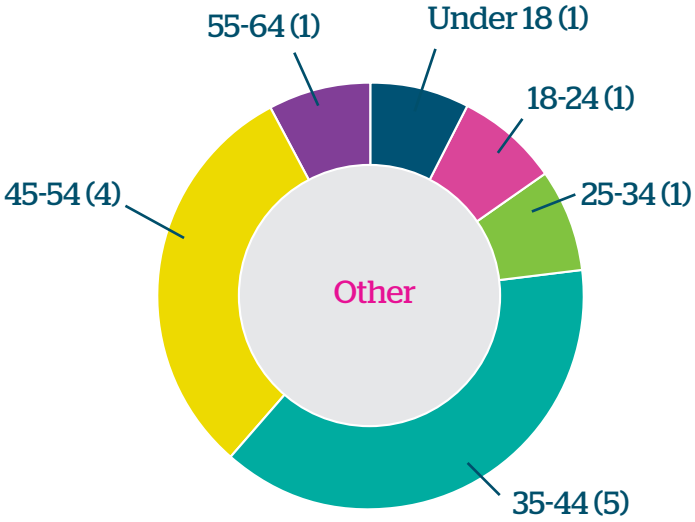






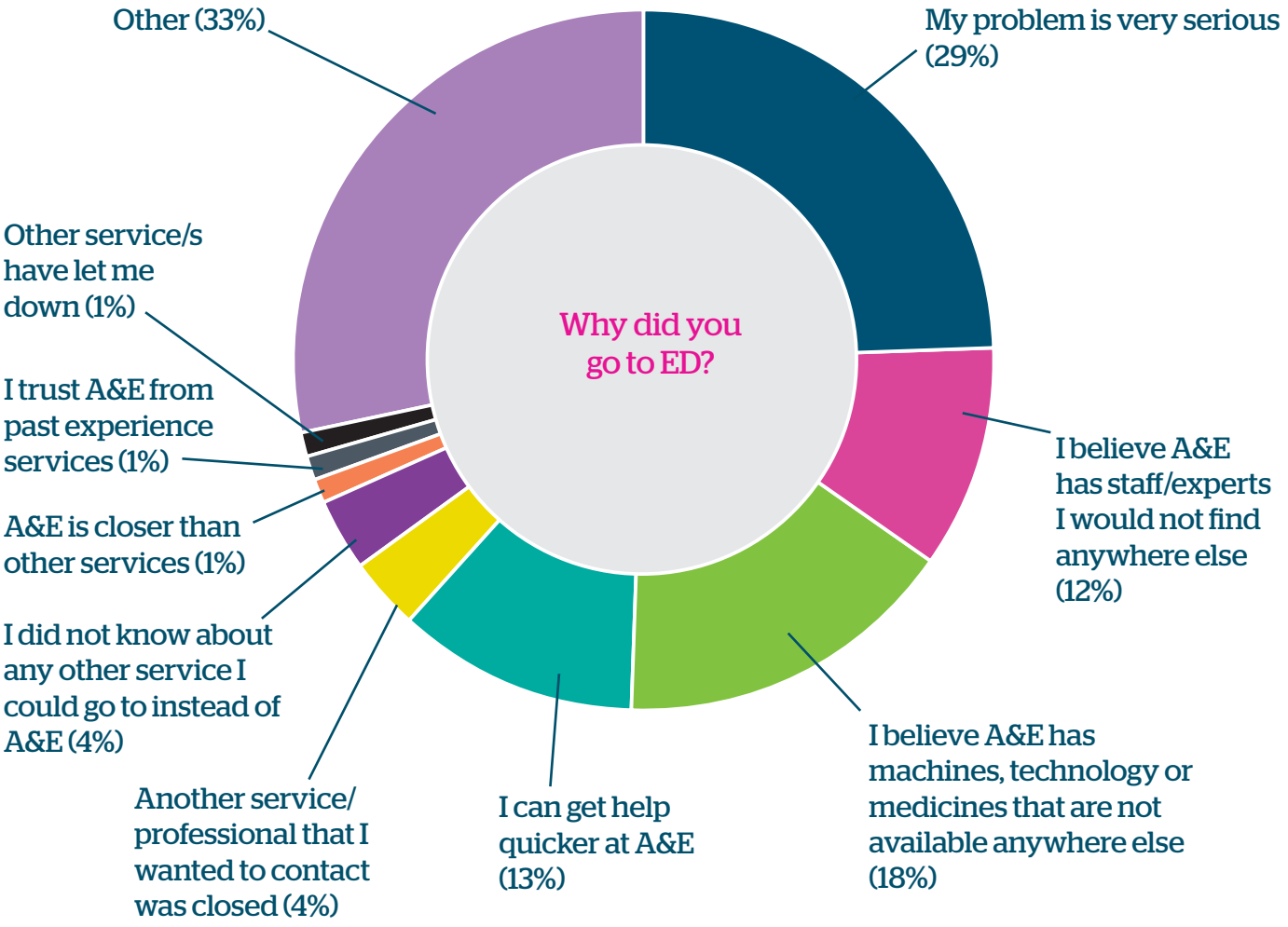






Why did people go to ED?

Our next question focused on the reasons why people decided to go to ED. Most people (29%) said it was because they considered their problem to be very serious, while those who selected Other (33%) gave a range of reasons, with 18 of the 25 respondents saying they had been advised to go there by a healthcare professional.



> My GP told me to go to the hospital immediately.

> Attended Urgent Care Centre as a "walk-in" – they sent me straight to A&E.

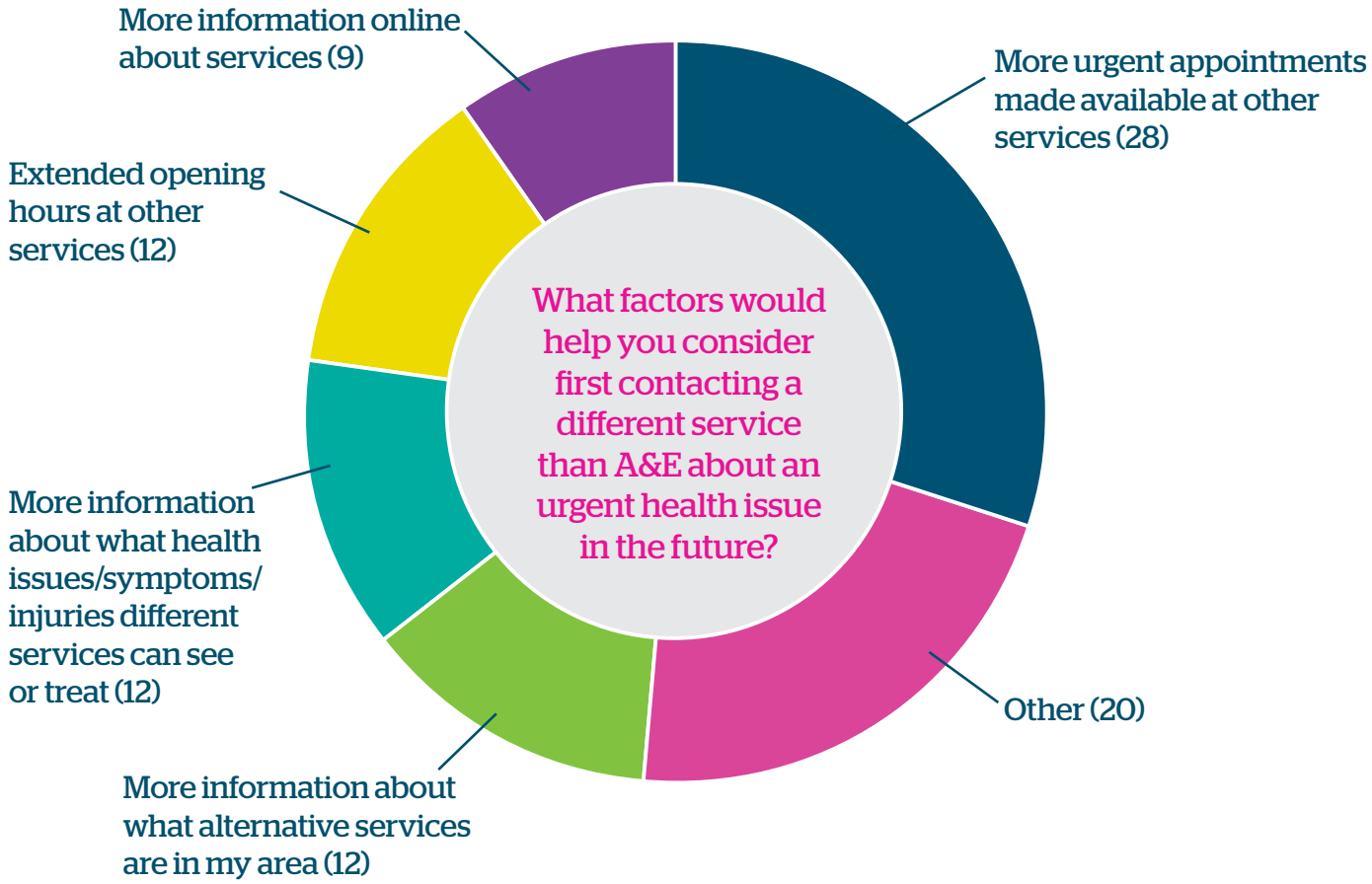
> I was sent here by 111.

What would enable people to seek help elsewhere first?

We asked what would need to be in place for people to consider contacting another service about an urgent health issue rather than visiting ED. Most people (28) said having more urgent appointments available at other services would help, while others mentioned extended opening hours at other services, more information about local services, as well as more information about health issues/symptoms in general would be useful.

Among the Other answers, four mentioned availability of X-ray or other specialist equipment elsewhere that would meant they didn't need to attend ED.

The comments given here reflect how some people have delayed going to the ED in spite of urgent need, while others have gone there in desperation when they haven't been able to access another service.



> I should have contacted 999 after my first collapse of the day so blame myself for downplaying my symptoms.

> I would only use A&E if needed!

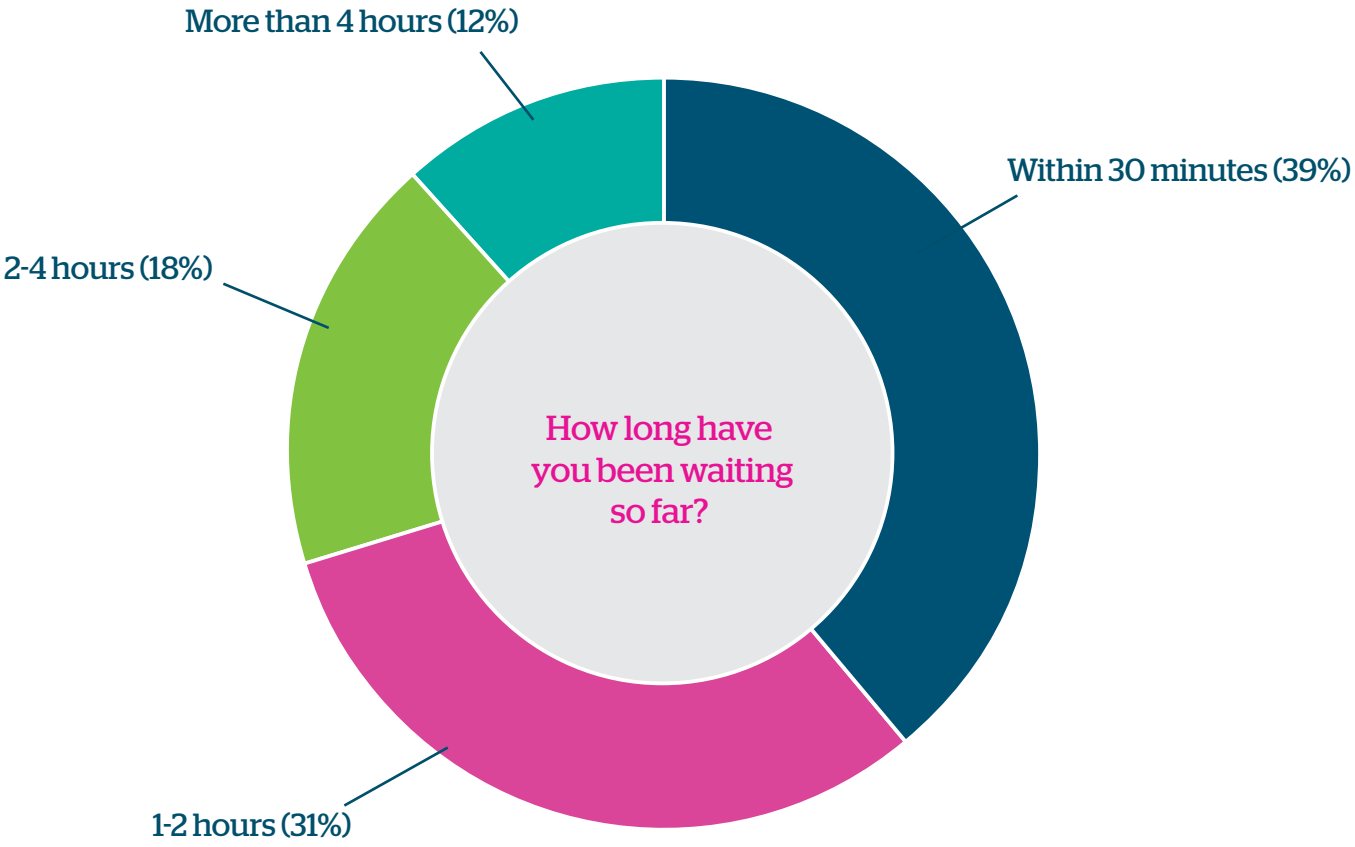
> Actually being able to see a GP on a "same day basis", as we could before the Covid madness.

> This time the Great Western was undoubtedly the best and only option as they would be able to deal with anything necessary.

How long were people waiting?

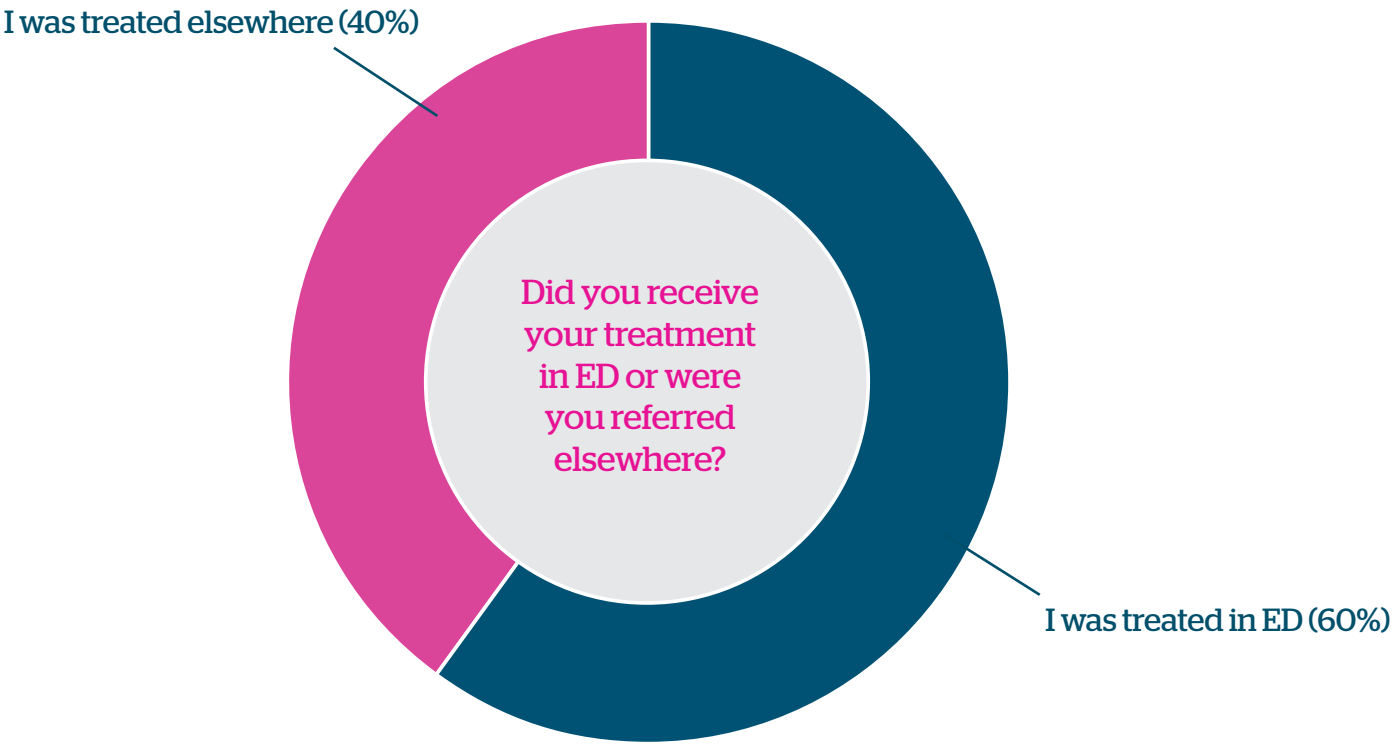
We should note that our visits to the Emergency Department were carried out during a quieter period in order to maintain social distancing between interviewers and patients. The people we spoke to may have had a shorter waiting time because of this. However, the online survey we ran would have captured people that had visited at busier times.

Most people (39%) told us that they had been waiting less than half an hour, but nearly a third more (31%) had been waiting up to 2 hours. 12 people (11%) said they had been waiting for more than 4 hours.

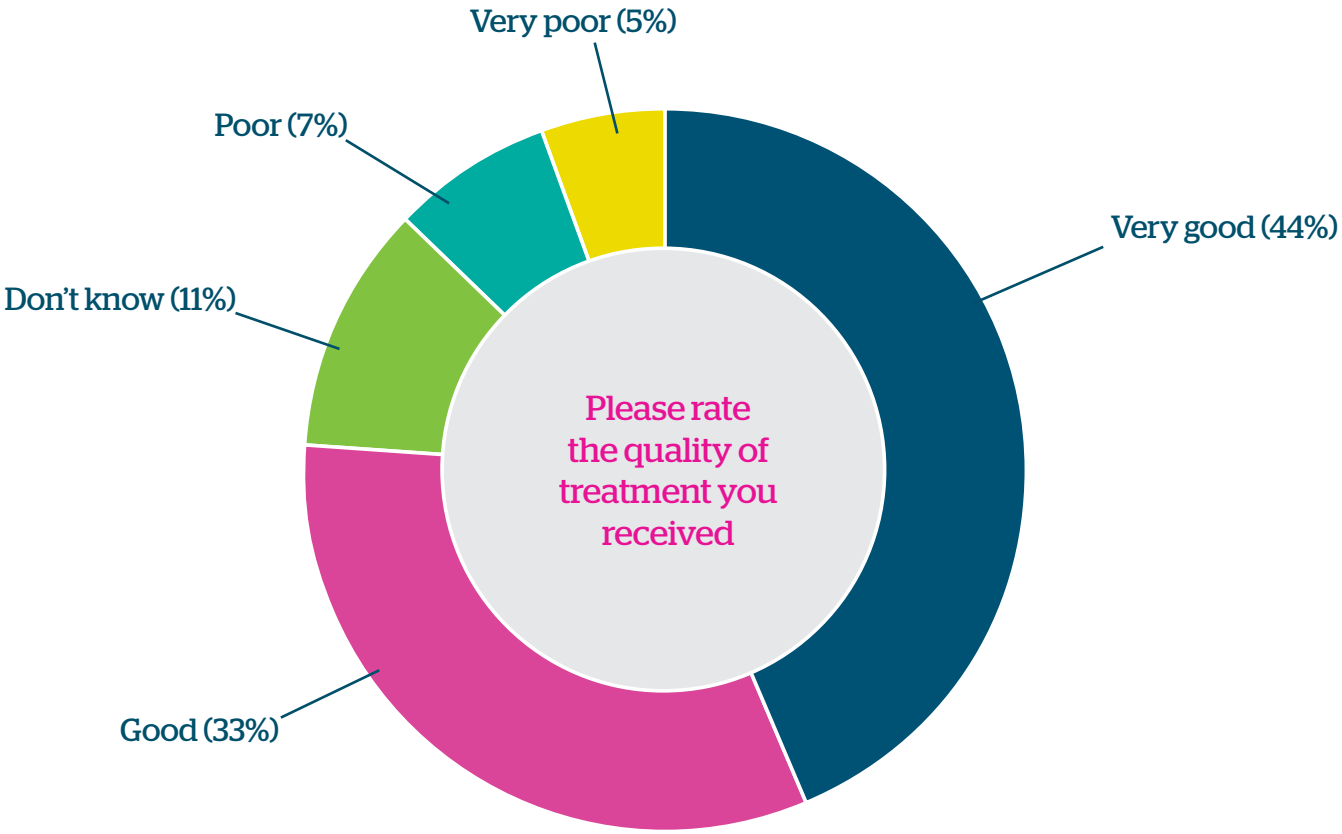


Assessment and treatment

We asked people when they had been assessed whether they received their treatment in ED or if they were referred elsewhere, such as the Urgent Treatment Centre at GWH. 60% said they received their treatment in ED as the chart below shows.

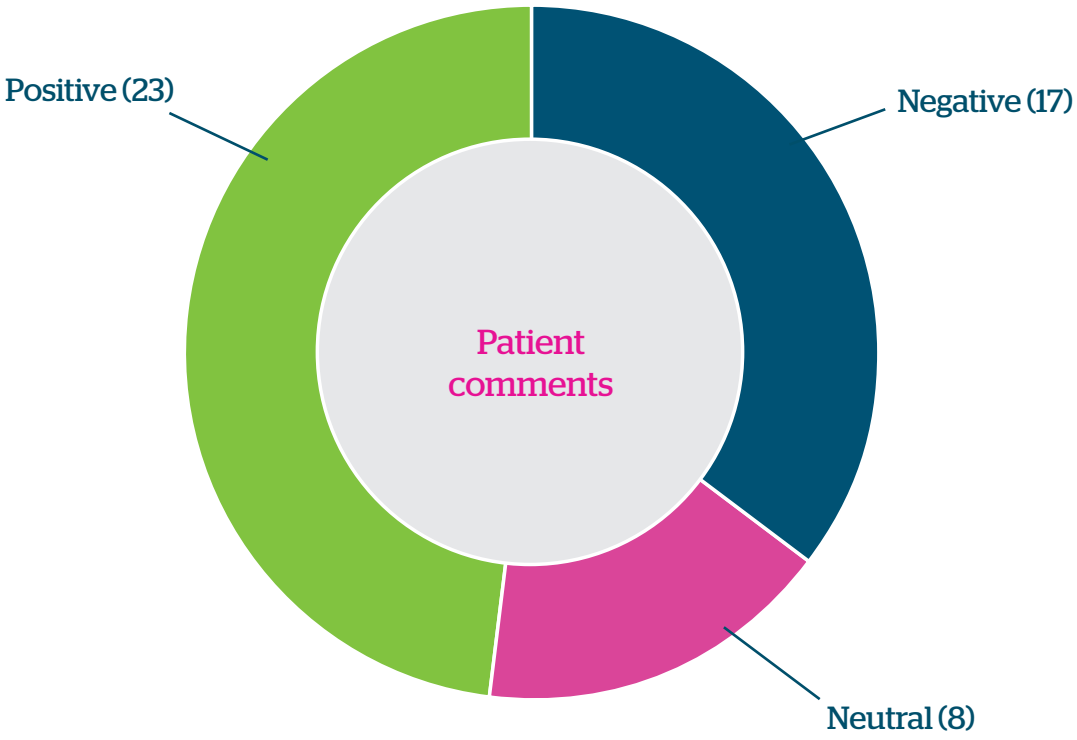


We asked people to tell us about the quality of the treatment they received. Most people reported the quality of treatment as good or very good. The chart below shows a breakdown.



Patient comments about ED

When asked if there was anything else they would like to say about their visit to ED, 48 people shared comments. We categorised these as positive, neutral and negative.



A selection of negative comments

> The staff were rude and judged me and assumed that I had been injured (which I have not) I was in agony and made to just be left alone and told to go to urgent care when I couldn't physically walk and was in so much pain. I couldn't function and had to crawl, I was also on my own and my partner who is disabled was at home alone. I was told by NHS 111 online to go to A&E and I put it off because of the fear of being treated like this which I then was. I was in the worst pain I've ever been in for 12 hours before I ended up going. The reception staff are not trained to triage and should not have assumed I was injured because my leg was affected. It wasn't an injury. No one helped me or offered to find someone to help. I am never ill and have never been to hospital before, this was very serious and I was treated like I was a burden and wasting peoples' time.

> Don't turn up during a shift change on a Sunday evening.

> Very long waiting time. Arrived approx 1800 hours discharged 0000 hours.

> Too long to wait, feeling unwell, hungry and thirsty.

> Very long wait to see the doctor.

A selection of neutral comments

> Some confusion between staff and ward but feel correct treatment given.

> It is what it is, willing to wait as just want to be seen by someone.

> I came last night but it was packed so I went home and came back today. It's much quieter this morning. Parking is a bit of an issue at the moment.

> Excellent service from everybody. Staff gave me information, lent me a mobile so I could update my husband. On my worried husband's side, the ambulance staff told him to ring the hospital in two hours' time, when it took 4 hours to get through tests. My husband could not get through to the hospital to check if I was still alive so he was very worried.

A selection of positive comments

> All very good here. The staff were lovely when I checked in.

> I was met with astonishing kindness and consideration.

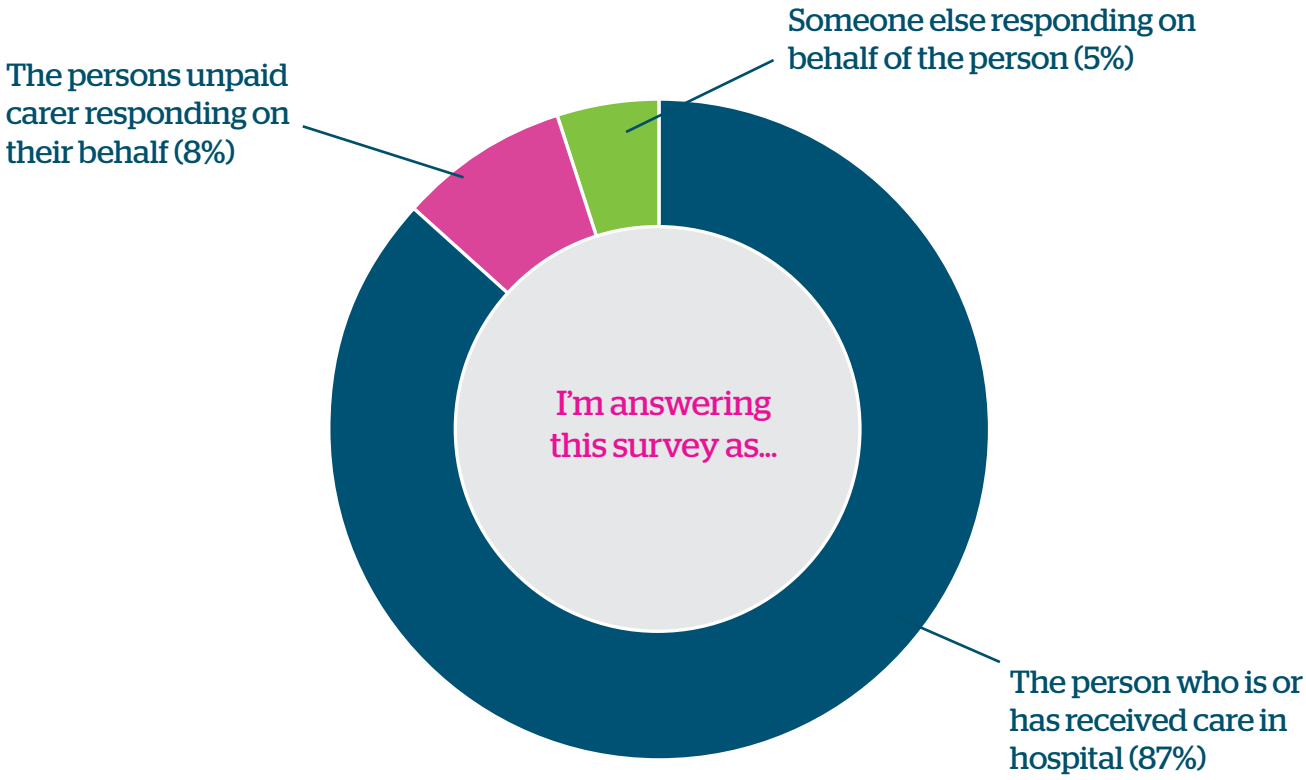
> I was very impressed and grateful for all the care I received while in A&E. All the staff from the reception to the nurses to the doctors were kind, caring and compassionate. I attended at a very busy time but was always looked after and kept updated as to what was going on. The care I received from start to finish was outstanding.

> Due to the serious nature, I was taken to resus [resuscitation area], staff were great.

> I am very pleased and happy with the way I have been treated.

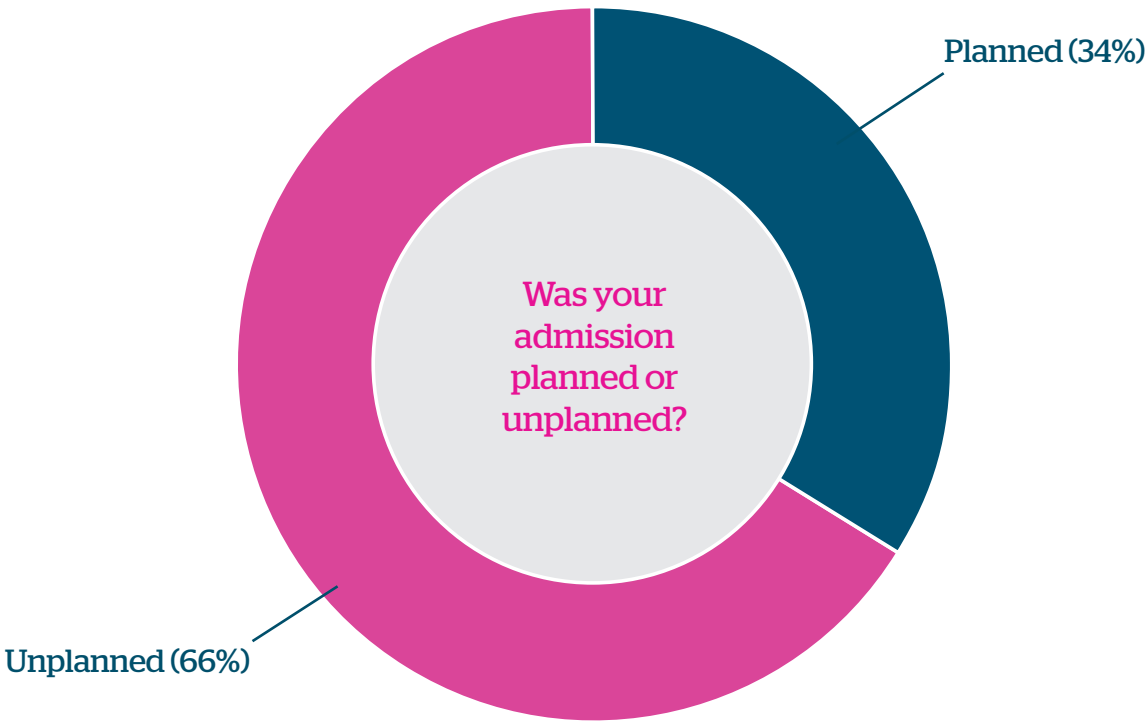
Findings: Inpatients survey

84 people completed our inpatient survey, either online or through conversations with the Healthwatch team when we carried out visits to the wards. Most people completed this survey as the person receiving care in hospital (87%), 8% completed the survey as an unpaid carer and a further 5% as someone else responding on their behalf.



Admission into hospital

66% of survey respondents had an unplanned admission in to hospital, and 34% planned. 55 people left a further comment about their admission.



There are many positive comments about the admission process.

> Very easy coming in. Couldn't have been better.

> Had a knee replacement appointment and admission went smoothly.

Nine people said they had arrived at the hospital by ambulance. There are positive comments about the ambulance staff but some mentioned the long wait times for the ambulance to arrive.

> Ambulance Service were brilliant and I was attended to as best they could in Covid circumstances.

> The ambulance crew were lovely. The admission went ok as far as I am aware.

> Biggest problem is the ambulance getting to you. Say it won't be with you till 2 hours and actually not for 6. They asked if I could get her in the car but thought couldn't. Did one time as had to. But a few times came quickly. But next time waited 5 hours. But you can't fault the ambulance people. They're brilliant.

Some people were admitted via ED and they reported a mixed experience, including long waits to be seen and for a bed.

> Had a gall stone. Reached hospital A&E in the morning had to wait 2 hours in tremendous pain to be examined. Then had to wait an extra 3 and a half hours for a bed.

> Due to Covid I wasn't allowed anyone with me. But nurse [name] in accident and emergency looked after me. She took away my fears and made me feel safe.

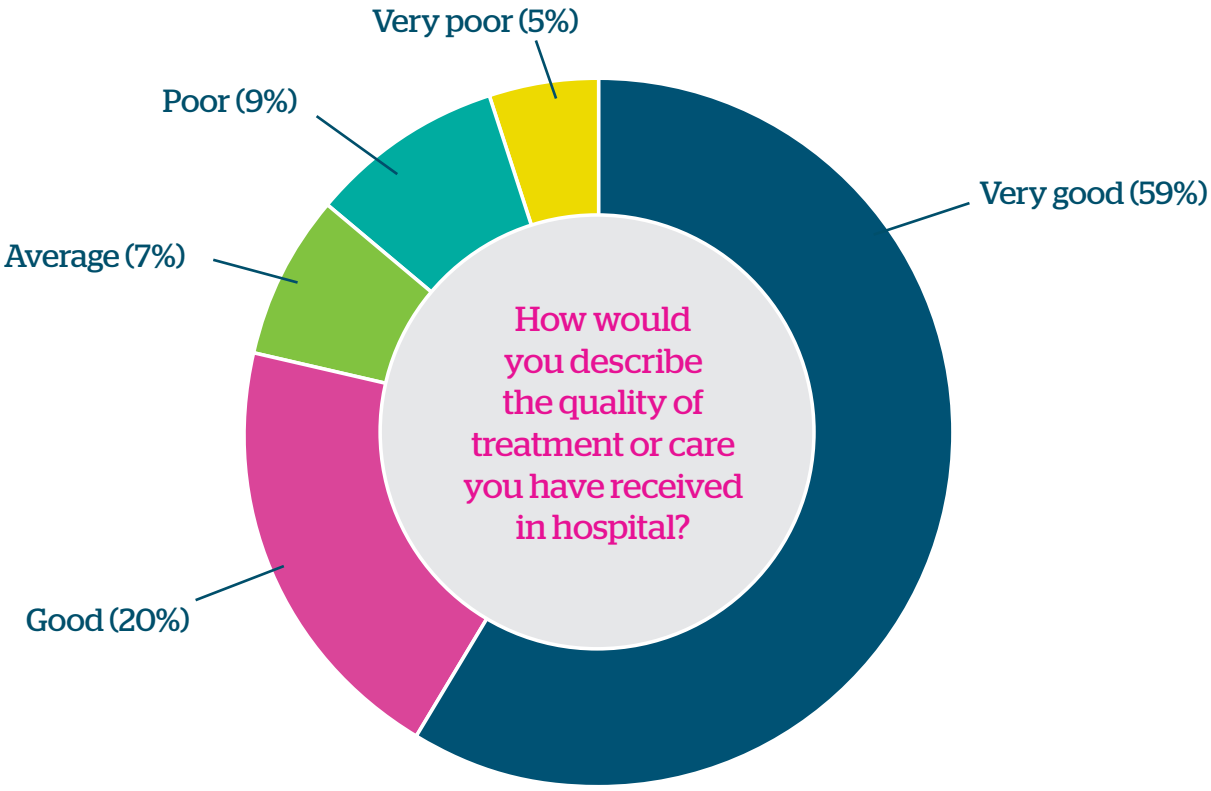
The wait time for surgery was mentioned by those with planned admissions, with some telling us how their procedures had been cancelled and rescheduled.

> Hip replacement. I was referred. I had to wait quite a while — 2 years. It has been cancelled once as there was no bed on ICU (I'm a heart patient). I felt emotional after it was cancelled but they gave me another date that was 2 weeks later.

> I have been waiting for 18-24 months but from previous experience I knew it would take a long time. I had to call the hospital a number of times as I didn't know what was happening. I had been given a Contact Point in the Booking Team but the person was invariably away and not doing return calls. I had at least three communications giving different times of admission. Eventually I was given an admission time but was rung up two days before to see if I could come in early. I went immediately and was in the theatre within an hour. I did find I had to repeat answers to a number of questions I had already answered.

Quality of treatment

We asked people to describe the quality of care and treatment that they had received while in hospital. The majority of people (79%) reported a good or very good experience, and 14% poor or very poor, with the remainder rating it as average.



54 people left additional comments and many talked about the care and compassion received by the staff, however they also noted how busy the staff seemed and noted the impact this had on the care received.

> Whilst all departments I visited were very busy they all were very efficient and I was very pleased with the care and treatment received.

> I was treated as a patient and not just a name/number. When I asked for pain relief it was quickly given.

> Outstanding treatment, Staff were attentive, caring and empathetic with a sense of humour. All really Kind.

> Tremendous shortage of all staff, thus they were unable to give the care that they wished to give!

> Can be difficult to attract people when you need them because they're overworked, but good when you get them.

> Haven't needed much help. I'm quite mobile. Sometimes get a half done job as staff are busy but they'll come back when they can.

A few people felt that the quality of care could have been better.

> Some very rude staff and put in a side ward with almost no contact with anyone.

> Not had a good experience, staff too busy, rushed off their feet thus delay in getting support.

> Clinical/medical treatment was good, communication, after care/follow up referrals, etc. very poor support.

> I was stressed about coming in. The booklet was long but wasn't an easy read when stressed. The staff put me at ease when I arrived and answered my questions.

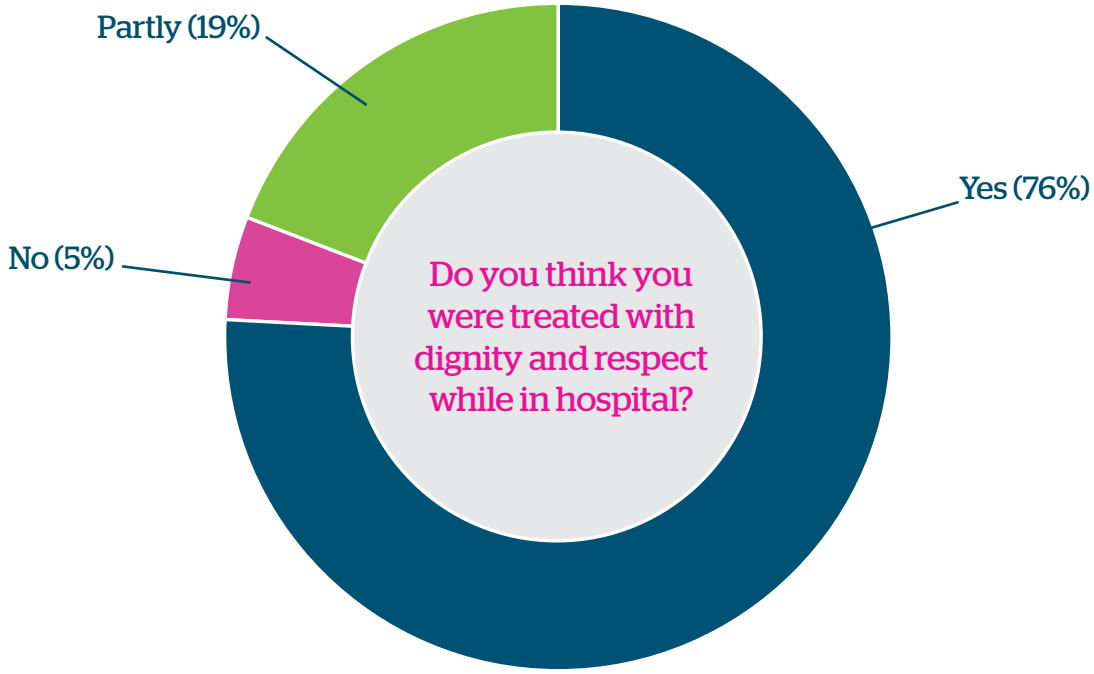
We also asked people to rate any support they were given with personal care tasks, such as washing and getting dressed. 80% rated this as good or very good, although there were comments from some that this was an area that could have been improved.

> Not needed, I was independent, but was offered help.

> He tried to keep himself clean but no one bathed him since his admission, over two weeks. Most if not all of this time, he has been unable to stand up long enough to shower or wash properly or shave himself and no one has been in to offer a shave, so he is unshaven, which bothers him as he's normally so meticulous.

Dignity and respect

76% of survey respondents felt that they had been treated with dignity and respect during their hospital stay, 5% felt that they hadn't and 19% felt they had been treated with dignity and respect to some extent.



Most of the additional comments made were around staff but others mentioned the environment.

> Clothing provided, area and screening to change.

> Doctors are very rude, not listening, however nursing staff are lovely.

> Everyone from the Consultant down to the ward "cleaner" were very polite and courteous.

> The curtains around the bed don't fully close and don't offer enough privacy. This isn't the staff's fault; they are great.

Safety

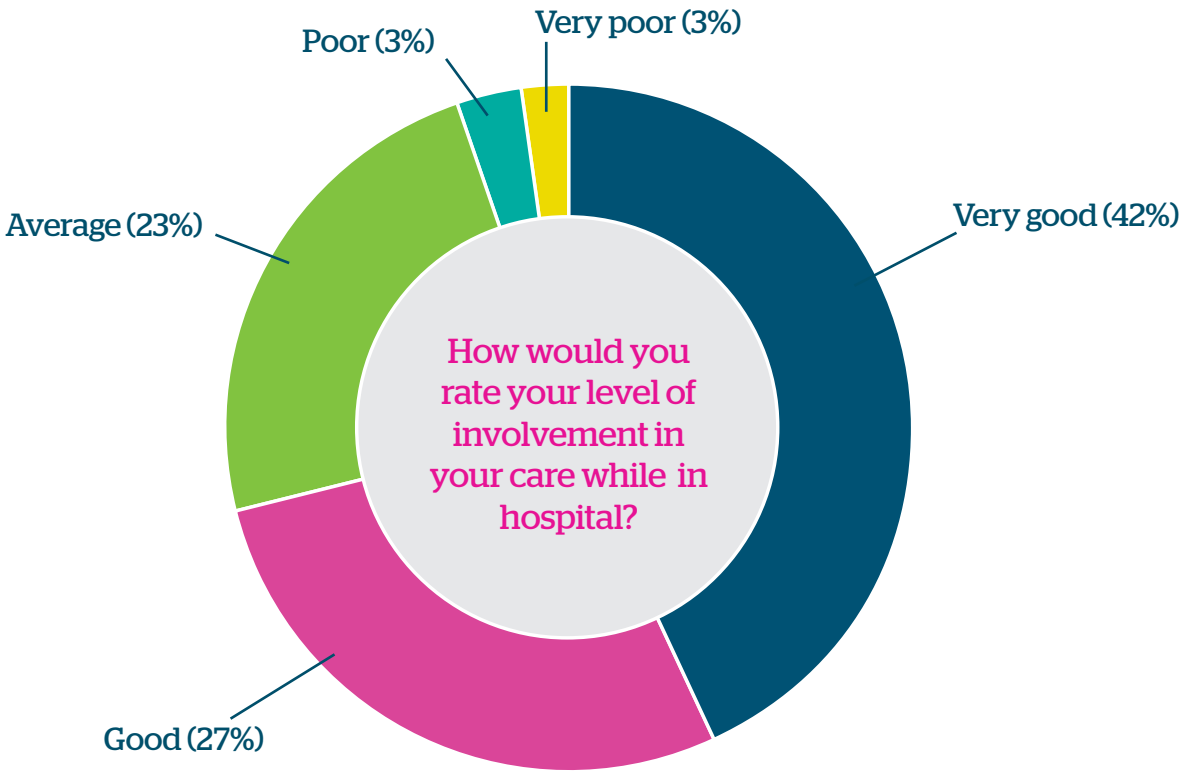
Most of the survey respondents said that they felt safe while in hospital (81%), but 4% said that they didn't feel safe and the rest felt partly safe (15%).

> In side ward everyone kept an eye on me. Generally, 5 min response to ringing Bell.

> I do feel safe to a degree, need to ask instead of being reassured.

Involvement in care

We asked respondents to rate the level of involvement in their care. Most rated their involvement as either good or very good as shown in the chart below.



> Quite a lot. They explain what they are doing and I feel listened to.

> Husband allowed in to help with information being given, lots of information to be absorbed. All well explained and clarified when needed by all staff.

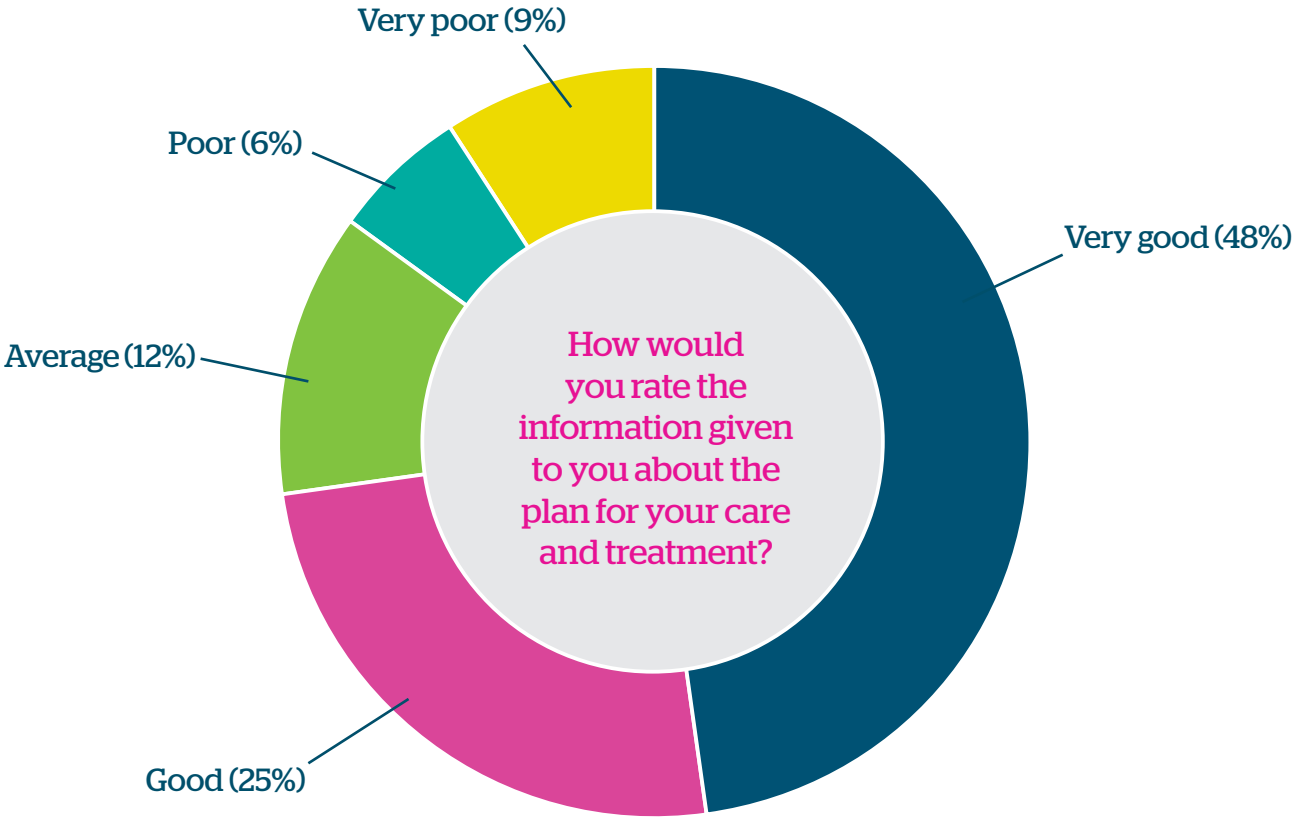
However, some thought that staff weren't listening to them, and some said they struggled to find out information about their care.

> I'd give it 5/10. It's all going on in the background, but can't find out what's going on. Can't find out when I will get out. Trying to find out where you are in the plan, what's going to happen next is tricky.

> Lack of communication from medical staff.

Information provision

73% of those who answered our survey said that the information given to them about their care or treatment was either good or very good. This was rated poor or very poor by 15% and average by 12%.



> Very informative. Explained aftercare plan in great detail and was easy to understand.

> Information given to me to enable me to discharge was good (monitoring my wound, how to inject myself, etc). Information given to me about my in-patient treatment was less comprehensive (no explanation of planned duration, no explanation as to why consultant had prescribed reduced pain control).

> I received a pre-op book which was full of information and links to websites for physio exercises.

There were some comments that written information might have been useful and that this should be in plain English.

> When you haven't been in hospital before it's hard to take everything in especially in an emergency. I would have liked things written down.

Keeping in touch with friends and family

The vast majority of people had been able to stay in touch with friends and family using their mobile phones or face to face visits. But 5% said they hadn't had any contact with friends or family.

While most people had been able to stay in touch it was noted that it would have been more difficult for people that didn't have their own mobile phone. Although phones were available on the wards, patients were not always aware of this. Access to Wi-Fi was also reported to being good on some wards, but less so on others.

> I wasn't made aware that there was a telephone I could have used on the ward. Especially since the service in my room was very bad so I really could have made use of the telephone.

> Wi-Fi access was poor.

> I have phone signal here, would be difficult if not. Also used the Wi-Fi. Face to face appointments need to be booked. I made sure my family knew what ward I was on.

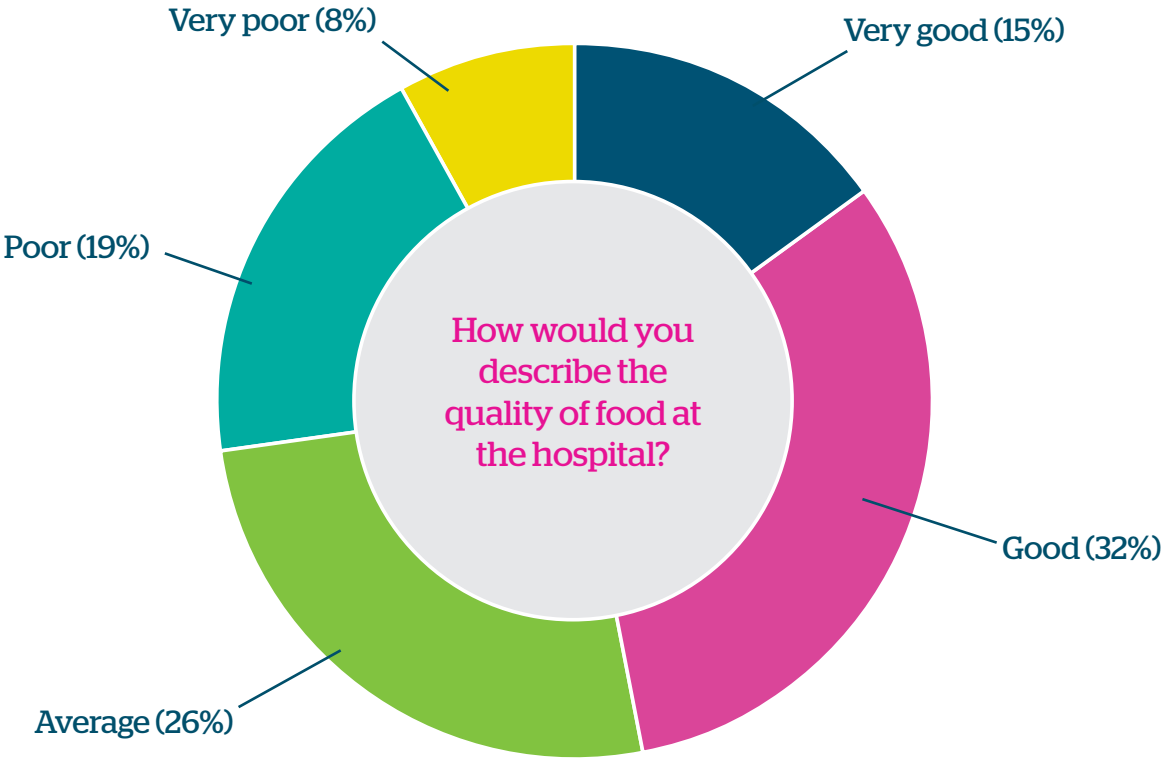
Some also struggled to understand what visiting restrictions were place for face to face visits and had trouble calling ahead to book these.

> It was very difficult for my husband to make an appointment to see me as the ward phone was not always answered. Other patients' families had the same problem.

> It would have been good if someone had explained the visiting system at the beginning of his stay. Whilst I understand less people on the ward was best, because of the pandemic it was hard if I didn't get an appointment to see my husband. Calling some days could take an hour or two before I got through to make an appointment and then it meant I didn't always get an appointment as it was booked up. I do understand why the system was in place but calling everyday must have taken so much of the nurses' time up when knowing my husband was going to be in for a few days I could have booked a few days in advance.

Food

We asked people to rate the quality of the food they received during their stay and this was quite mixed.



There seemed to be inconsistencies around food, with some saying that it arrived hot and others saying that it was cold. People said they were given choices but that the portion sizes could be small. There was also mention of a 'secret menu' for hot meals in the evening instead of sandwiches. Several people said they had lost weight during their hospital stay.

> I have been surprised how good it was. Always something tasty.

> Variety and quality good. But after three and a half weeks been round the menu too many times. Have just discovered yesterday that can get hot food in the evening. A "secret menu".

> It was perfectly adequate for a short stay. The quantity was a little small and food sometimes arrived cold but on the whole it was adequate. There were good options to choose from.

> It wasn't very tasty and I lost 9 pounds during my stay there because I couldn't eat the food.

Some respondents who were diabetic, said they had particular difficulties, which had knock-on effects.

> I am diabetic and there is no specific diabetic food – blood sugars very high in hospital.

Cleanliness

Just over three quarters of respondents (77%) felt that the cleanliness at the hospital was either good or very good. Several people mentioned how they saw the cleaners daily and that they were polite and friendly. However, some said the cleaners didn't clean the harder to reach areas and that spillages were left for a long time before being cleared.

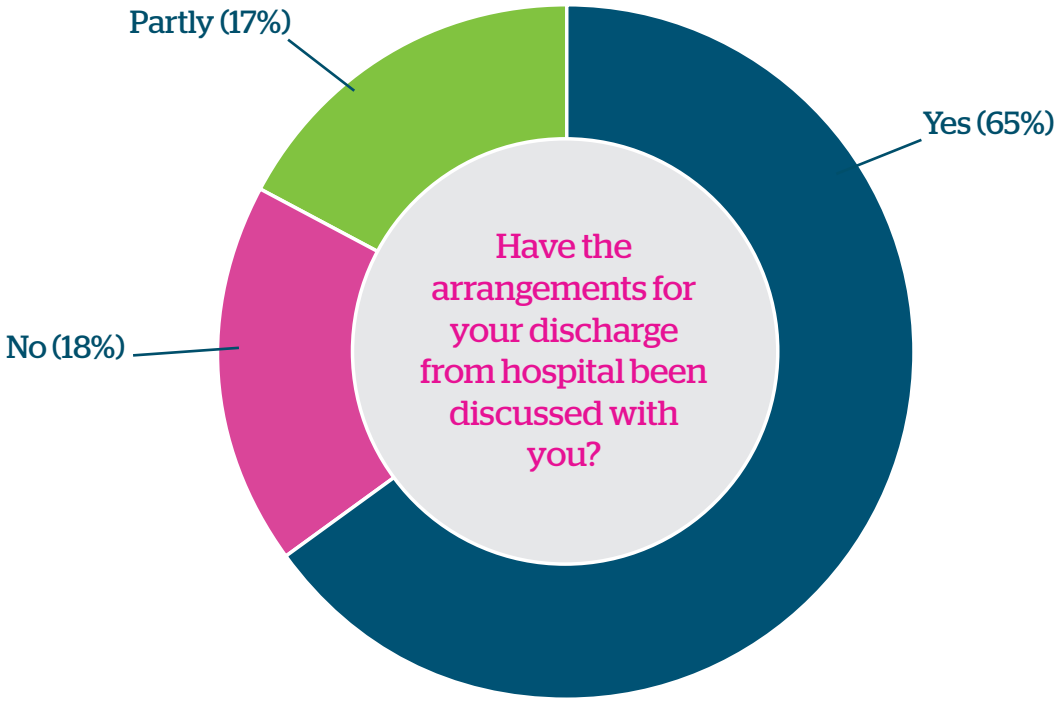
> Amazing. Come round every day, clean all round the bed, and very polite. When took for scan, she passed me in the corridor and said good luck. So, they go the extra bit.

> Cleaners did very a thorough job. They would arrive early in the morning and scrub the ward from top to bottom.

> There are two spillages on the floor in my room which have been there all day.

Discharge

We went on to ask a series of questions around people's experiences of the discharge process. Arrangements for discharge had been discussed with 65% of respondents as shown in the chart below.



38 people left further comments to this question. Some people said they had been kept fully informed of discharge plans. For others, the discharge plans seemed uncertain, with lack of communication being a key issue.

> The consultant has seen me and I know what is planned.

> There was a lot of miscommunications. First I was told I was going home then I was told I wasn't then a nurse came in threw a gown on my bed and told me I was going home. That wasn't enough notice for me.

76% of respondents said they knew or partly knew what support that they would receive on discharge. 54 people went to share who would be supporting them. Most people described follow-up appointments with specialists at the hospital as being arranged, and that ongoing support was from family and friends as no formal support was needed.

> Son stayed with me and still helping out, going home at weekends.

> I was told I would be having follow-up appointments with the cardiologist.

Some people had social care arranged for them, and this was either pre-existing before their hospital admission or newly arranged. However there did seem to be some delays with this, and some people weren't sure who would be providing their care.

> Waiting for a care package to be put in place so that I can go home.

> Carers increased.

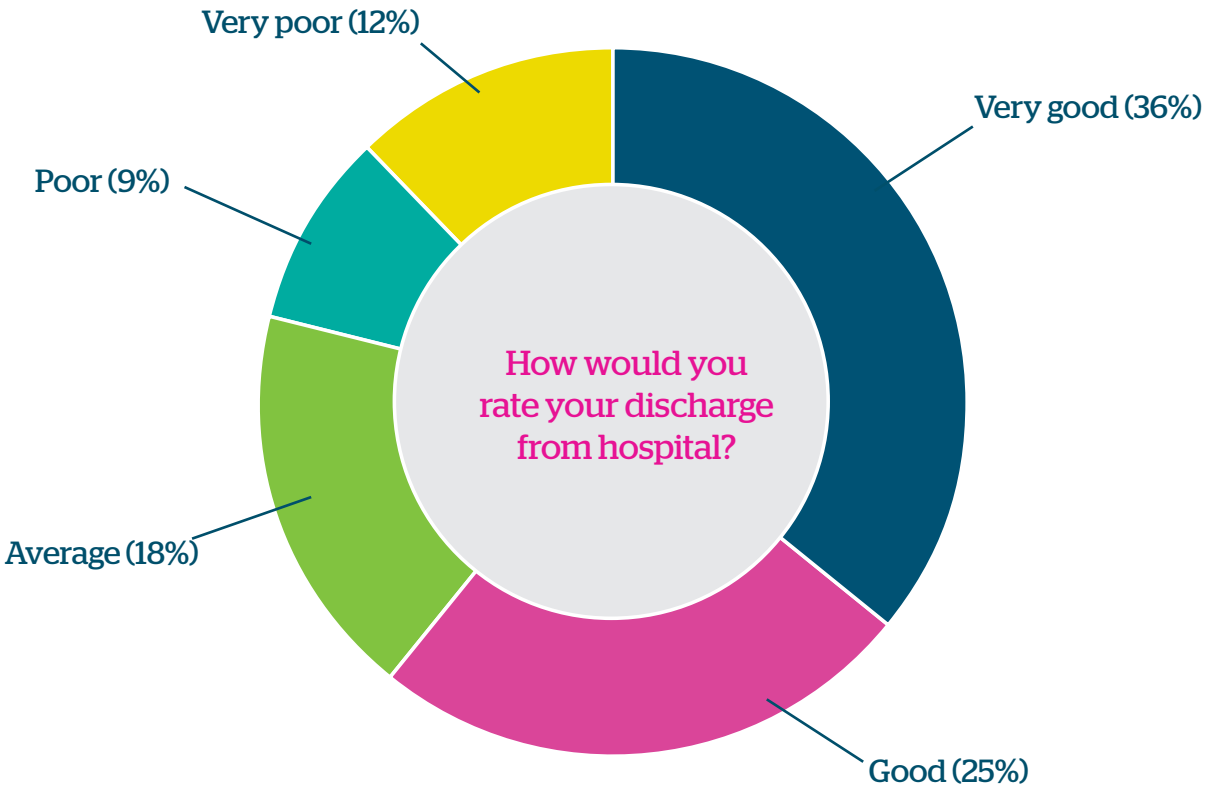
Others talked about not knowing what support was going to be in place for them on discharge and the uncertainty that caused.

> No contact from support people on the options when go home. May come when go to the rehab centre. Short of breath and can't stand up. And not been told about any other support you will get. It will depend how able you are when you leave so presumably the support package will depend on that. So could say don't need to tell you yet, but would be good if said that, there is a support package and will be told at the time. Support needed depends what wife can do. At the moment need for wash, to bed, dressed, go to toilet. So a high level of support.

> I am a bit concerned as I live on my own. I have been re-assured that someone from the team will go though everything with me and the equipment I need will be delivered.

75% of respondents completed this survey following their discharge from hospital and were asked some additional questions about their experience of the discharge process.

While most reported a good or very good experience (60%), others rated their discharge experience as average, poor or very poor. Some people left additional comments about their experience and these are quite mixed.



Some reported a positive experience, where plans were organised in advance and family members were informed.

> My discharge went very well. My wife was informed of when I'd be leaving so she was ready to pick me up. The doctors gave me an information pack and they made sure I had check-up appointments.

> Again this was excellent. My husband wasn't sure if he was coming home and I when I visited the Dr said yes he could but had to wait for his medication which could take a few hours. The nurse on duty went to pharmacy herself to collect it which meant he could come home straight away.

Some people reported delays to discharge due to wait times for medications, while others were not aware of their impending discharge.

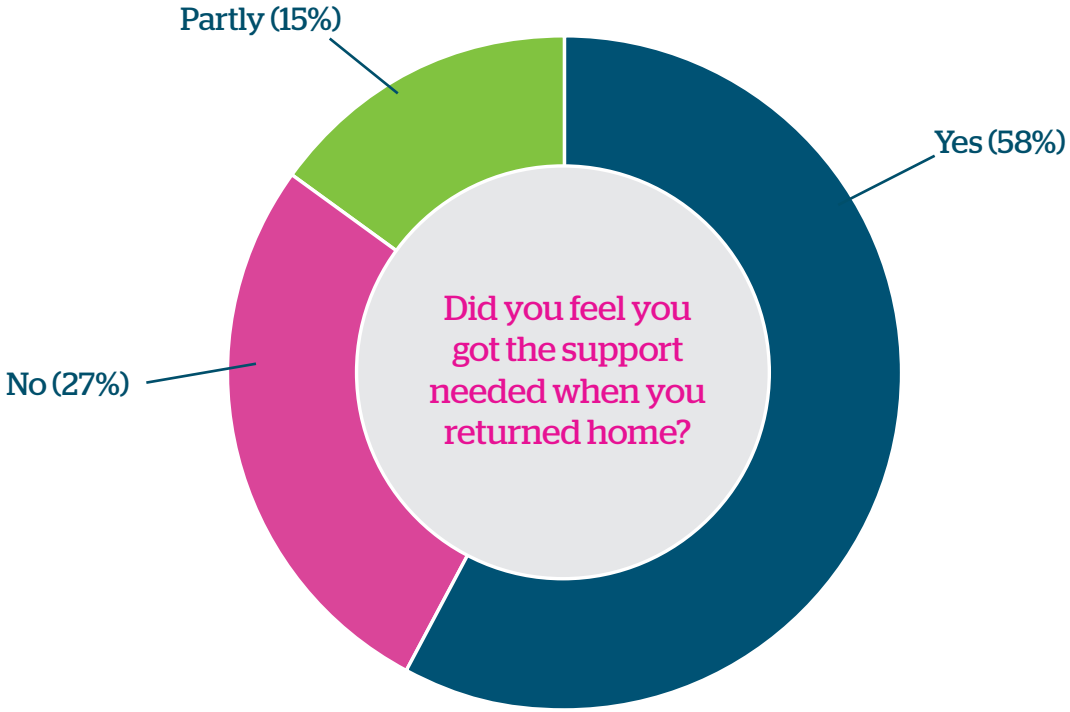
> Doctor saw me in the morning for an afternoon discharge. Waited from lunch time to 4pm for drugs!!!

> Wait for pharmacy to complete meds for discharge seemed slow.

> I was not aware of most things going on. Family were not aware other than potential to go to SWICC [Swindon Intermediate Care Centre] or other hospital/care home. Family found out when trying to book a visit and told I was in a care home.

> Not really, no warning of discharge informed by a doctor he had never seen before.

We then asked if people felt that they had got the support that they needed once they returned home. 58% felt that they had, 15% answered partly and 27% answered no.

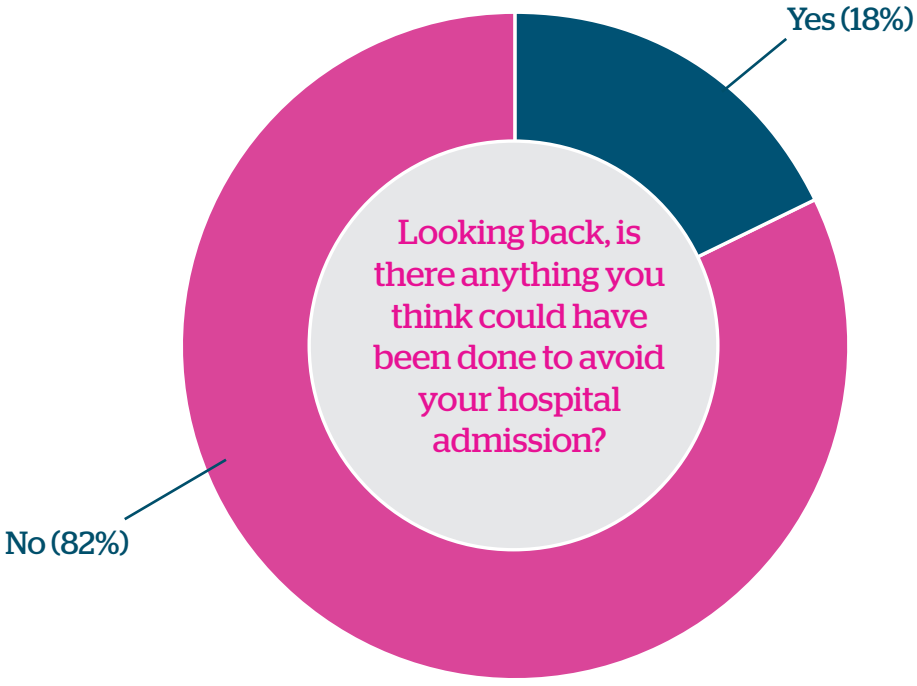


> Physio came for about two months, just finished coming. Son supports me with shopping, etc.

> I didn't need support.

> Surprised to be discharged with no follow-up checks.

We asked if people felt anything could have been done to avoid their hospital admission. Most people (82%) felt that it couldn't.



Some people mentioned that a healthier lifestyle could have perhaps helped to avoid a hospital admission, and some said that improved community support could have been beneficial.

Those that had multiple admissions also mentioned how better treatment in the beginning could have prevented further admissions.

> I tried and failed to get help from my GP so ended coming in as an emergency.

> I had a very serious illness, so would have needed hospitalising regardless. However, I feel if my treatment had been better, then I would not have needed hospitalising twice or for so long.

> A healthier lifestyle.

Communication needs

We asked people if they had any communication needs and 58 people answered this question. Eight of these said they had communication needs.

Additional needs ranged from being hard of hearing, living with dementia or that a shortness of breath had an impact, but people said that they were able to communicate and understand what they were being told.

> Been mixed but fairly understandable. I understood what they were saying.

> Due to health (breathing, fatigue – blood pressure, delirium, possible concussion, throat issues) still struggle to talk for long and be understood as well as understand staff.

We asked people if their communication needs had been met and seven people left comments. Half of these suggested that needs were not met.

> Could not understand the accent and language of some of the staff.

> Nope. No exceptions were made to update my family on my behalf.

Others said of how staff seemed to understand, or how they would ask for things to be explained further. However, some people may not have felt comfortable to do this.

> If I didn't understand I would say stop and ask them to explain.

> Nurses seem to understand him – so they are doing well.

What was good and what could have been improved?

Finally, we asked what was good and had gone well about their hospital stay and to identify any areas that could be improved.

What was good

63 people left comments about what had been good and worked well and the majority of these mention the kindness and caring nature of the staff.

> Excellent care from the staff.

> I feel that I have been listened to and that means a lot really. Its a really important thing for me. Anything they plan to do I'm told about and they explain.

> Hospital was clean. Doctors and nurses were amazing. Everything was explained clearly support after discharge has been very good.

> The staff were brilliant. The nurses always responded quickly and all the staff were very friendly.

> No problems were encountered. The wait for surgery was long because of covid 19 delays but that was understandable apart from that everything went as it should and I received the care I needed.

What could be improved

64 people gave ideas for improvement and they covered a few broad areas. Many mentioned that wards seemed short staffed, and that staff were very busy. Several people mentioned not wanting to bother staff or add to their workload.

> More staff on Meldon Ward, they were clearly under staffed and I felt very sorry for the nurses who were clearly at breaking point.

> More staff as they are constantly busy that you don't want to bother them till your pain is bad

Some people felt that communication between wards, and with them as patients, could have been better.

> More staff training around sensitivity and confidentiality.

> Prioritise staffing communication – wish they would listen to me.

There were comments about the environment, including the beds, parking and lighting.

> Spotlight in ward ceiling at night is annoying. Bigger car park for visitors.

General entertainment, Wi-Fi access and the food were also mentioned as areas that could be improved.

> Hospital is boring, the entertainment system is poor.

> Music/access to radio. Robust free Wi-Fi would make the world of difference. (There is one but drops out).

> Take allergy information seriously, improve the food, given written discharge information.

Other things mentioned included reducing overnight ward moves and that it could be noisy during the night. Some people also mentioned difficulties with the visiting restrictions and not being sure if they were allowed visitors.

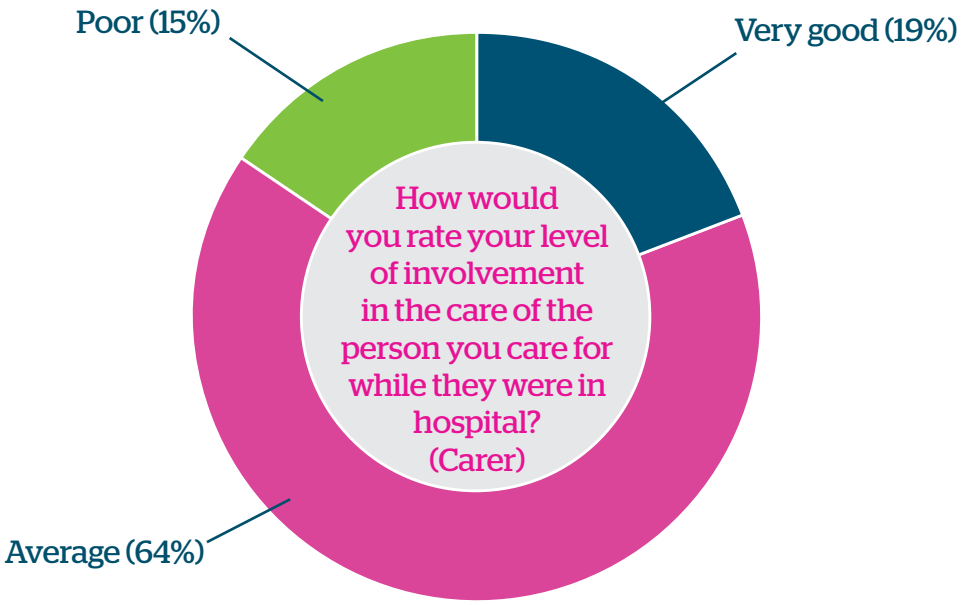
> Just the visiting information about having to book and also the food.

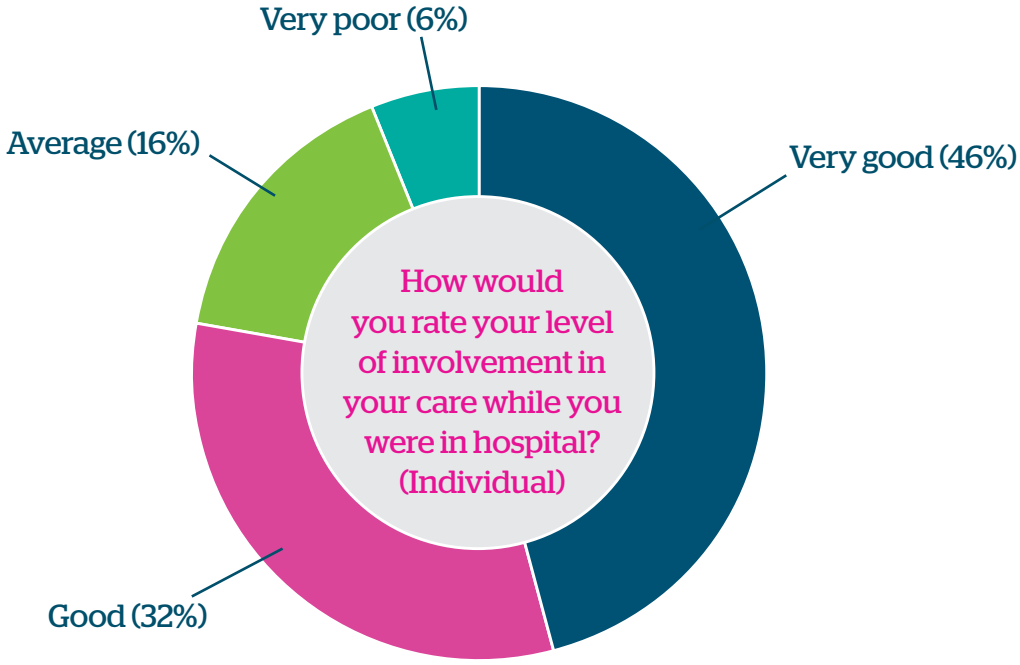
> It was very noisy particularly at night.

The experiences of carers

We compared the responses we received from carers with responses from patients, and noted a few disparities. Carers felt they had less involvement in the care provided than individuals, with most carers rating their level of involvement as average.

We should note that we received fewer responses from those that identified as carers than individuals who were receiving treatment.

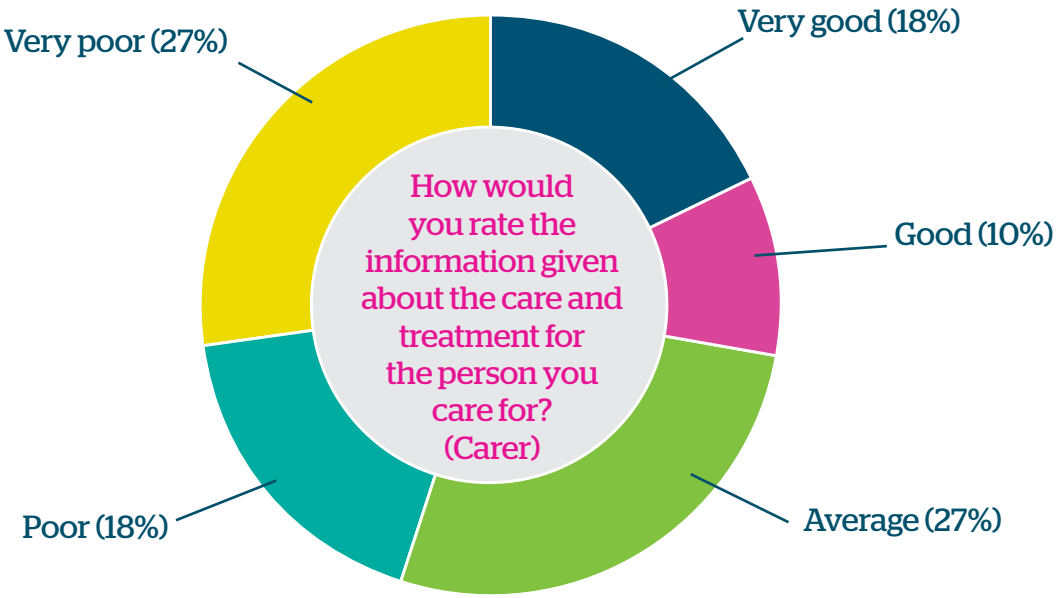


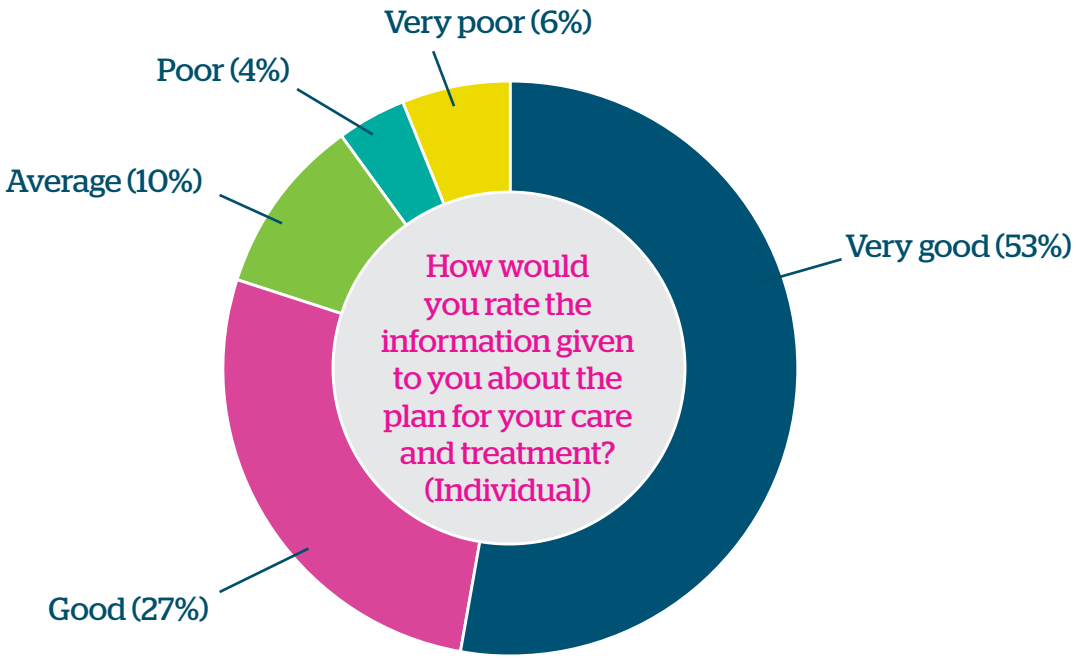


> In Shalbourne Ward it was a bit pot luck, but it was not the right place for her. Overall it was OK, but sometimes the staff were a bit out of it. When she changed wards to Ampney, then the consultant and palliative care doctors knew when I was coming in, so made time to see me. — Carer

> Quite a lot. They explain what they are doing and I feel listened to. — Individual

There were similar themes when asked about information provided about care and treatment, with carers choosing average, poor and very poor compared to individuals that mainly rated them as good or very good.





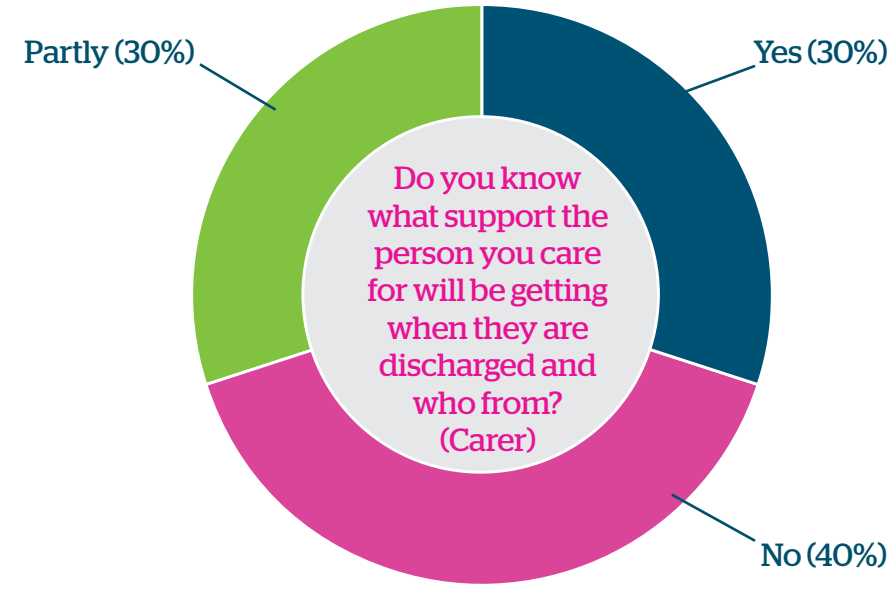
> As doctors very busy difficult to get information. — Carer

> Very informative. Explained aftercare plan in great detail and was easy to understand. — Individual

When asked about their awareness and involvement in their discharge from hospital, the responses here were similar from carers and individuals.

Arrangements for discharge had largely been discussed with both carers (60%) and individuals (68%) although there is still a notable proportion of people who said that discharge plans hadn't been discussed with them.

Individuals however, seemed to have more knowledge of support that might be received on discharge than carers.



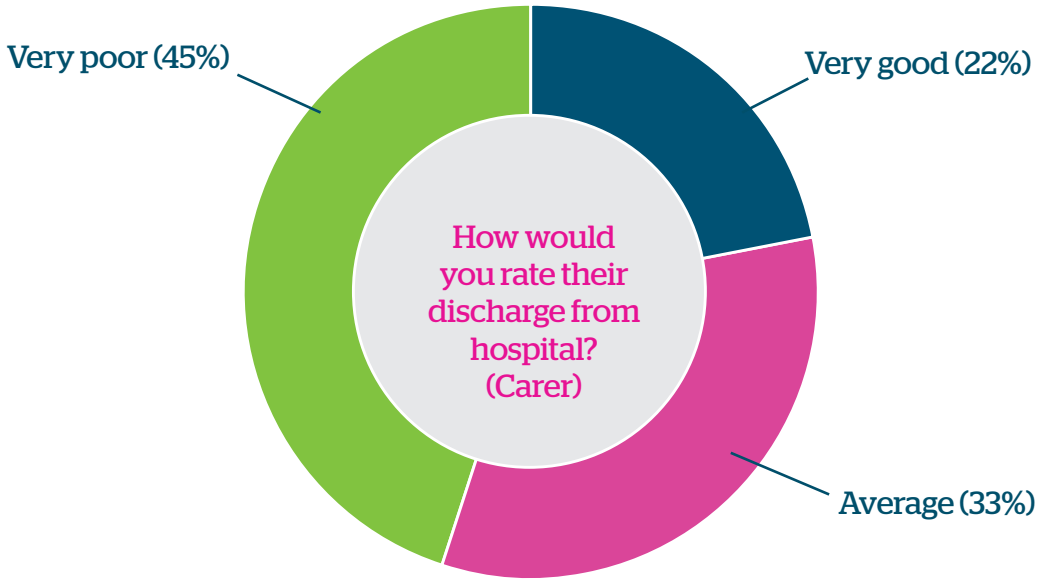
> I was told I would be having follow-up appointments with the cardiologist.

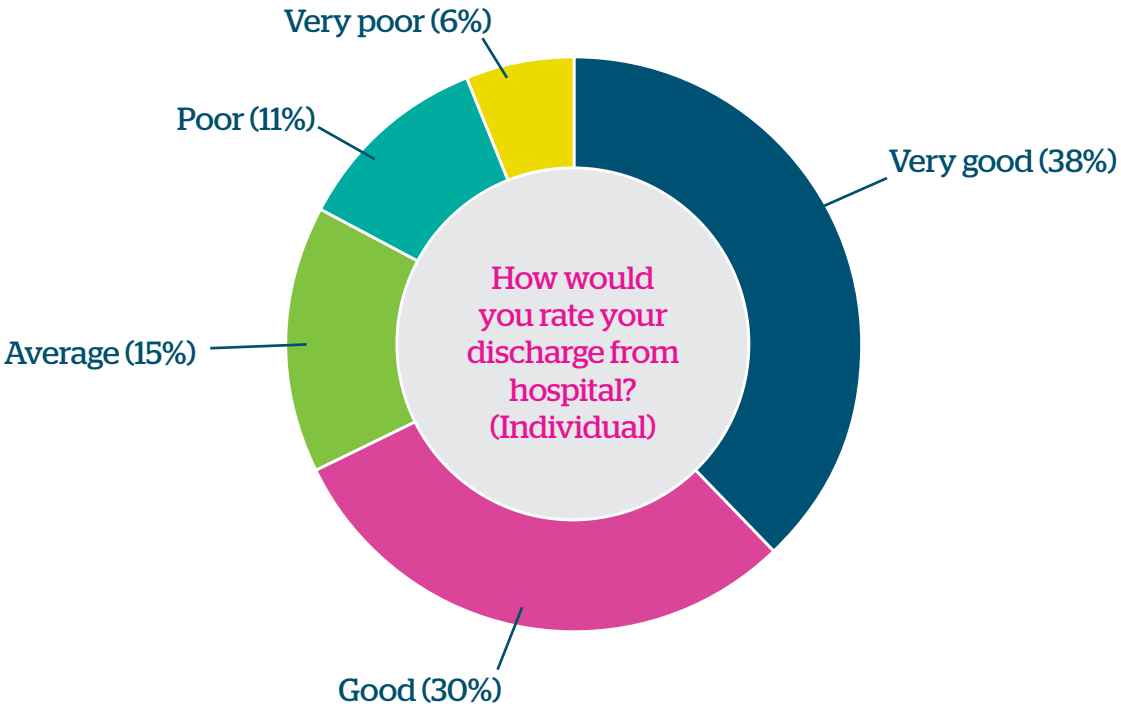
> Just told will get rehab, physio and OT [occupational therapy].

> No one. No support was offered.

When asked to rate the discharge from hospital, carers again seemed to rate it less highly than individuals.

The differences shown in this chart suggest improvements could be made to ensure carers are informed and fully involved in the care, planning and discharge process.





Conclusions

The majority of findings from this review were positive, for which Great Western Hospitals NHS Foundation Trust should be applauded. However, there were also some areas where change is needed.

The different approaches used for evaluating the Emergency Department and Inpatient wards surveys means the conclusions for each need to be considered separately.

Emergency Department

Although it is difficult to be sure from the figures alone, it appears that most people had good reason to attend the ED, due to a new physical or mental health issue, an accident at home, or change or worsening of a physical or mental health condition.

Most respondents said they had first sought help from other services, most often this was a GP or through NHS 111 or 999. The vast majority said they were able to speak to someone who could give them advice, but some had not been able to speak to anyone.

A few respondents chose to go to ED for other reasons, such as getting help more quickly, because another service was closed, they didn't know of an alternative service, A&E was closer or other services had let them down. However, people could tick more than one answer to this question, so they might have said they could get help more quickly at A&E but also that their problem was very serious.

While most patients were treated in ED, just over a third were referred elsewhere. This may indicate that ED might not have been the most appropriate place for some of the people attending, but we recognise that these decisions are often complex and not necessarily because a patient doesn't need urgent care.

Most people said having more urgent appointments available at other services would help reduce the need to go to ED, while others mentioned extended opening hours at other services, more information about the local services available, as well as more information about health issues in general would be useful.

While negative comments mainly focused around long wait times, three quarters of respondents rated the quality of treatment they had received in ED as good or very good, and most additional comments about the department were positive.

Inpatient wards

Most people were satisfied with the quality of the care and treatment they had received in hospital, with many mentioning the kindness and caring nature of staff.

Most said they were satisfied with the level of involvement they had in their care, and many said the information they were given was good or very good.

However, some staff attitudes were criticised, and some respondents felt they weren't treated with dignity and respect. Others said that they did not feel safe.

While most patients were able to keep in touch with friends and family, this often required the use of a mobile phone (either for the communication itself or to arrange a visit) with the

available phone or Wi-Fi access poor. There were also reports of relatives and friends finding it difficult to obtain information since ward telephones were not always answered.

People gave a mixed response to the food, with some concerns raised about special diets not being catered for. Three quarters of respondents said they thought cleanliness was good or very good, and the cleaners themselves were given high praise.

There were several comments about things which could impact on the quality of sleep, such as lights, noise and moving patients around in the night.

Delays in receiving medications was highlighted as a concern.

While 65% said that their discharge from hospital had been discussed with them, 35% said they hadn't been informed or not all the information they wanted had been shared with them.

While most people said they had received the support they needed once they had returned home, more than a quarter said they hadn't.

On the whole, carers said they felt less involved and communicated with than patients, and gave poorer ratings than patients for being involved in the discharge process.

Some respondents felt that an admission to hospital might have been avoided and gave a variety of reasons such as self care, community support and feeling that they had received poor care on an earlier admission.

Recommendations

Based on people's feedback from the two surveys, we make the following recommendations.

Emergency Department

- Look at ways to improve information about other services available and how they can be accessed.
- Consider increased monitoring of patients while they are waiting. This could help identify general problems and give the opportunity to explain to patients what was happening, which may reduce their dissatisfaction.

Inpatient wards

- Consider how communication with patients, family and friends could be improved including direct communication, written communication and access to Wi-Fi and phones.
- Look at the provision of 'accommodation services', including cleanliness and conditions affecting sleep and how these could be improved.
- Review the quality and quantity of food provided at mealtimes, particularly for those with certain conditions such as diabetes. Opportunities for increasing menu choice should be investigated.
- Consider how the Trust can increase the involvement of unpaid carers.
- Consider how delays to receiving medications could be improved.
- Work with system partners, to consider the whole patient pathway, including reasons for admission, support which could prevent admission or readmission.
- Work with system partners to review the discharge pathways and how these could be improved.

Healthwatch Swindon, Wiltshire and West Berkshire meet with the Trust on a quarterly basis and will be following up progress made regarding the recommendations at these meetings.

Thank you!

Thanks to the staff at GWH who worked with us to plan and deliver this project particularly, Sharon Keene, Regulatory and Compliance Manager; Lisa Cheek, Chief Nurse and the support of Kevin McNamara, Chief Executive.

Special thanks to volunteers from Healthwatch Swindon, Healthwatch West Berkshire and Healthwatch Wiltshire for their support with the visits, and input to the final report. Also thanks to volunteers from GWH who supported our virtual visits.

Thanks to all those who shared their views and experiences with us.

Thanks to Healthwatch England for providing advice and guidance around virtual Enter and View visits.

Response

Lisa Cheek, Chief Nurse, Great Western Hospitals NHS Foundation Trust

I am really proud of the care our staff provide and I was pleased to welcome Healthwatch in to our organisation to support them to talk to our patients in different areas of the hospital.

Whilst we have a good understanding of the level of care we provide, it is feedback from patients and carers that helps us improve our knowledge of how well we are doing and where we could do a little better.

The experience of patients is key to helping us improve the care we provide and my thanks go to Healthwatch for providing us with this rich body of evidence.

As we all know, the last 21 months have been the most challenging that the whole health and social care system has ever experienced, so I was particularly pleased to read that patients had praised our staff for the kindness and compassion they demonstrated both in the inpatient areas and in the Emergency Department.

We know there are areas where we can do more to improve and are implementing plans to address these as part of our Great Care campaign, which is focused on four areas:

- Delivering patient-centred care that meets the individual's needs at a personal and bespoke level
- Care that reduces the risk of harm to every patient
- The environment — recognising that great care extends beyond the patient, and wards and departments should be looked after too
- Expert care — building on our expertise.

I am reassured that there were no new areas for improvement identified in this report that we were not previously aware of, but Healthwatch have provided us with different perspectives which will help us to re-examine some of our thinking and look to how we make improvements in different ways.

I would like to extend my thanks to Healthwatch for this really helpful report, and to those patients who gave their views as part of this process. I would like to say a particular thanks to those who gathered the opinions, despite the restrictions in place, and adapted to new and different ways to collate the information.

We will use this document alongside other surveys, data, and feedback from patients to make improvements to deliver better care.

Appendix

Breakdown of demographics

ED/Urgent Care

Do you care for someone who needs extra support day to day?	
Answer choices	**Responses**
Yes	14% (14)
No	86% (89)
Prefer not to say	0% (0)

Are you	
Answer choices	**Responses**
Male	38% (40)
Female	60% (63)
Prefer not to say	1% (1)
Prefer to use my own term	1% (1)

What is your age?	
Answer choices	**Responses**
Under 18	8% (8)
18-24	6% (6)
25-34	10% (10)
35-44	22% (23)
45-54	14% (15)
55-64	15% (16)
65-74	14% (14)
75-84	7% (7)
85+	4% (4)

How would you describe your ethnic group?	
Answer choices	**Responses**
African	2% (2)
Arab	0% (0)
Bangladeshi	2% (2)
Black British	2% (2)
Caribbean	1% (1)
Gypsy, Roma, Traveller, Boater	0% (0)
Indian	4% (4)
Pakistani	1% (1)
White British	77% (79)
White Eastern European	4% (4)
White Other - please specify if you wish in the comment box below	5% (5)
Other - please specify if you wish in the comment box below	1% (1)
Prefer not to say	1% (1)

Do you consider yourself to have a health condition or disability? (Please tick all that apply)	
Answer choices	**Responses**
No	63% (63)
Mental health condition	9% (9)
Visual impairment	1% (1)
Hearing impairment	3% (3)
Learning disability	2% (2)
Physical or mobility disability	23% (23)
Prefer not to say	1% (1)

Inpatients

Do you care for someone who needs extra support day to day?	
Answer choices	**Responses**
Yes	11% (8)
No	89% (66)
Prefer not to say	0% (0)

Are you	
Answer choices	**Responses**
Male	28% (23)
Female	70% (56)
Prefer not to say	2% (2)
Prefer to use my own term	0% (0)

What is your age?	
Answer choices	**Responses**
Under 18	1% (1)
18-24	4% (3)
25-34	10% (8)
35-44	9% (7)
45-54	8% (6)
55-64	22% (18)
65-74	19% (15)
75-84	20% (16)
85+	2% (2)
Prefer not to say	5% (4)

How would you describe your ethnic group?	
Answer choices	**Responses**
African	0% (0)
Arab	0% (0)
Bangladeshi	0% (0)
Black British	0% (0)
Caribbean	0% (0)
Gypsy, Roma, Traveller, Boater	0% (0)
Indian	1% (1)
Pakistani	0% (0)
White British	90% (71)
White Eastern European	0% (0)
White Other - please specify if you wish in the comment box below	4% (3)
Other - please specify if you wish in the comment box below	1% (1)
Prefer not to say	4% (3)

Do you consider yourself to have a health condition or disability? (Please tick all that apply)	
Answer choices	**Responses**
No	56% (43)
Mental health condition	9% (7)
Visual impairment	3% (3)
Hearing impairment	4% (3)
Learning disability	1% (1)
Physical or mobility disability	37% (28)
Prefer not to say	3% (2)

Survey for people who have used the Emergency Department at Great Western Hospital since 1st March 2021.

This survey may be completed as a 1-1 face to face, virtual or telephone interview with a Healthwatch volunteer or staff member or as an online or paper survey.

Introduction from volunteer

I'm (name), a volunteer with Healthwatch and I understand that you've agreed to talk to us about your experience at Great Western Hospital. We are working with Great Western Hospitals Trust to find out more about people's experiences of care whilst using the Emergency Department and Urgent Care Centre. The Emergency Department is also known as A&E and we will be referring to the service as A&E throughout the survey.

Healthwatch is the independent champion for people using health and care services in Wiltshire. We listen to what people like about services and what they think could be improved and share their views with those who have the power to make change happen.

The responses to this survey will be collated and put into a report. All responses are confidential and will be anonymised, no individuals will be named in the report. The report will be used to help the hospital to develop and improve its services.

Please note that if you share with us anything that we believe to be a Safeguarding concern we do have to let the Trust and/or Local Authority know.

The interview should take about 10 – 25 minutes depending on your answers. Are you happy to go ahead? You can ask to stop at any time.

1. **What is the main health issue that led to you coming here today?**

- Accident at home
- Accident at work
- Accident at other place
- Sports injury
- New physical symptom
- New mental health issue
- Change/worsening of an existing long-term physical condition
- Change/worsening of an existing mental health condition
- Alcohol/drug use
- Victim of crime
- Prefer not to say
- Other (state if you wish)……..

2. **How long have you been experiencing the problem that led you here?**

- Immediately before coming here
- Up to 24 hours ago
- Between 1 and 7 days ago
- Longer than a week

3. **Have you been discharged from hospital about this problem in the past 30 days?**

- Between 1 and 7 days ago
- Longer than a week
- No

4. **Did you try and seek help from any other services before coming here today?**

- Yes, go to Question.5
- No, go to Question 8

5. **Which service/s did you contact? (tick as many that apply)**

- GP surgery
- Pharmacist
- Dentist
- Optician
- NHS 111 helpline
- 999 emergency number
- Mental health crisis service
- Community midwife
- Palliative care (end of life) staff
- Sexual health walk-in clinic
- Social worker
- NHS website
- Other (please state if you wish)……..

If you used the NHS 111 helpline were you given an appointment time to go to A&E? If yes, how did this work for you?

6. **Were you able to speak to a person who could give you advice?**

- **Yes, go to question 7**
- No, their phone line was engaged
- No, I only got a recorded message, go to Question 8
- No, I only got a recorded message, go to Question 8
- No, they did not return my call, go to Question 8
- No, the service said no-one was available to speak or see me as quickly as I wanted, go to Question 8

7. **Did the service advise you to go to A&E?**
   - **Yes (go to question 10)**
   - No (go to question 8)
   - Other (please state if you wish)……

8. **Why did you decide to go to A&E? (tick all that apply)**

   - My problem is very serious
   - I believe A&E has staff/experts I would not find anywhere else
   - I believe A&E has machines, technology or medicines that are not available anywhere else
   - I can get help quicker at A&E
   - Another service/professional that I wanted to contact was closed
   - I did not know about any other service I could go to instead of A&E
   - A&E is closer than other services
   - I trust A&E from past experience
   - A&E is more anonymous
   - Other service/s have let me down
   - Other (please state if you wish)……

9. **What factors would help you consider first contacting a different service than A&E about an urgent health issue in the future?**

   - More information about what alternative services are in my area
   - More information about what health issues/symptoms/injuries different services can see or treat
   - Extended opening hours at other services
   - More urgent appointments made available at other services
   - More information online about services
   - Other (please sate if you wish)……

10. **How long have you been waiting so far?**

    - Within 30 minutes
    - 1 – 2 hours
    - 2 – 4 hours
    - More than 4 hours

11. **FOR ONLINE SURVEY ONLY When you had been assessed did you receive your treatment in A&E or were you referred elsewhere eg to the Urgent Treatment Centre?**

- Yes
- No

12. **FOR ONLINE SURVEY ONLY Please tell us about the quality of the treatment you received.**

- Very good
- Good
- Don't know
- Poor
- Very poor

13. **Is there anything else you'd like to say about your visit to A&E?**

About you:

It's important that we hear from a diverse group of people. We ask some questions about you so that we can identify any issues that affect different groups of people. This information is anonymous, and you do not have to answer any questions if you don't wish to.

14. **Please provide the first four digits of your postcode.**

15. **Do you care for someone who needs extra support day to day?**

- Yes
- No
- Prefer not to say

16. **Are you?**

- Male
- Female
- Prefer not to say
- Prefer to use my own term - Please specify if you wish to)

……

17. **What is your age?**

- Under 18
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 – 64
- 65 – 74
- 75 -84
- 85 +
- Prefer not to say

18. **How would you describe your ethnic group?**

- African
- Arab
- Bangladeshi
- Black British
- Caribbean
- Gypsy, Roma, Traveller, Boater
- Indian
- Pakistani
- White British
- White Eastern European
- White Other - please specify …….
- Other - please specify …….
- Prefer not to say

19. **Do you consider yourself to have a health condition or disability?**

- No
- Mental Health condition
- Visual Impairment
- Hearing Impairment
- Learning Disability
- Physical or mobility disability
- Prefer not to say

20. Please tell us which sexual orientation you identify with:

- Asexual
- Bisexual
- Gay
- Heterosexual/ straight
- Lesbian
- Pansexual
- Other
- Prefer not to say

21. Would you be interested in taking part in a video talking about your experiences?

- No
- Yes

If yes, please leave your contact email and phone number here:

22. If you would like to be added to the Healthwatch mailing list where you will get updates including the final report, please tell us your name and email/address.

This information will be held securely and in compliance with data protection laws. Your details will not be shared with any other organisation, and you can withdraw your consent to us holding your details at any time by email or telephoning your local Healthwatch. You can view our privacy statements here:

www.healthwatchwiltshire.co.uk/privacy
www.healthwatchswindon.org.uk/privacy
https://www.healthwatchwestberks.org.uk/privacy/

Thank you for taking the time to speak to us. Your responses will be analysed and put into a report. The report will be used to influence the way the service further develops.

Survey for people who have been inpatients at Great Western Hospital since 1st March 2021.

This survey may be completed as a 1-1 face to face, virtual or telephone interview with a Healthwatch volunteer or staff member or as an online or paper survey.

Introduction from volunteer/ staff member

I'm (name), a volunteer/staff member with Healthwatch and I understand that you've agreed to talk to us about your experience at Great Western Hospital. We are working with the hospital to find out more about people's experiences.

Healthwatch is the independent champion for people using health and care services in Wiltshire. We listen to what people like about services and what they think could be improved and share their views with those who have the power to make change happen.

The responses to this survey will be collated and put into a report. All responses are confidential and will be anonymised, no individuals will be named in the report. The report will be used to help the hospital to develop and improve its services.

Please note that if you share with us anything that we believe to be a Safeguarding concern we do have to let the Trust and/or Local Authority know.

The interview should take about 10 – 25 minutes depending on your answers. Are you happy to go ahead? You can also ask to stop at any time.

1. **Are you answering this survey as?**

- The person who is or has received care in hospital.
- The persons unpaid carer responding on their behalf.
- Someone else responding on behalf of the person.

2. **Was your admission to the hospital?**

- Planned
- Unplanned

If there anything you'd like to say about your admission into hospital?

3. **How would you describe the quality of treatment or care you have received in hospital?**

- Very good
- Good
- Average
- Poor
- Very Poor

Please tell us more about your answer.

4. **Do you think have been/ were treated with dignity and respect whilst in hospital?**

- Yes
- No
- Partly

Please tell us more about your answer.

5. **Have you felt safe whilst in hospital?**

- Yes
- No
- Partly

Is there anything else you'd like to say about this?

6. **How would you rate your level of involvement in your care whilst in hospital?**

- Very good
- Good
- Average
- Poor
- Very Poor

Please tell us more about your answer.

7. **How would you rate the information given to you about the plan for your care and treatment?**

- Very good
- Good
- Average
- Poor
- Very Poor

Please tell us more about your answer.

8. **How would you rate the support you were given with personal care, if needed?**

- Very good
- Good
- Average
- Poor
- Very Poor

Please tell us more about your answer.

9. **Have you been able to keep in touch with relatives/friends whilst you have been in hospital?** (Please tick all that apply)

- No, I've not had any contact with relatives or friends.
- Yes, I've had contact by email.
- Yes, I've had contact by phone.
- Yes, I've had contact by online video.
- Yes, I've had face to face visits.

Please tell us more about your answer.

10. **How would you describe the quality of food at the hospital?**

- Very good
- Good
- Average
- Poor
- Very Poor

Please tell us more about your answer.

11. How would you describe the quality of cleanliness at the hospital?

- Very good
- Good
- Average
- Poor
- Very Poor

Please tell us more about your answer.

12. Have the arrangements for your discharge from hospital been discussed with you?

- Yes
- No
- Partly

Please tell us more about your answer.

13. Do you know what support you will be getting when you are discharged and who from?

- Yes
- No
- Partly

Please tell us who you have been told will be supporting you.

14. Have you already been discharged from hospital?

- Yes - please continue to question 15.
- No - please move on to question 17.

15. How would you rate your discharge from hospital?

- Very good
- Good
- Average
- Poor
- Very Poor

Please tell us more about your answer.

16. Did you feel you got the support needed when you returned home?

- Yes
- No
- Partly

Please tell us more about your answer.

17. Looking back, is there anything you think would have avoided your needing to be admitted to hospital?

- Yes
- No

If yes, what could have been done differently?

18. Do you have any individual communication needs?

(E.g., English as a second language, require easy read information, use sign language, lip read, need support with reading and writing, use braille)

19. Were these needs met whilst you were in hospital and, if so, can you tell us how they were met?

20. What has been good or worked well about you stay in hospital?

21. Is there anything you think could be improved?

About you:

It's important that we hear from a diverse group of people. We ask some questions about you so that we can identify any issues that affect different groups of people. This information is anonymous, and you do not have to answer any questions if you don't wish to.

22. What are the first four digits of your postcode?

23. Do you care for someone who needs extra support day to day?

- Yes
- No
- Prefer not to say

24. Are you?

- Male
- Female
- Prefer not to say
- Prefer to use my own term.

25. What is your age?

- Under 18
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 – 64
- 65 – 74
- 75 -84
- 85 +
- Prefer not to say

26. How would you describe your ethnic group?

- African
- Arab
- Bangladeshi
- Black British
- Caribbean
- Gypsy, Roma, Traveller, Boater
- Indian
- Pakistani
- White British
- White Eastern European
- White Other - please specify
- Other - please specify
- Prefer not to say

27. Do you consider yourself to have a health condition or disability?

- No
- Mental Health condition
- Visual Impairment
- Hearing Impairment
- Learning Disability
- Physical or mobility disability
- Prefer not to say

28. Please tell us which sexual orientation you identify with:

- Asexual
- Bisexual
- Gay
- Heterosexual/ straight
- Lesbian
- Pansexual
- Other
- Prefer not to say

29. Would you be interested in taking part in a video talking about your experiences?

- No
- Yes

If yes, please leave your contact email and phone number here:

30. If you would like to be added to the Healthwatch mailing list where you will get updates including the final report, please tell us your name and email/address.

This information will be held securely and in compliance with data protection laws. Your details will not be shared with any other organisation, and you can withdraw your consent to us holding your details at any time by email or telephoning your local Healthwatch. You can view our privacy statements here:

www.healthwatchwiltshire.co.uk/privacy
www.healthwatchswindon.org.uk/privacy
https://www.healthwatchwestberks.org.uk/privacy/

Thank you for taking the time to speak to us. Your responses will be analysed and put into a report. The report will be used to influence the way the service further develops.

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Patient/Carer responses about Berkshire Healthcare Foundation NHS Trusts' Urgent Care Response Team (UCRT) Service

November 2021

How did you find the service?

healthwatch West Berkshire

Contents

Introduction

UCR aims to prevent unplanned hospital admissions by sending a team to people's usual place of residence within 2 hours of a referral for a crisis such as a fall, injury, or deterioration in health or within 2 days as part of a 'reablement' response. Berkshire Healthcare sought patient experience to find out what was working well and any areas for improvement.

Within the Reading locality care provision is delivered by the Reading Borough Council reablement team for both 2 hour and 2-day pathways.

Within the West Berkshire locality care provision is delivered by a range of source including inhouse teams from BHFT, West Berkshire Council as well as external providers. The teams work to ensure that communication with care providers so individuals needs are met.

Executive Summary

Overall, the UCRT service was well thought of, and the staff were praised throughout. However, it was clear that many of the people we were speaking with were still quite unwell and in some cases, it was decided by our team not to try to undertake the survey because of this. Fortunately, as had been agreed at the start with BHFT, we were able to refer back to UCRT, anyone we spoke with who we felt needed more assistance or were of concern.

It was pleasing to find that people talking about the service referred to it positively stating that they found the service helpful, the staff pleasant, kind and friendly. They also said that staff were knowledgeable, reassuring, and professional.

If there were any concerns raised by service users and/or their carers, Healthwatch escalated this to the services following individual consent.

Challenges

Although all those telephoned had been given a leaflet and asked by members of the UCRT about the interviews, some were still not clear on who we were; others seemed unaware of who had referred them to the UCRT service (This may have been due to the fact that a small group were unwell/did not remember). There were widespread issues about understanding who or what the UCRT team was. Only after some detailed conversation did the patients understand or recall the service that we were asking them about.

A clear challenge with an older frailer cohort is that communication is an issue (digital, text, even telephone use). Additionally, memory issues can impact the ability to remember face to face conversations with the UCRT. *With hindsight* Healthwatch West Berkshire/BHFT should have also sent a joint letter to arrive by post of the intention to telephone the patients to ask about the service, with a contact number in case there were any issues with this or regarding the surveys purpose.

HWWB also underestimated the number of contacts that were needed to secure a worthwhile conversation with the patient or carer. An unforeseeable challenge in arranging this piece of work was the recent Covid 'spike' upwards in case numbers and rising hospital admissions. This meant that arranging face to face meetings was impossible, not just for personal infection safety grounds for both the interviewee and the interviewer, but also because many felt they didn't want an unnecessary 'stranger' coming to their house. The high Covid infection rate also meant we were unable to interview any residents of local care homes who had used the UCRT service, despite prompts from BHFT to the care homes.

Recommendations

1. The service is clearly valued and welcomed by almost all who use it and expanding or increasing how it can be referred into should be considered i.e., by VCSO, carers, other professionals (Fire service, postman, Parish Clerks)

2. It is clear from our conversations that patients and carers do not always recognise who the UCRT service *are*, and why they are different to other health and care professionals- this should be given some thought- a lanyard for those with failing sight may not be enough

3. In choosing which patients to interview care should be given to the choice of who is selected as to whether they are really well enough to take part, or if the experience may upset them or cause added worry. Additional adjustments should be put in place prior for those who may struggle to take part on their own due to cognition or sensory issues.

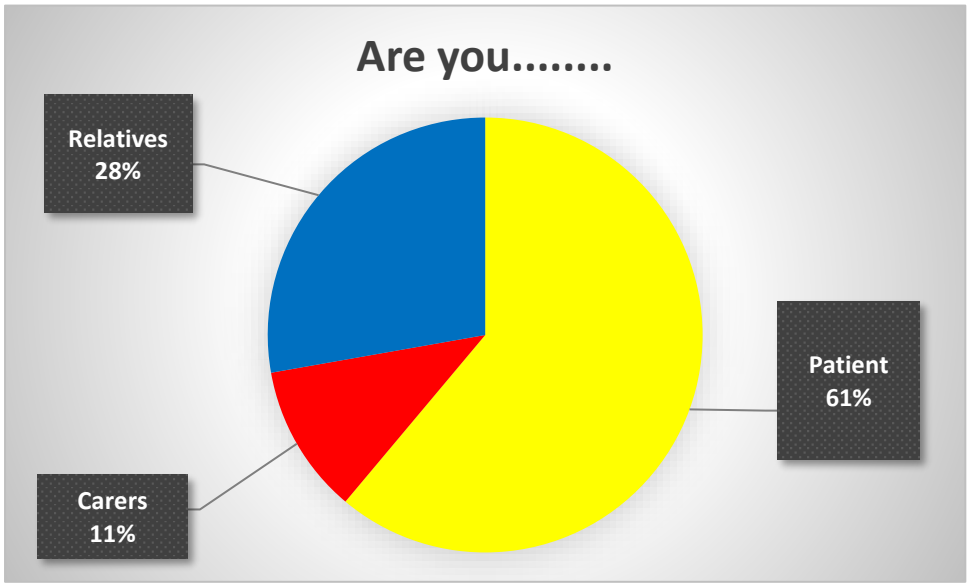
4. The service needs to be clearer who they are, where the referral was from and why it was made. Consistent use of "hello my name" is welcomed, but it seems many did not realise why the service was called out to them

5. Ensure there is good follow up after the service ends to check a 'high risk' patient is ok. Several patients we spoke to needed referring back into the service due to concerns about their wellbeing.

6. More thought needs giving to consultations, feedback mechanisms for a cohort with additional challenges in taking part. So, letters should always be considered alongside reasonable additional adjustments for those with memory or other sensory, or cognition issues to ensure a truly inclusive response

Survey Findings

Question 1- *Are you ……..?*



Of the 18 interviews 11 were patients (61% or nearly 2/3), 5 were relatives (28% or just over ¼) and 2 were carers (11%)

Question 2 - *What was wrong with you to be referred to the UCRT service*

(18 answers)

9 discharged from hospital after a fall (half)

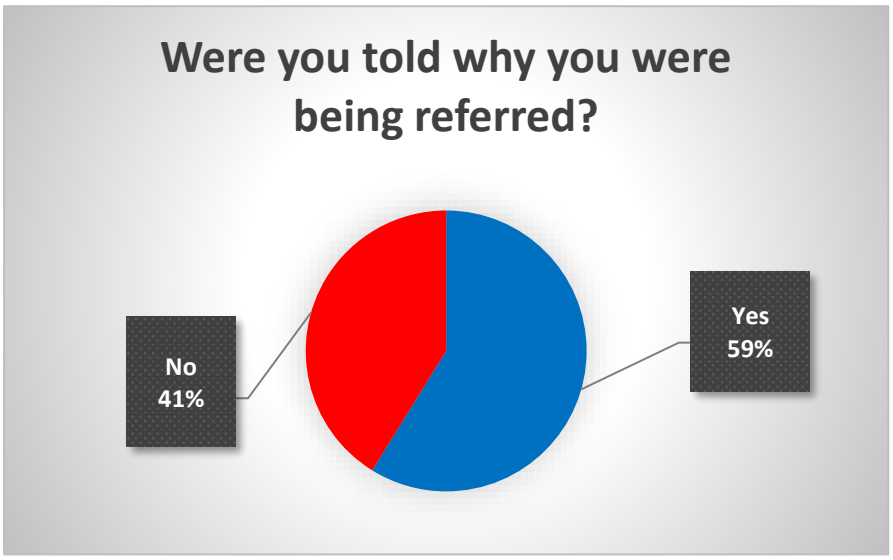
4 described themselves as 'unwell' (11%)

3 discharged from hospital with other conditions e.g., Parkinson's, stroke, dementia

2 discharged from hospital after surgery

1 respiratory problem

Question 3 - *Were you told you were being referred?*

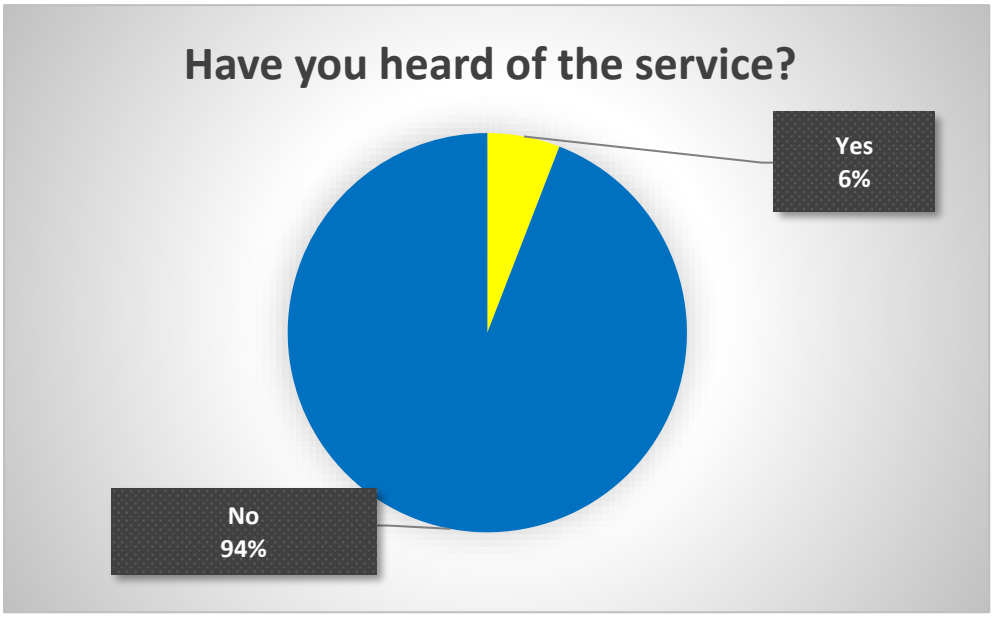


10 – yes (59%) 7-no (41%)

If no, what happened?

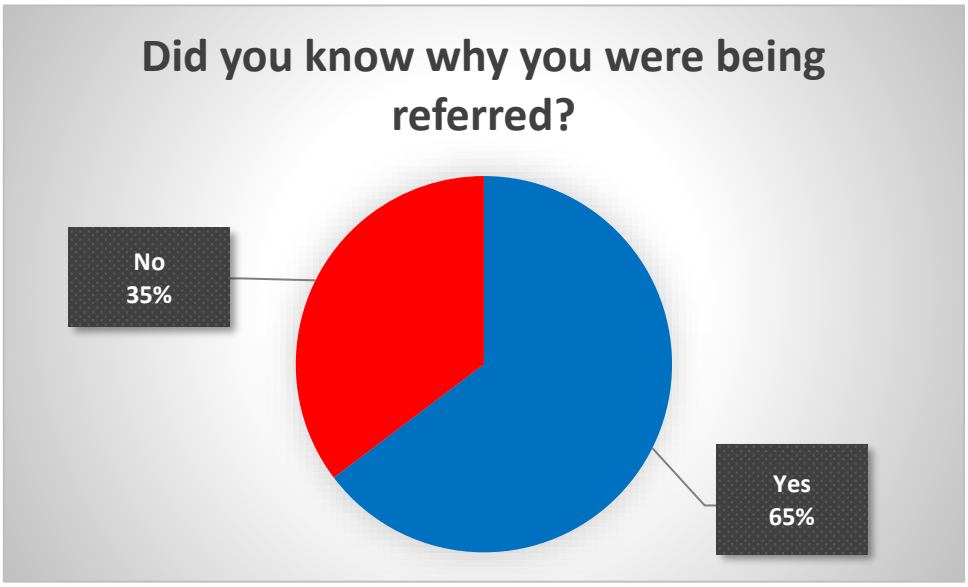
Of those who said no - all gave the reasons as they did not remember or understand what was going on at the time.

Question 4 - *Have you heard of the service before?*



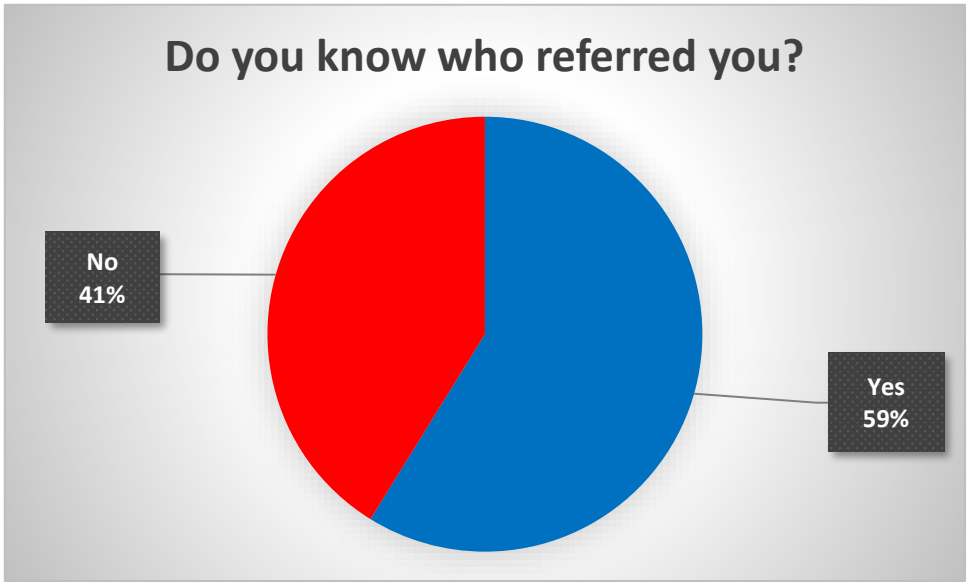
(17 responses) 16 said no and 1 said yes as her mother had used the service previously

Question 5 - *Did you know why you were being referred?*



(17 responses) 11 said yes (65% or 2/3) and 6 said no (35%)

Question 6 - Did you know who referred you?

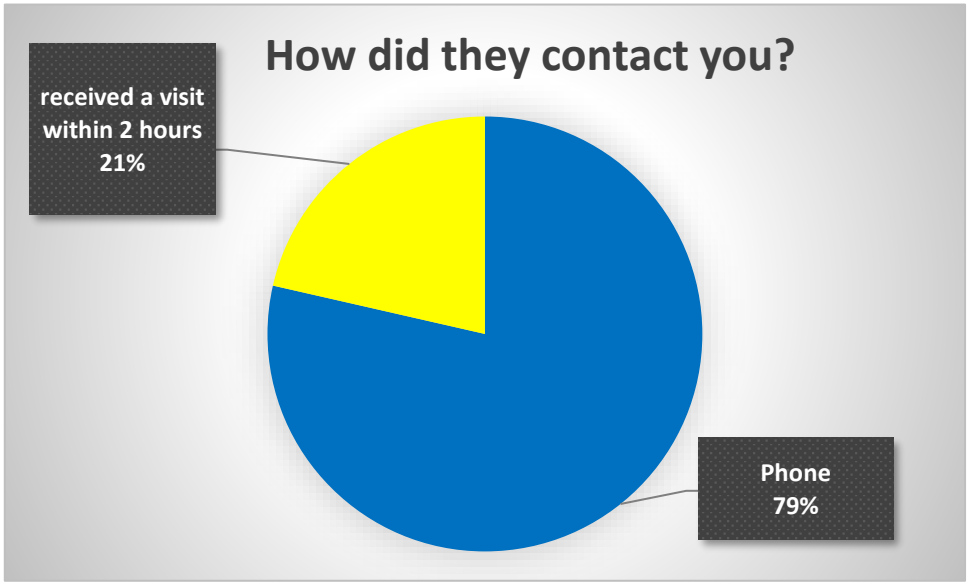


(17 answered) 10 said yes (59%) 7 said no (41%)

Can you tell me who….?

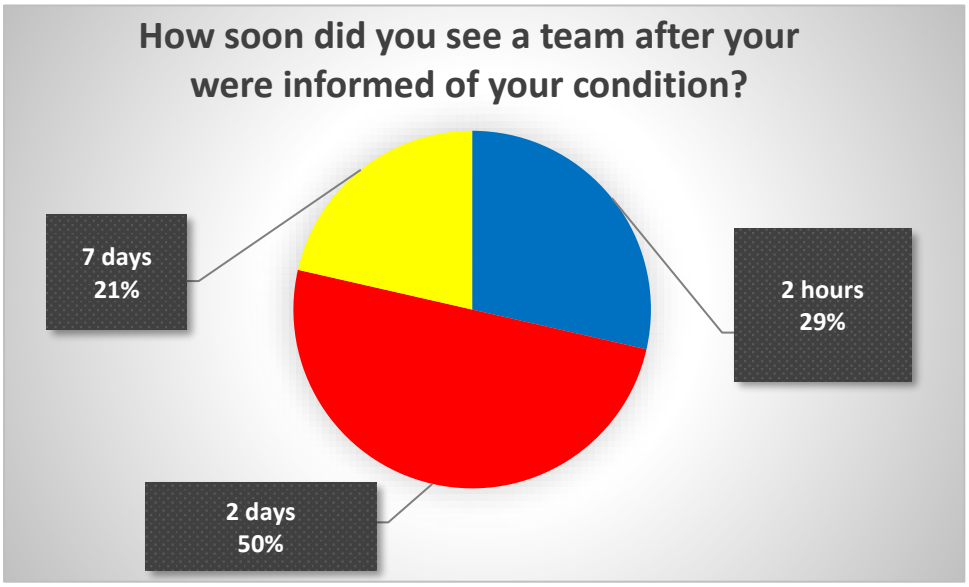
of those that answered 42% said GP and 58% said hospital

Question 7 - *How did they contact you?*



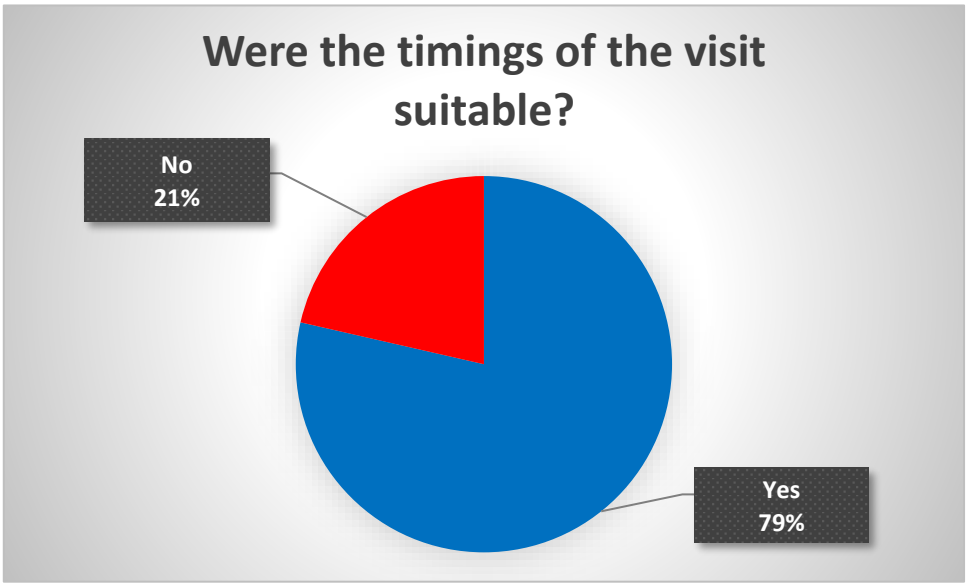
(14 answered) 79% were contacted by phone and 21% were seen within 2 hours

Question 8 - *How soon did you see a team after you informed of your condition?*



(14 answered) 4 (29%) seen within 2 hours, 7(50%) seen within 2 days, 3 (21%) seen within 7 days.

Question 9 - *Were the timings of the visit suitable?*



(14 answered) 11 (79%) said yes, 3 said no (21%)

Question 10 - *Tell me three things the service did well*

Helpful 3, pleasant/nice/kind/friendly 10, caring 3, knowledgeable/professional 5, reassuring/supportive 3, understanding/sympathetic 2, prompt 1, good physio 2, provided good equipment 2.

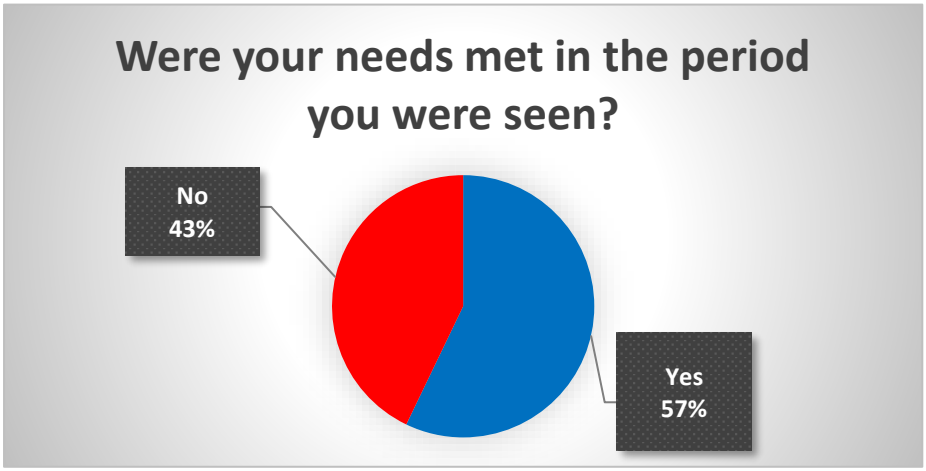
Question 11 - *what would you change about the service?*

(15 answered) 6 (40%) - nothing – very efficient, fantastic

3 – needed more explanation about what would happen at the end of team visiting ,2 – delay in being seen

Other responses were 'I wanted to continue with the service', 'had to repeat my story too many time', 'this service should be made more available'

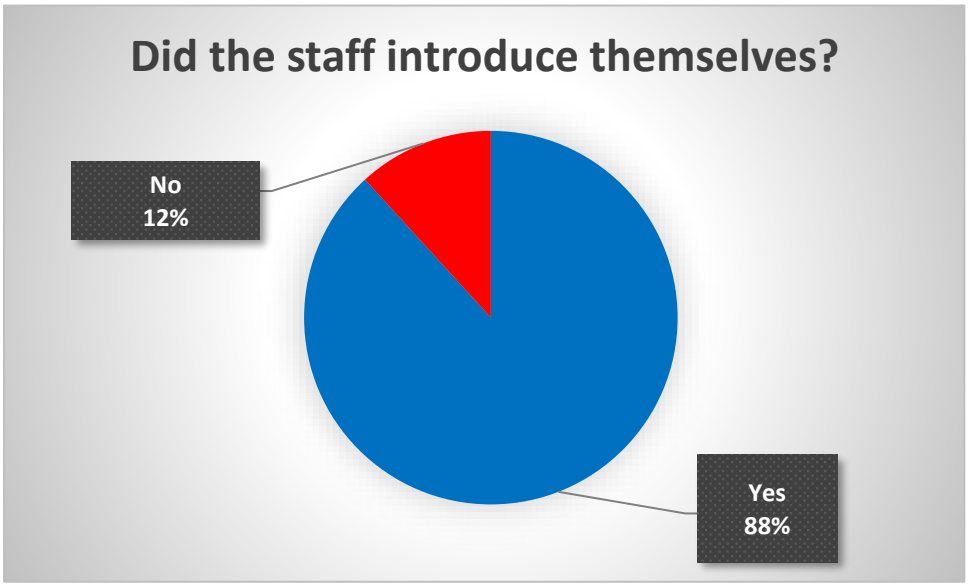
Question 12 - *Were your needs met in the period you were seen?*



(14 answered) 8 (57%) said yes, 6 (43%) said no

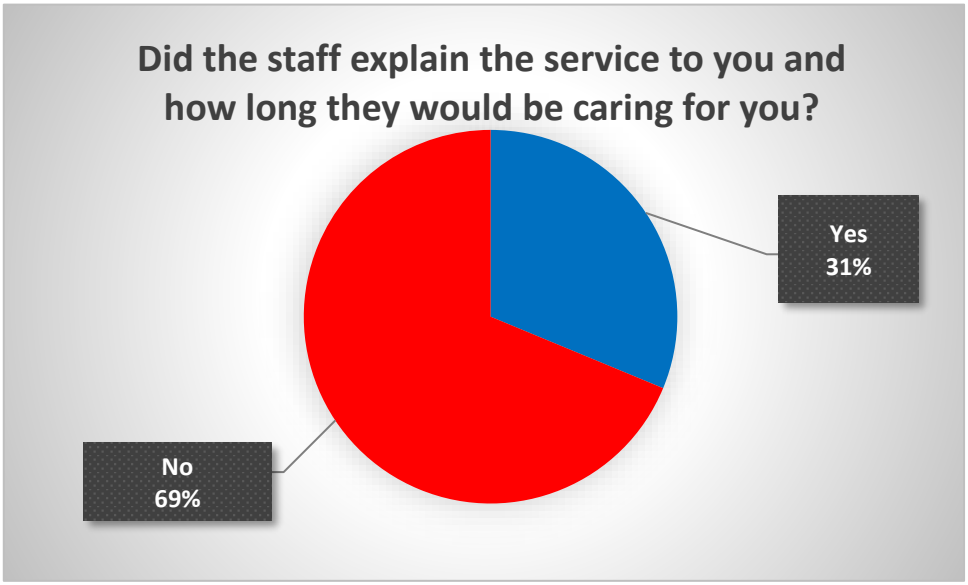
Individual's experience of using the service:

Question 1- *Did the staff introduce themselves?*



(17 answered) 15 (88%) said yes, 2 (12%) said no

Question 2 - *Did the staff explain the service to you and how long they would be caring for you?*

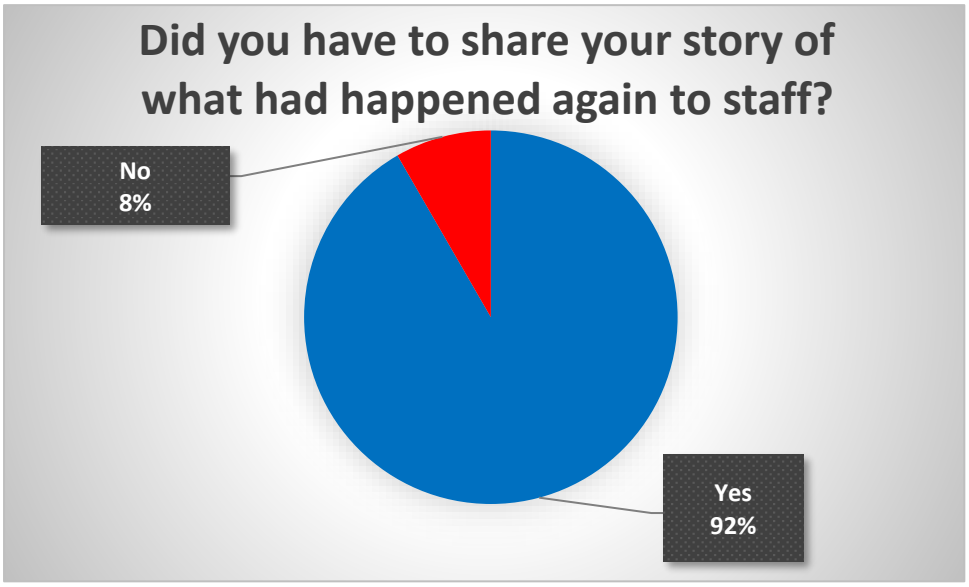


(16 answered) 11 (69%) said no, 5 (31%) said yes

Question 3 - *How were you made to feel by the staff?*

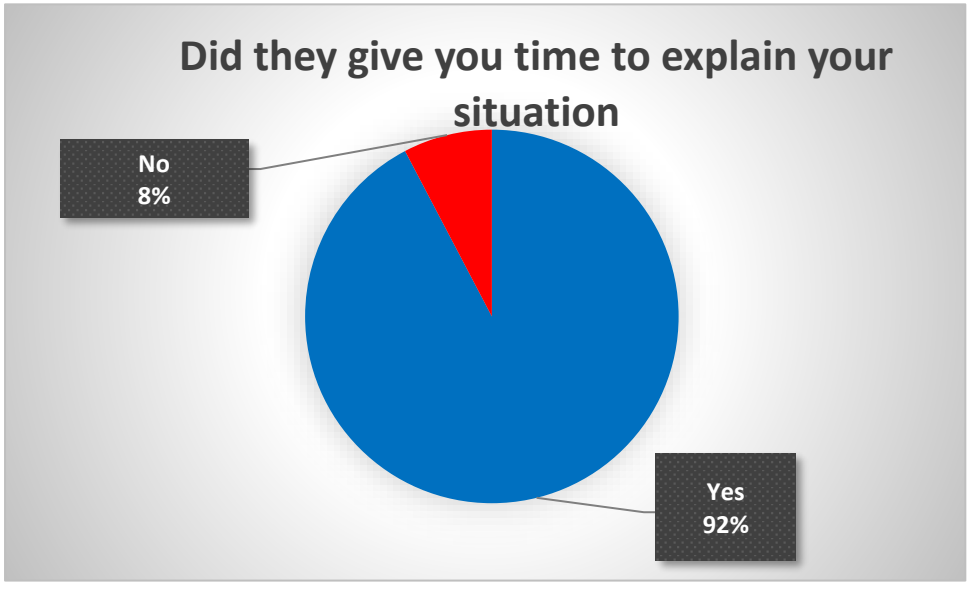
(14 answered) 4 were too unwell or could not remember, 4 said staff were supportive/nice/helpful/kind, 3 felt reassured and trusted the staff, 3 felt respected and listened to

Question 4 - *Did you have to repeat your story again to staff?*



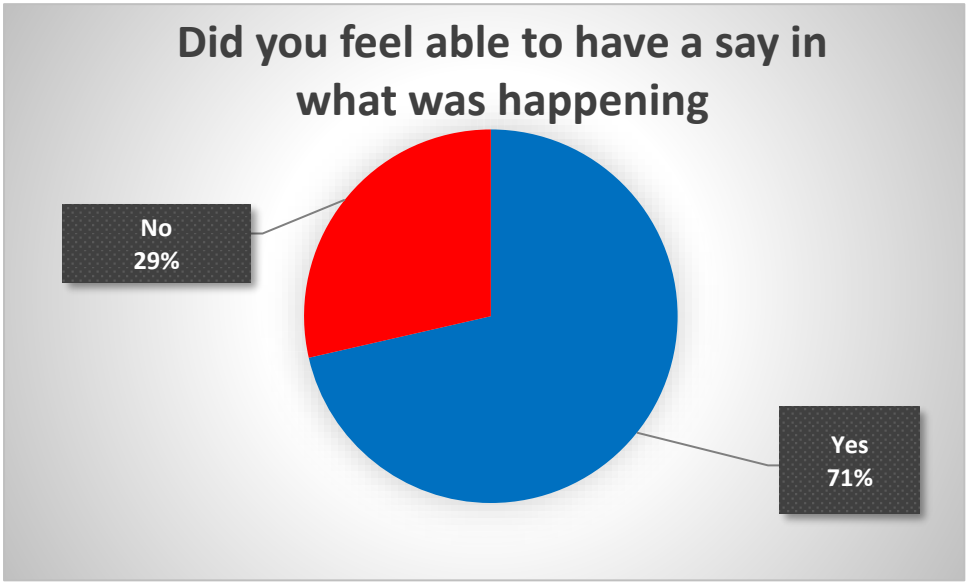
(12 answered) 11 (92%) said yes 1 (8%) said no

Question 5 - *Did they give you time to explain your situation?*



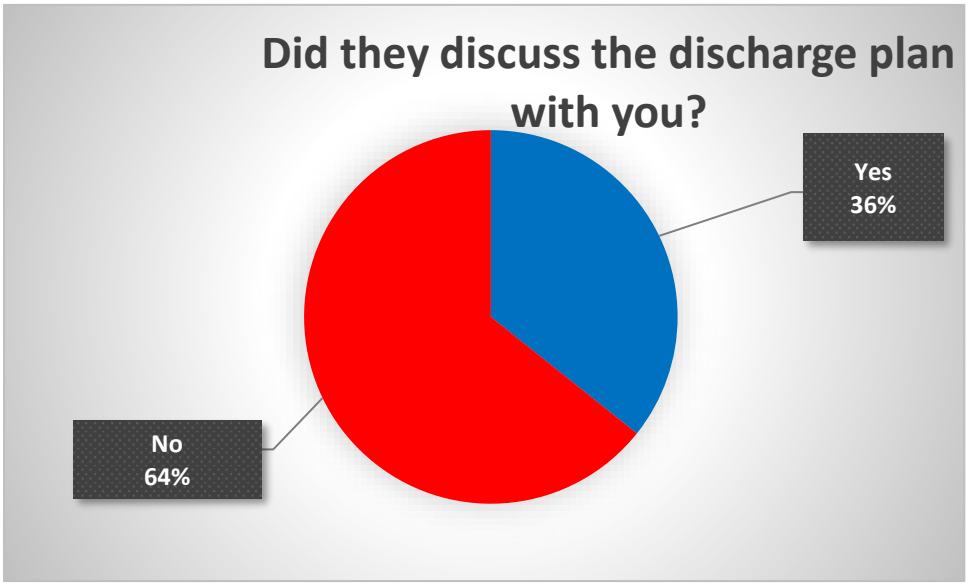
(13 answered) 12 (92%) said yes, 1 (8%) said no

Question 6 -*Did you feel able to have a say in what was happening?*



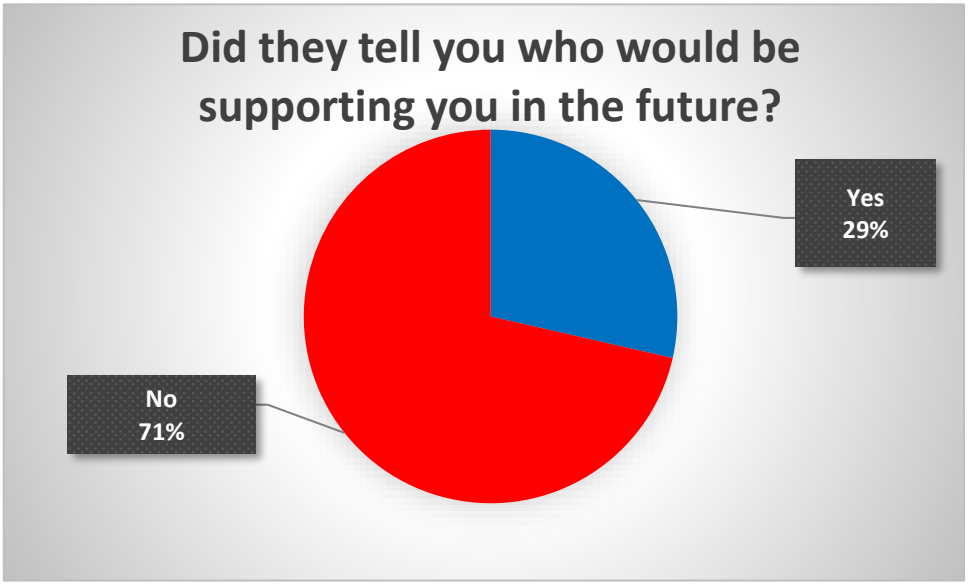
(14 answered) 10 (71%) said yes, 4 (29%) said no

Question 7- *Did they discuss the discharge plan with you?*



(14 answered) 9 (64%) said no, 5 (36%) said yes

Question 8 - Did they tell you who would be supporting you in the future?



(14 answered) 10 said no (71%), 4 said yes (29%)

If yes, who did they say:

of those who said yes, they cited GP, come back directly to this service, District Nurse

If no, what did they say:

of those who said no 4 said there was no signposting to any other service, 4 cited the family would need to take full responsibility for the patient, 4 were told to contact their GP, 1 was offered continued support from this team by phone, 1 was directed to Sovereign Housing to obtain an emergency bracelet.

Patient Quotes & Feedback

"I was discharged from the hospital after an X-ray showing a hairline fracture, with instructions to rest and analgesia. Pain got worse therefore son rang GP who referred to the UCRT service"

"The nurses were very caring and supportive to patient and daughter - they were very informative, told the daughter what the problems were and what she could do to help - they did a very thorough handover to the DN at the end of 2 weeks"

"I felt confident that I was receiving help right away and was able to have my husband at home following this seizure. I felt that the staff were very professional, and ***I*** trusted them to care for my husband well. Glad they came for several days. The physio that came twice was superb – gave him exercises and worked very well with patient"

"…did not know whether I had options to continue the service as I was told to go back to my GP. I was still unwell as was hoping someone to see me again, rather than disturbing the GP. Plus, I am alone and had to make arrangements for my grandson to stay with me now"

There was a suggestion that she should ask the GP if her husband needed more help at home, however, she has had to try to find a carer to help out and was not supported in this. Also, she is now paying for husband to attend a day centre 2 x per week and got no advice about this

The daughter feels that no-one is saying anything about what care is needed in the future. The physio has visited but no other care professional. An OT appointment was made for later in October; however, the physio has cancelled that as she does not believe it is necessary. The daughter also purchased a walking frame and a shower chair as nothing was provided until 12/10

Berkshire Healthcare Response

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

General

Berkshire Healthcare welcome this positive report as UCR is a new service delivery model, the report contains some valuable learning points and insights from the service user perspective that will feed into current and future service developments.

We are in agreement with the challenges that Healthwatch experienced when completing this survey given the cohort of service users and the Trust will adopt the recommendations made when undertaking future surveys.

We recognise their specific focus areas that require further improvements in relation to networking, signposting to a range of community and voluntary sector services and the need to review communication with our service users as appropriate to meet their individual needs.

Specific

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1. The service is clearly valued and welcomed by almost all who use it and expanding or increasing how it can be referred into should be considered i.e., by VCSO, carers, other professionals (Fire service, postman, Parish Clerks)

UCR Service can be accessed via NHS 111.

Health Scrutiny Review Matrix

Review Topic: Continuing Health Care (CHC)	**Timescale:** **Start: April 2022** **Finish: September 2022**

Review Rationale:

Continuing Health Care (CHC) is a package of care for adults aged 18 or over, which is arranged and funded solely by the NHS. In order to receive CHC funding, individuals have to be assessed by the relevant Clinical Commissioning Group (CCG) according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'. CHC covers the full cost of care and residential accommodation for those entitled to it on the basis of disability, accident or illness.

Concerns have been raised about the assessment process and rate of CHC award to West Berkshire residents through public questions submitted to the Health and Wellbeing Board. There has been also been a request for the Health Scrutiny Committee to look at this.

Considerations of the review would include:

- What is the experience of local carers in West Berkshire when applying for CHC?
- How does the number of people assessed as being eligible for CHC awards by Berkshire West CCG compare to that in other CCG areas (particularly those with comparable health profiles) and how does it differ within Berkshire West?
- How does the Berkshire West CCG interpret national guidance on CHC?
- What steps has the CCG taken to ensure that its approach to assessment is correct and consistent with that of other CCGs?
- What steps has the CCG taken to make the application process as simple and as possible for applicants?
- What will the arrangements be for assessing CHC applications from July 2022 when the CCG is integrated into the Integrated Care System?
- What alternative support is made available to carers whose CHC applications are unsuccessful?
- What communications are in place to make carers aware of CHC and alternative options?

Terms of Reference:

The Task and Finish Group will:

1. Form an understanding of the CHC process, the types of awards available and any alternative options for carers to access funding in the event of their CHC application being unsuccessful.

2. Analyse national data around CHC awards to see how West Berkshire compares to other areas in terms of the number of people eligible for each type of CHC award and how quickly applications are processed.

3. Collect evidence from local carers with experience of applying for CHC. This will be done by holding facilitated meetings with local carer groups and / or online surveys. Healthwatch West Berkshire may be used to support this.

4. Ascertain whether any independent assessment / benchmarking takes place within the CCG to validate the local interpretation of the national guidance and associated processes.

5. Understand the implications for CHC assessments once the CCG is integrated into the ICS in July 2022.

6. Understand what joint working has been done by the CCG and West Berkshire Council's Adult Social Care Service around funding of care for those whose CHC applications are unsuccessful.

7. Review what has been done already to help local people to access CHC. For example, this could be communications around the package itself and support with the application process.

8. Consider any other relevant reviews that have taken place for example by other Local Authorities Health Scrutiny Committees in Berkshire West.

Members will collate their findings which will then form the basis of a report to be considered by the Health Scrutiny Committee.

Review Membership:

Membership of the Task and Finish Group will be agreed by the Health Scrutiny Committee on 05 April 2022.

Councillor
Councillor
Councillor
Councillor

Chairman: TBC

Vice-Chairman: TBC

Lead Officer: Vicky Phoenix

Information Required:

- Information on CHC awards and the assessment process
- Data on applications / approvals / rejections for West Berkshire / Berkshire West and benchmarking data from other CCGs including those from Buckinghamshire and Oxfordshire.
- Interviews with individual patients / carers and representative groups
- Interview with the Berkshire West CCG
- Reviews undertaken by other Health Scrutiny Committees

Witnesses:

- Patients / carers with experience of the CHC process.
- Groups representing patients / carers with experience of the CHC process
- Healthwatch West Berkshire
- Berkshire West CCG
- West Berkshire Adult Social Care

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Health Scrutiny Committee Work Programme

The following items will be considered in addition to Standing Items: Updates from Task and Finish Groups

Last Updated: 22 Mar 2022

Ref	Item	Purpose	Health Body	Prioritisation Score
5 April 2022 (Report Deadline 24 March)				
1	Continuing Health Care (CHC)	To agree the Terms of Reference for a Task and Finish Group to look at CHC assessments and awards locally compared to other areas and to consider the review made by the CCG.	Berkshire West Clinical Commissioning Group (CCG)	14
2	Maternity Services	To provide an update on the response to the recent CQC report.	Hampshire Hospitals NHS Trust	14
3	Children and Young People's Mental Health Service (CYPMHS)	To provide an update on Tier 4 services and an interim update on the local transformation plan.	Berkshire Healthcare NHS Foundation Trust	13
14 June 2022 (Report Deadline 3 June)				
4	Motion regarding Royal Berkshire Hospital Redevelopment	To consider the motion rasied at Council on 17 March 2022	Royal Berkshire NHS Foundation Trust	N/A
5	Covid Reponse	To agree the Terms of Reference for a Task and Finish Group to look at the ongoing impact of Covid on health services and treatments.	Berkshire West Clinical Commissoining Group (CCG) / Royal Berkshire NHS Foundation Trust	12
6	Thornford Park Hospital	To provide an update on the response to the Care Quality Commission report and plans for future investment.	Elysium Healthcare No.2 Limited	12
7	Cancer Treatment	To provide an update on current performance re. waiting times and referrals, and the mitigation measures introduced.	Royal Berkshire NHS Foundation Trust	11
13 September (Report Deadline 2 September)				
8	South Central Ambulance Service	To present an overview of current performance re. response times and hospital transfers, and winter service plans for 2022/23.	South Central Ambulance Service	11

9	Westcall Out of Hours Care	To present an overview of demand in urgent and unscheduled out-of-hours calls. Consider response and issues arising.	Westcall / Berkshire Healthcare NHS Foundation Trust	11
13 December 2022 (Report Deadline 2 December)				
10	Facilities for New Developments	To agree Terms of Reference for a Task and Finish Group to look at the provisions of healthcare serving new developments.	Berkshire West CCG	11
14 March 2023 (Report Deadline 3 March)				
Other Items to be programmed				
	Hospice Provision	To review hospice service provision for residents of West Berkshire, including the palliative care hub in Newbury.	Sue Ryder	tbc
	Blood Tests	To review patient access to phlebotomy services	Royal Berkshire NHS Foundation Trust	10
	Royal Berkshire Hospital Redevelopment - Building Berkshire Together	To provide an update on the status and activites of the redevelopment programme and the creation of a JHOSC.	Royal Berkshire NHS Foundation Trust	14
Standing Items				
	Berkshire West Clinical Commissioning Group Update	To receive an update from the Berkshire West Clinical Commissioning Group on their activities.	Berkshire West CCG	N/A
	Healthwatch West Berkshire Report	To receive an update from Healthwatch West Berkshire on patient feedback received, reports prepared and other activities.	Healthwatch West Berkshire	N/A