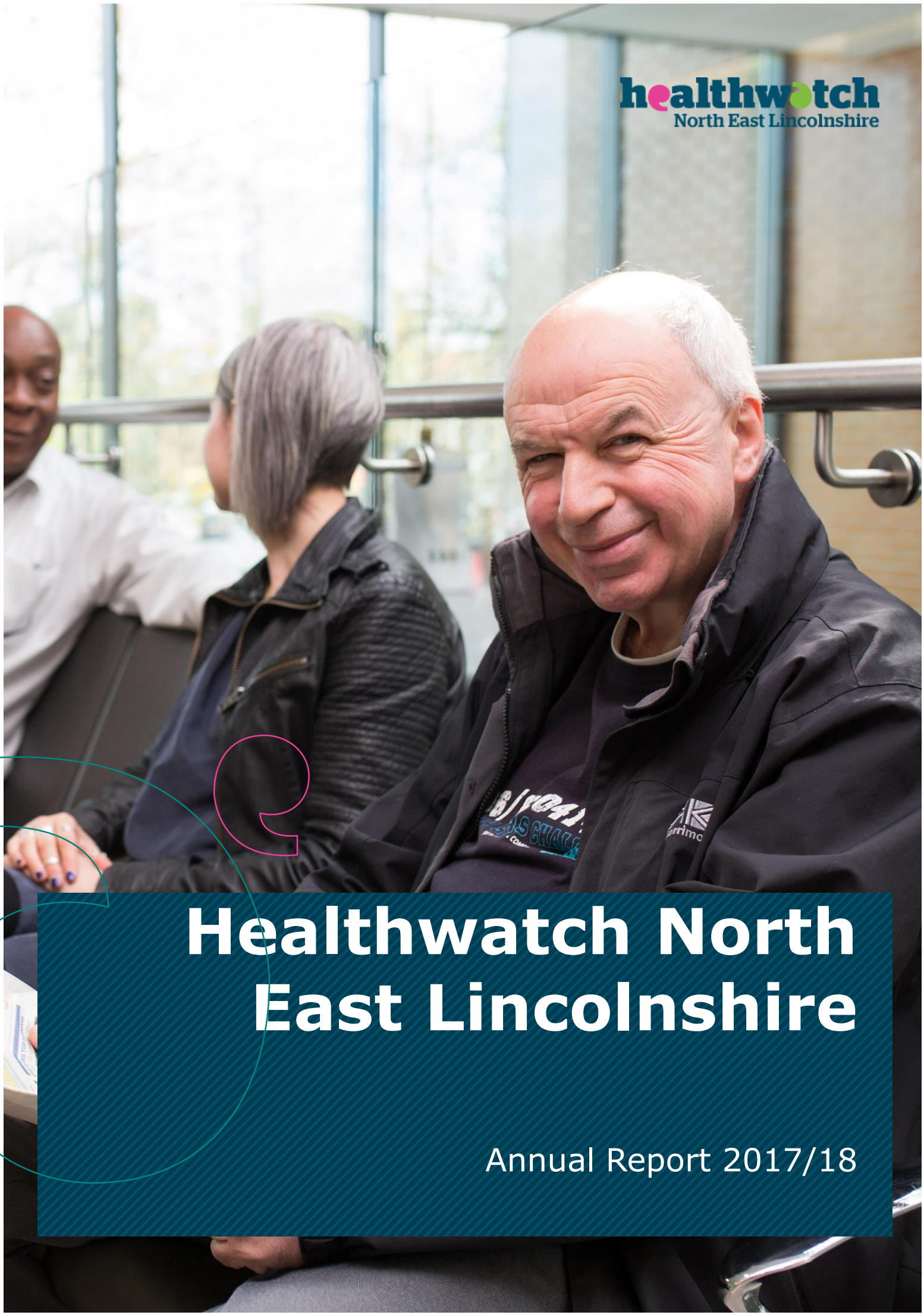
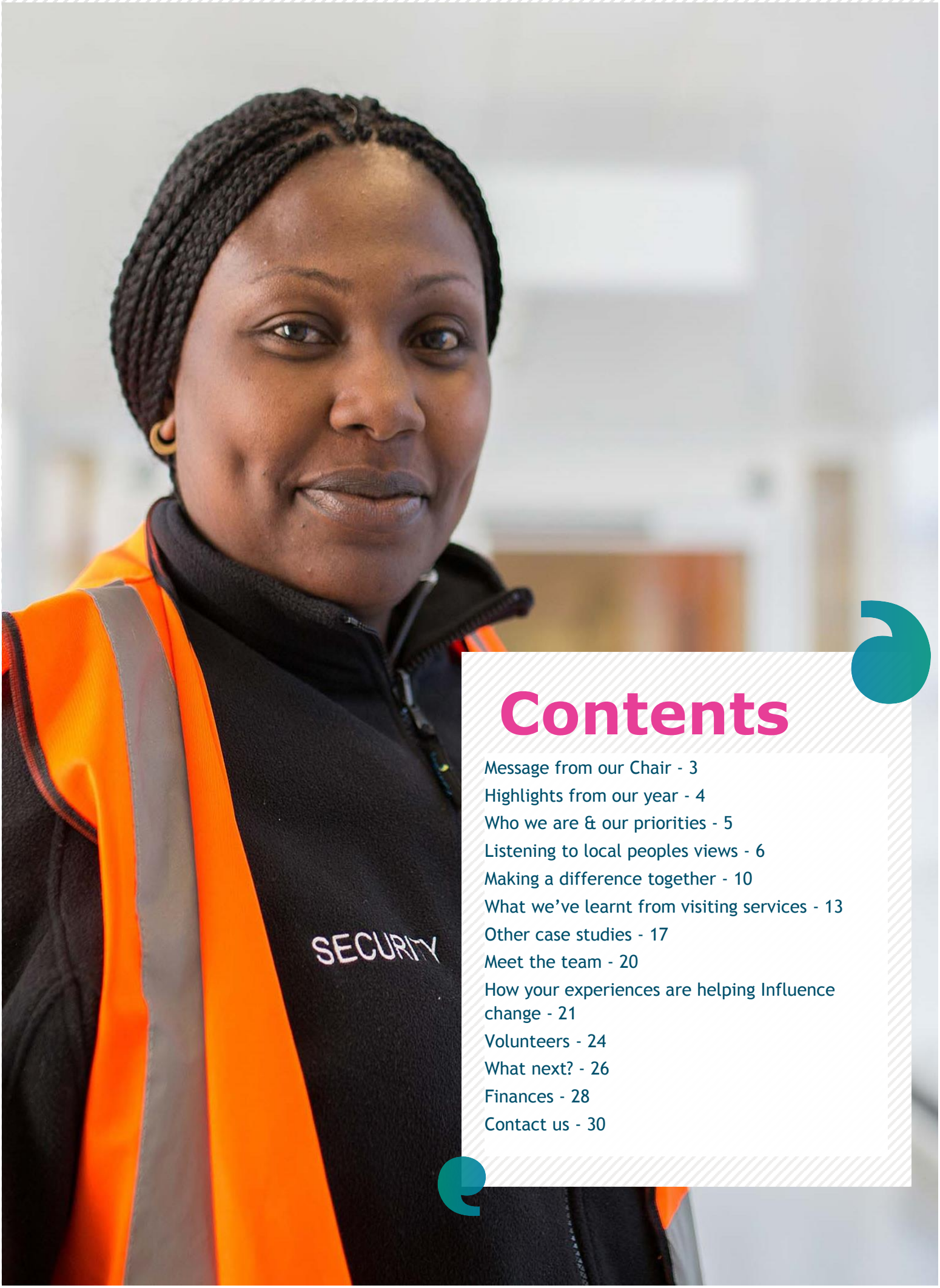


healthwatch
North East Lincolnshire

# Healthwatch North East Lincolnshire

Annual Report 2017/18




# Contents

# Message from our Chair

## We look back on this last year with a continuing sense of pride in our achievements.

There are many highlights but it would be remiss if I did not particularly mention last year's AGM in June which incorporated information stands and a question time panel and which was so well appreciated by those who attended.

During the year we have carried out a number of important pieces of work including a survey of `seldom heard voices' over their awareness of plans for changing the shape of local health services. We particularly want to thank Partner Programme organisations that assisted in ensuring that some of their service users completed this survey. We maintain that there has been insufficient engagement with the local community on these plans and want to make sure that local people have a say over changes before they are made. We have also carried out an online survey on patient's attitudes for charging patients that do not attend appointments and have followed this up with a survey of GP practices about their Did Not Attend data, policies and practices.

We have continued to use the information and insights from local recipients of health and care services to challenge both commissioners and providers. The pressures upon our local health and social care providers only increase but it is important, in the face of increasing demands, that the impact upon patient experience is recognised. As a Healthwatch we have taken every opportunity to raise concerns on behalf of patients in different settings and to gain an assurance that these matters are appreciated and acted upon. I want to thank the local commissioners and major providers of health and social care for their support in listening to the challenges that we have posed and in responding openly to the issues that we have raised.

I want to pay tribute to both our staff and my fellow volunteers for their hard efforts and the quality of their work over this last year. In particular, mention must be made of the enter and view work that we have carried out in various residential and nursing homes, in the acute hospital and local private hospital, and in the local hospice. These all bear testimony to our objective that the views of patients/users inform local services and help drive up the quality of that provision.

As you may now be aware, the contract for 2018/19 for this Healthwatch has been awarded to Meeting New Horizons, commencing from 1st April 2018. We have worked hard to ensure a smooth handover and continuity of support for the people of North East Lincolnshire and we hope that the local Healthwatch service locally continues to grow from strength to strength.

Mike Bateson
Chair

# Highlights from our year

**1418**

We have 1418 followers on social media

Our **22** of volunteers help us with everything from Enter & View to Community Engagement

We've visited **14** local services

Our reports have tackled issues ranging from **Outpatients** to **Did Not Attends at GP Practices**


We've spoken to **2574** people at various events

We've given **106** people information and advice

# Who we are & Our Priorities

**You need services that work for you, your friends and family. That's why we want you to share your experiences of using health and care with us - both good and bad. We use your voice to encourage those who run services to act on what matters to you.**

As well as championing your views locally, we also share your views with Healthwatch England who make sure that the government put people at the heart of care nationally.

Healthwatch North East Lincolnshire has been a project of North Bank Forum, the `host body', awarded the contract by North East Lincolnshire Council to deliver a Healthwatch locally, since its inception in April 2013. This contract was extended to its maximum limit of 31 March 2018 and following re-tendering in autumn 2017, the contract has now been awarded to Meeting New Horizons. Work has been undertaken during the last few months of 2017/18 to ensure a smooth transition into the new arrangement.

## Our Priorities

Healthwatch locally will continue to seek to give a strong voice for local people including voluntary and community groups so that those views can be used to inform commissioners and major providers of health and social care services over the way that those services are planned and provided. Healthwatch North East Lincolnshire has developed a good relationship of trust and respect locally and this will be built upon going forward.

# Listening to local peoples views

**We give some examples below of where your voice has helped shape our representations on your behalf.**

**Disabled Toilets** - Early in the year, we again raised with North East Lincolnshire Council (NELC) the issue of a lack of a `changing places' facility at Cleethorpes following their decision to close toilets. We asked whether an equalities impact assessment had been carried out and the response indicated that it had not. However, we were informed that a plan was in place to reinstate the Boating Lake facility and this is now open

**Overnight bed transfers** - We raised the issue of overnight bed transfers with Northern Lincolnshire & Goole Hospital Trust. We were aware that their policy indicates that this should not occur between the hours of 11.00 p.m. and 6.00 p.m. but we had received information that this was still happening. We asked the Trust to comment on incidence and what steps are made to free up beds earlier so that transfers are not made in the middle of the night, disturbing that patient's sleep and possibly that of others in bayed areas. The Trust informed us that the movement of patients outside of normal hours is always a last resort, and that they had been working hard to reduce this. However, the winter period had seen some particular pressures. Transfers are monitored through their Transfer and Discharge Group and key indicators are reported through their Quality and Patient Experience Group but are not currently broken down into `out of hours'. They accepted that patient flow and freeing up beds earlier in the day was the objective and have since established a range of measure with partners including `discharge to assess' to tackle winter pressures. In addition, nursing care beds in the community are being used to relieve pressures. However, they felt that there would always be pressures around our critical care areas like ITU & CCU that sometimes means out of hours moves have to be undertaken, but hopefully these will be minimised. We did express our surprise that actual figures on night transfers were not available and sought further clarification on transfer for clinical versus non-clinical reasons and were told that non-clinical is largely about the complexity of dealing with other providers. Clinical reasons include all those waiting in emergency care who need to be admitted but that timing of transfers also relates to timing of ward rounds which vary according to other work pressures upon consultants or other senior doctors.. We also asked for figures on comparisons with other acute Trusts but were told that these were not available.

**Parking ticket machines at Diana Princess of Wales Hospital** - In November 2017 we became aware through public comments and the experiences of our own staff and volunteers that significant queueing was occurring as the result of new registration plate recognition ticket machines being introduced at Diana Princess of Wales Hospital, Grimsby. Queueing was primarily related to user unfamiliarity with number plate recognition systems and the inputting of car registration details before making payment. The resultant delays meant that some people were being bumped into the next payment tariff. As a result of our representations (and those of others), a third (credit card only) machine was initially installed but this appeared to have little impact on the problem. We were then approached by University of the Third Age who reported that, when snow fell at the end of November, chaos ensued because registration plates were not being read by the system and vehicles were queueing right out into Scartho Road. In addition, they argued that waiting outside with minimal protection from the elements was not acceptable. We again raised the situation with the Trust who informed us that one of the ticket machines was being moved into the hospital foyer entrance and that a fourth machine was also being installed in that area. Enclosure of the area where the other two machines were located would be added to the list of capital works but no timescale could be given for this to be approved. In addition, contracted staff would be deployed to clean plates covered by snow. Since this, arrangements have generally been much improved but the impact of any significant driving snow was not tested until late February.

**Public Awareness** - During this year, we have been taking the opportunity to ask the question "Have you heard of Healthwatch North East Lincolnshire?" at some of the main promotional meetings that we have held. We put this question to 69 people at 6 separate events and found that 22 (32%) said they had while 47 (68%) said they had not. Although these numbers on awareness are not as high as we might have hoped, they do reflect a higher level of awareness at 32% than that based on earlier local soundings back in 2013/14 and on findings from elsewhere in the Healthwatch network. However, there are no grounds for complacency here with 68% unaware and we need to explore ways in which we can improve this further.

**Parent Carer Assessments** - We have raised issues with Children's Disability Services within the local Council over the right to and use of Parent Carer Assessments under the Children & Families Act 2014. We found that known parents of children with a disability had been invited by the Council's Children's Disability Service to complete self-assessments but many had not done so. However, there was also contention from some parents about how information they supplied fitted with the assessment of the child under the Single Assessment Process. Also it was argued that the focus of the parent carer assessment was more about parenting capacity than on their needs. Children's Disability Services maintain that the current process takes account of the needs of parents but we have asked them to review their policy and procedure so that the rights to a parent carer assessment and not just a self-assessment are distinctively made.

**From March - September 2017 a Young Peoples Healthwatch Survey was distributed.**

A series of 8 questions were included:

1. How often have you used any kind of health service in the past 12 months?
2. Which of these services have you used In the past 12 months
3. Which of These Services Were You Happy With?
4. Can You Tell Us Why?
5. Were There Any Services That You were Unhappy With?
6. What's Your Age Range
7. Employment Status
8. Gender

> Overall this survey has helped to narrow down the type of services in which young people feel let down by and the ones they feel most confident in

75 people took part in this survey. It was anonymous and optional to answer each question. The aim of this survey was to see which services were being used most and which had a positive and negative impact on young people. The majority of those surveyed gave positive responses but with some negative comments.

The most popular services used that had positive feedback were: GP/Family Doctor with 70.97% and NHS Dentist with 64.52%. For GP/Family Doctor, the most common themes were: Helpful; supportive; feel safe and trusted; friendly and quick services. For NHS Dentist, the most common themes were: helpful; friendly; quick services; safe environment; and felt relaxed and comfortable. The next most popular services were Hospital (A/E) with 25.81%, Pharmacy/Chemist with 25.81% and Opticians with 22.58%. These services received all similar feedback in regards to: Treat with dignity; felt well looked after; friendly and supportive.

The most common services young people were unhappy with were: Child & Adolescent Mental Health Service (CAMHS); Hospital (A/E); and GP/Family Doctor. CAMHS common themes were: Pressure on young people; quick to put a label on; did not feel any affect from the services.

GP/Family Doctors common themes were: slow services; rude; and unresponsive. Hospital (A/E) common themes were: long waiting times.

Overall this survey has helped to narrow down the type of services in which young people feel let down by and the ones they feel most confident in. The survey helped break down the age range, educational/employment status and gender in which we had the highest responses. The most common responses were from the age group 11 - 15 years. This popular age group could relate to the time the survey took place, with ages 16+ it was around the timing of when schools and college exams were taking place. If distributing another survey, we would need to take into consideration the timeframe and the method in which we share this survey.

The nature of the questions within this survey gave indications of the most popular services that young people use. If a Young People Healthwatch ever wanted to collaborate with service providers to gather more information, we can now identify which services would be most useful for example: GPs, dentist, hospitals etc.

# Making a difference together

**Health Scrutiny Panel** - We have continued to work closely with the Health Scrutiny Panel at North East Lincolnshire Council by sharing our Annual Report and providing two updates on our Work plan activity. In addition we have attended all Panel meetings as observers and meet periodically with the panel Chair to discuss issues of mutual interest. We do all this to make sure that there is no unnecessary overlap between the work of Healthwatch locally and the Panel particularly around investigative work. We also have the power to escalate matters to the Panel which we believe need airing in a publicly accountable setting. In this last year, we raised concerns about East Midlands Ambulance Service (EMAS) response times and were able to join councillors around the table in asking questions of the Trust. In going forward we believe that a strong community voice is imperative to hold health and social care organisations to account, so we look forward to continued co-operation with the Panel on this front.

**Ophthalmology Engagement Group** - As a result of our direct involvement in the Clinical Commissioning Group's Communications & Engagement Group, we were asked, along with our Healthwatch colleagues in North Lincolnshire, to facilitate a dialogue with patients that might be affected by proposed changes to the eye clinic arrangements in North and North East Lincolnshire (consideration of moving from hospital out-patients to a community-based setting). Commencing this work was delayed a little until we were satisfied that staff affected by the proposal were aware. At the Diana Princess of Wales Hospital site, HWNEL made 5 visits and spoke to 66 patients, providing information on the proposals (`A Clearer View') and invited them to complete the survey form and return it to the CCG.

**Community Advice Shop** - Co-ordinated by Friendship at Home, we helped run the Community Advice Shop which opened in Clayton Walk, Freshney Place from early November until Christmas. However, as the main signage advertises Friendship at Home and not other partners, most members of the public only came in to enquire about Friendship at Home and not wider aspects of community advice, so we did not feel we could continue to support this activity into the New Year.

**Autism diagnosis & support** - A local resident approached us asking us to escalate the lack of local autism diagnosis and support to the joint Ofsted/CQC inspection regime. HWNEL has been actively involved in the local Autism Forum and other meetings and has heard from a number of parents frustrated at a perceived lack of explanation of their child's condition or package of appropriate support. We therefore initially expressed support for this idea but also recognised that we needed to reach a balanced position based on the various perspectives from the local community and the responses of both commissioners and providers.

Meetings were held over August/September 2017 with commissioning representatives of the council (NELC) and the Clinical Commissioning Group (CCG) and key points emerged from these sessions:

**1.** The plan for 0-5s is to move to a Single Point of Access (SAP) through Families First as a means of identifying needs and how EHCPs can work to meet needs while people are still awaiting diagnosis. The Families First Access Point will be the gateway/entrance into initial help/ assessment/support. From October 2017, existing CAMHS will also use it as their first point of referral. Although a single common pathway, it is also bespoke for each individual and is about transparency but also about community resources and developing a well-established `toolbox'. The pathway is where the parent/child stays and it is the professionals that bring in the tools. The layered levels of support being developed need to be captured in revisions to the Local Offer.

**2.** The early help offer will include:

+ Signs of safety – building resilience/family strength.
+ Multi-disciplinary team & specific specialisms: Community Learning Disability Team (CLDT), Education Welfare, behavioural support service etc.
+ Specialist targeted support e.g. substance misuse.

**3.** It is recognised that many professionals especially schools are still wanting a diagnosis before offering support but no service will be dependent upon diagnosis in North East Lincolnshire. It means, for example, that this authority cannot adopt the `Early Bird' system of National Autistic Society for under 5's because they insist on diagnosis first but an alternative model is being developed in conjunction with Barnardo's.

**4.** There are still issues locally about articulation and communication of the pathway that need to be addressed. The CCG have been listening to parents who have gone to their Patient Advice & Liaison Service (PALS) and this has highlighted that many parents have been unintentionally misled with the wrong advice over the position their child has reached and so they may not have received the help and support that could be made available. The new spec for CAMHS using the Thrive model will broaden the base for support with Children's Service staff being trained to offer a more specialist service alongside what current CAMHS do. The CCG and NELC say it is important that parents come forward and do not let fear of the consequences of complaining prevent their child's circumstances being better addressed.

**5.** Although there is a belief that there is deliberate under-diagnosis in NEL, the CCG say there is no valid professional reason for doing this. There is still a lack of unanimity among professionals about what is supposed to be happening but a massive sign up to partnership to be able to speak with one voice. A Development Plan is being approved to move this agenda forward.

Our conclusions, taking account of various parent experiences and perspectives is that, while we are still being appraised of some situations where families are not getting the help and support they need, these are being highlighted and pursued with the relevant agencies. We therefore concluded that escalation would not be a constructive or appropriate step. If, however, the planned developments do not bear fruit as envisaged, this position will be re-evaluated.

# What we've learnt from visiting services

**Out-patients** - Healthwatch North Lincolnshire (HWNL) informed us of their plans to visit out-patients and asked if we would join them by doing the same survey at the Grimsby end. We agreed to this but time constraints limited our work to over the first half of December 2017. We made 4 visits and 35 surveys have been logged from this area which have been added to the main report compiled by HWNL. The report with recommendations was published in March and the Trust have welcomed the report and have produced a detailed action plan to address the issues raised. Both North and North East Lincolnshire HW have been invited to be involved in work to produce a patient friendly access policy for the Trust and contribute to discussions on improvements to patient information during the coming year.

**Enter and View visits to residential care homes** - 11 Enter & View visits were made from April 1st 2017 – March 31st 2018. We visited:

1. Brooklands
2. Clarendon Hall
3. Havenmere
4. Ravendale Hall
5. St Margarets
6. Bradley House
7. Grimsby Grange
8. Orchards
9. Amber House
10. 22 Abbey Drive West
11. Churchview

33 recommendations were put to the care homes in this period and 26 out of the 33 recommendations have been actioned.

## Case Study 1 - Clarendon Hall Care Home

**Recommendations** –

**1.** There were a number of wheel chairs /hoists/ chairs stored in corridors. If possible could one of the spare lounges/out of order bathrooms accommodate these? Between the upper floors there is an area with a table in it, it might be an idea to remove this if it is unused to accommodate and store some other equipment as it is out of the way.

**2.** The staff kitchen area had a key in the door with washing liquids, cutlery and a boiler in it. Could the room be locked when not in use to avoid any accidents and the keys be on hook next to door or above door out of a residents reach.

**3.** Two storage cupboards were unlocked with keys in doors. Could these please be locked when not in use.

**4.** Beakers appeared to be the only option for residents who needed a drink. Please explore other options for residents who are capable to maintain their dignity and basic motor skills.

**5.** An unoccupied room had an oxygen cylinder in with no aware notice on door. Please remove oxygen cylinder or leave notice on the door.

**Initial response** – Home Manager said:

"Thank you for your report. A couple of points that I would like to clarify if that is ok"

**1.** I am unsure which bathroom it is on the ground floor that was out of order, as there were no areas out of order at the time of the visit?

**2.** Although there were only beakers noted for the residents use, there are also glasses available which are on the tables.

I have an action plan in place to rectify the areas that were identified.

**Follow-up findings** –

**1.** Agreed that storage is an issue but home is doing what they can to minimise clutter in the hallways. They were storing some of the linen trollies in one of the unused bathrooms at busy periods.

**2.** The staff kitchen unfortunately still had the key in the door on our follow up visit. Manager said she has reminded staff to use the hook to hook the keys onto when it is not in use. She would be reminding all staff again.

**3.** Both storage cupboards were locked with no keys left in the doors.

**4.** There were a number of glasses on tables in the dining area and also near the drinks area in one of the main lounges as well as beakers.

**5.** The unoccupied room which had an oxygen cylinder in is no longer there. The rooms we checked which had oxygen cylinders in all had the notice on the doors.

We were happy and satisfied that most of the recommendations we had originally made had been actioned. We would just like to see keys put in a safe place and doors locked in rooms with hazardous items for safety of residents when not in use.

## Case Study 2 - Ravendale Hall – 6th June 2017

**Recommendations** -

Overall we were satisfied with the standard of care seen within Ravendale Hall and commend the manager's "hands on" and enthusiastic approach. We would just recommend that:

1. A risk assessment should be undertaken, if not already carried out, with reference to the resident who is propelling herself by her feet in a wheelchair.

2. The call bell should always be answered promptly and staff should have clear guidelines about responding.

3. Staff should explore having embroidered names to aid identification and the staff photo board should be updated.

4. Whilst the refurbishment is taking place perhaps some soft furnishings could be replaced with ones that are waterproof and can be wiped clean. These would not only be more hygienic, but would minimize the risk of odours. We would welcome a chance to return after the alterations.

5. Extra reminiscence pictures, artefacts could be introduced to make the environment more stimulating,

**Initial response** - Home Manager said: "I would like to say I am very pleased with the report and I take on board any recommendations, which I might add were small. I also like the fact that I was mentioned in the fact that I am hands on which is what I do every day and for someone to see that proves that you can be a manager that doesn't sit in the office at a desk, you muck in like you should and this way you get to know changes in your residents. They say a second set of eyes is better so I would like to say thank you again to the 3 ladies that came to the home."

**Follow-up findings** –

**1.** A risk assessment had not been undertaken regarding the resident who was propelling themselves by their feet in a wheelchair to access the dining room because of the raised carpet gripper. They were aware of the woman in question but not aware of the higher raised carpet gripper. The manager informed me she would look into this.

**2.** Since the takeover of the new Service Provider and Manager staff has increased allowing calls bells to be answered promptly.

**3.** Name badges are on order for all members of staff as well as new uniforms. The staff photo board has been updated.

**4.** The manager was not aware of any past refurbishment but went on to explain they are in the process of a 9 month refurbishment plan starting from March. They have invited us back to have a look at the home after completion.

Extra reminiscence pictures and artefacts etc. are all part of the newly planned refurbishment.

**Final comments** - A lot has changed since our original visit with a new Service Provider, Manager and an increase in staff. There were a lot of positive comments from the new manager who came across as really enthusiastic. She has a great understanding of the home and went into great detail about the new refurbishment. I look forward to returning to the home to see how it is after the refurbishment has been completed.

# Other case studies

## From the year 2017/2018 here's some cases we found from interacting with you

**Use of MRI scanners** - A patient who is claustrophobic and needed an MRI scan felt that, as she was asked in a pre-visit questionnaire about this condition, then she should have had more help on the day e.g. giving her a sedative. Instead, the local hospital referred her back to her GP but she felt that she could have done this herself if she had known their stance in advance. The acute Trust (NLaG) initially responded that they no longer asked that question as it made some patients more anxious but our informant confirmed that this was in the recent letter sent to her. The Trust then indicated that there were possible practice differences between the Hospital scanner staff and mobile scanner staff. They maintained that reference to claustrophobia was not in the current letters used but we felt as a Healthwatch that it was important that managers heard from this person direct and she agreed for her details to be passed on to them. It is also important that other patients with this condition see or consult with their GP in advance of such scans.

**Charging for not attending GP appointments** - We carried out an online `quick survey' asking `Do you agree that patients should be charged if they fail to attend GP appointments?'

This question emerged following discussions at the Patient & Public involvement Group's (PPG) Chairs group when there appeared to be some support for the notion. 62 people responded online with 41 (66.1%) agreeing, 7 (11.3%) disagreeing and 14 (22.6%) who were not sure.

An analysis of the `yes' comments indicate the following themes. Charging or the threat of charging will:

+ Act as a deterrent and make people take greater responsibility for their health care.
+ Help them better understand the costs (in time and money wasted).
+ Help people value their appointment and the service more.
+ Reduce those booking appointments `just in case' and not cancelling when not needed and will open up that slot for another patient.

However, many `yes' voters qualified their support for charging with reference to ascertaining genuine reasons for not attending. Also, that failure should be repeated over a short rather than long period e.g. three times over 6 months. Exceptions included unforeseen circumstances such as emergencies, vulnerable individuals such as those with dementia and those on benefits who would struggle to pay (one suggested charging should be limited to £5). One felt that the practice open to dentists of de-registration for not attending should also be applied. For those voting `no' the main reasons were:

+ There are valid reasons why many vulnerable people do not attend, we can all forget and it is rarely deliberate.
+ There are particular difficulties for carers in getting a cared for person to appointments or in getting someone else to care so that they can attend their own appointments.
+ Things can happen at the last minute and you can't always get through to the surgery to tell them because of wait times holding or because you are tied up in an emergency.

The `not sure' group tried to balance the pros and cons:

+ We all forget sometimes but maybe fine `serial DNA's'.
+ It depends on the person's circumstances.
+ There may be genuine reasons for not attending including dementia.
+ Sometimes it is the receptionist who made an urgent appointment and forgot to cancel the non-urgent one.
+ If everyone turns up you will only have to wait longer.
+ Those that book `just in case' need to advised and counselled out of this habit.
+ It should depend on the ability to pay.

With two-thirds of respondents favoured charging for not attending a GP appointment, the findings of this quick poll appear clear. However, many `yes' voters provided caveats, along with the `no' and `not sure' voters, highlighting the complexities in imposing such charges in a fair and equitable way.

Demand for GP appointments sits alongside other pressures in the NHS e.g. Emergency Care and Out-patients in acute settings. Such pressures require an NHS and community-wide response so that people go to the right place for the right reason. The introduction of social prescribing could be one way of alleviating some of those NHS pressures locally.

HWNEL recommended:

+ That local GP practices (and their Patients Participation Groups) respond to these findings by sharing examples of actions they have taken which have helped to reduce levels of non-attendance.
+ That the findings are shared with the local Clinical Commissioning Group, NHS England (Region) and Local Medical Committee (LMC) for their views.
+ That local responses are incorporated in a fuller report for wider dissemination including Healthwatch England and the Care Quality Commission.

The findings were discussed at the PPG Chairs meeting and the report has been circulated to all GP practices and PPG Chairs with the Chairman agreeing to explore the issue further with the CCG.

**Survey of GP Practices on Did Not Attends -** Following on from the above work on charging for non-attendance, and at the request of the PPG Chairs Group, HWNEL carried out a survey of local GP practices to see what information, if any, local GP practices hold on did not attend activity in order to:

**1.** Get a better understanding of the level of the issue locally including any trend comparisons over time (where available) and how this impacts (waste of clinician time/resources).

**2.** Identify whether it is identified as a particular issue for certain groups e.g. for children or for older people.

**3.** Identify what steps practices take to tackle the problem e.g. information on screens in waiting areas or on websites or telephone or letter contact with patients affected.

**4.** Understand what initiatives have been taken which have proved effective in reducing the monthly out-turn.

Ten practices responded with many providing historical data on levels of non-attendance and some in terms of time lost/wasted and estimates of financial impact to the NHS. DNA rates varied from 2 to 7%. Some practices broke down their non-attendance by age to better target particular groups. However, although some have found that younger adults or parents with young children are most likely to not attend and not cancel the appointment, others say there is no clear difference by age.

A range of strategies are in place across different practices to try to tackle non-attendance including:

+ Most practices responding included information on monthly non-attendance on their screens in waiting areas. Some also included it on their website or on Facebook or Twitter.
+ Some practices sent text messages confirming appointments booked while others sent text messages as reminders usually the day before the appointment.
+ Some followed up with text messages reminding the patient about the impact including cost of not turning up and failure to cancel. Others made telephone calls, including to those who cannot access texts, to better understand the reasons for non-attendance and what the practice can do to help.

- Warning letters were sent stating that continued non-attendance could jeopardise continued registration with the practice.
- Systems are being developed that allow patients to book and cancel online or via texting or email.

Although this question was not raised, it became clear from practices that had surveyed patients that a common feature of non-attendance is simply patients forgetting or being unaware of the appointment or urgent pressures preventing their attendance. Some repeat non-attenders were recognised as having vulnerabilities where a more pro-active approach was needed to secure their attendance including the help of family carers.

The report recommended that these finding were shared across GP practices and that the local Clinical Commissioning Group explore ways of promoting and encouraging a more consistent approach across these local practices.

# Meet the team

**Paul Glazebrook**
Delivery Manager

**Tayo Davenport**
Volunteer & Engagement Worker

**Amy Hallett**
Project Support Assistant (Part Time)

**Karen Smith**
Independent Complaints Advocate (Contract with Carers Federation)

# How your experiences are helping influence change

## Thames Ambulance Service (TASL) -

During the second half of the year we have a raised a number of concerns about Patient Transport Services on behalf of local patients through joint meetings with the local Clinical Commissioning Group and TASL. We have also liaised with our Healthwatch colleagues in Lincolnshire and North Lincolnshire as this has been an area of mutual concern.

**Issues Raised** -

**1.** Patients having to repeat their basic details each time they ring in to book.

**2.** Some patients claim they are having to wait a long time before their call is answered (45 minutes in one case)

**3.** Some patients have either not been picked up for appointments or kept waiting a long time (several hours) before being returned.

**4.** Some patients are being refused PTS on the grounds of not meeting the `medical need' requirement but are not always given advice on all alternatives.

**Response** -

**1.** TASL are developing dedicated PTS booking staff which should improve this.

**2.** TASL says this should not happen as all call staff should pick up any incoming call. However, they are now developing separate lines for booking calls to those for complaints or general enquiries to speed up booking call responding.

**3.** This issue has been compounded by changes to volunteer driver's terms and conditions which led to many leaving the service. These terms have now been renegotiated and some volunteers are now returning. It is also important that the acute Trusts work closely over the timing of hospital discharge to ensure that `peaks and troughs' in demand are smoothed out.

**4.**TASL say they are inviting those refused transport to go back to their GP if they believe their GP will support their request. Patients need to understand that if they can use public transport or a family member or friend can take them, they should do so. Those on certain benefits can claim reimbursement under the Hospital Travel Cost scheme Alternatives like other volunteer driver schemes may also be able to help.

In turn, the CCG will continue to closely monitor performance against the contract.

## East Midlands Ambulance Service -

We tried to get a representative from EMAS to come to our January Board meeting to talk about changes to emergency response arrangements but his car broke down on the day. We then arranged a one-off extra Board meeting in February but the representative took ill on that day. In these circumstances, we resolved to put our issues to EMAS in writing to get a formal response. Here are the questions and responses:

**Question 1** - What is the current strategy?

**Response 1 -** The Trusts current strategy revolves around 5 key areas:

+ Our Performance – we continually work to deliver the performance our patients expect and deserve.
+ Our People – we value and support our workforce to deliver their best for patients.
+ Our Development – we continue to develop our organisation to meet the needs of patients and aspirations of our staff.
+ Our Quality – we continually seek to improve quality for our patients, delivering high quality care.
+ Our Money – we ensure we use our funding carefully, delivering value for money for patients and taxpayers alike

**Question 2** - What are the changes that are being made?

**Response 2 -** The 2 main changes that are being introduced are ARP and to support this rota Changes. ARP is about getting the right clinician on the right vehicle at the right time. This should be backed up by a front face build of the staffing rotas to resource demand again at the right time in the right areas. We have also introduced Urgent care crews that will respond to the lower graded emergencies freeing qualified crews up to deal with the higher grades calls.

**Question 3** - How is the emergency response service going to improve as a result?

**Response 3** - We should see an improvement in response times against RAP standards and the amount of vehicles available at key times. This should improve the patient experience and work towards hitting the KPI's.

**Question 4** – What is the impact of delayed handover times at DPoW Hospital for EMAS and how is this communicated to the acute Trust and commissioners?

**Response 4** - There are delays at the acutes but thankfully NLAG isn't a problem for us. We work very closely with DPOW to reduce the amount of time a crew is in the department by streamlining and constantly reviewing the processes in place. Commissioners and the acute have daily, weekly and monthly data to review the hours lost pre and post-handover. We have worked with NHSI to improve the systems in place. In real time we have daily conference calls to review the issues.

**Question 5** - To what extent are EMAS staff currently able to make a decision that someone does not need emergency care and what, in your view, is needed to divert patients away from this setting?

**Response 5** - Qualified EMAS staff have the ability to use Paramedic pathfinder to support a decision they make to leave a patient at home or direct to another health care professional. To help with these decisions there needs to be more pathways available to staff that they can refer into.

**Question 6** - How can the local community help to make sure that appropriate use is made of the service?

**Response 6** - We use the leaflet (right) to try and promote the right type of pathways patient and the public can follow to get the right type of care.


**Oral Health** - During the year we have been approached by a number of people who have had difficulty accessing an NHS dentist and we have been able to feed these concerns into the Oral Health Partnership that we have attended (also attended on behalf of Healthwatch North Lincolnshire). More recently an Oral Health review was set up to examine Oral Health Promotion across Northern Lincolnshire and we have attended these meetings too and facilitated promotion of a survey which has been completed by just over 600 people. The findings of this are being incorporated into a wider report for publication early 2018/19, with recommendations on how dental care needs can better be met.

# Volunteers

There has been some improvement in our volunteering position at year end as we now have 23 volunteers as opposed to 19 at the start of the year. In particular, our Enter and View resource has grown from 11 to 15 and this has helped us better maintain a programme of visits to residential and nursing care homes.

We want to say a big thank you to those who have retired or moved on from volunteering. For example, we have had two volunteers who have regularly helped us in administrative support and we are delighted that we have been able to provide a positive experience and reference for one of these who has moved into paid employment.

We place on record our thanks to all our volunteers without which Healthwatch could not have been able to carry out its expected functions or have been able to challenge and drive up improvements in local health and social care provision.

# What next?

**One of the aims during transition to a new `host body' was to complete work where possible and not to start new work unless really necessary. Looking at work plan items that were not completed during 2017/18, the following areas have been identified for consideration in the year ahead:**

**Volunteer recruitment** - We have had a small increase in volunteers over the year (from 19 to 23), especially to assist our `Enter & View' activity, but more volunteers are required, particularly to assist in community engagement.

**Working with young people** - This has been led by our Project Support Officer and involves engagement with various groups to raise our profile and secure their views. Recent links to a Youth Matters Workshop and the Nexus Forum (NAViGO) are currently being followed up.

**STP (Sustainability & Transformation Partnership) questionnaire and follow-up** - The survey of `seldom heard voices' over potential changes to health and social care provision locally highlighted the lack of local understanding over the change agenda. We are looking to ensure people are properly engaged in the planning for change moving forwards.

**NLaG** - We have been involved in unannounced visits to Maternity and to Emergency care and have recently carried out a survey of out-patients in conjunction with Healthwatch North Lincolnshire. A quarterly meeting with the trust's Chair and Chief Executive is now in place.

**Domiciliary care** - We have been involved in monitoring pilot developments and we will be discussing with the Clinical Commissioning Group as to how HWNEL can support an evaluation in 2018/19.

**ASD (autism) support** - Progress has been made around a single pathway for 0-5 year olds but continuing issues remain regarding access to diagnosis and effective support (also under consideration by joint Health and Children & Young People's Scrutiny Panel as reported 13.2.18).

**ENT, Urology & Haematology** - Working with Healthwatch North Lincolnshire, CCGs and NLaG to agree a line of questioning and to survey patients affected by previous temporary decisions taken on grounds of safety/urgency.

**Access to GP Services** - Any further review of this has been deferred but we have completed a survey of views about charging patients for not attending and asked one GP practice about Did Not Attend prevalence and management.

**Mental Health Crisis Care** - Healthwatch is now joined to the Mental Health Concordat Group and will use this membership as an opportunity to raise any concerns that we hear about.

# Our finances

How we spent our money in 2017/18

The following provides details on how we funded our work this year.

| Income | £ |
|---|---|
| Funding received from local authority to deliver local Healthwatch statutory activities | 110,058 |
| Additional income | 0 |
| Total income | 110,058 |
| | |
| **Expenditure** | **£** |
| Operational costs | 32,599.96 |
| Staffing costs | 72,190.12 |
| Office costs | 5,267.92 |
| Total expenditure | 110,058 |
| Balance brought forward | 0 |

# Contact us

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## Address of contractor for 2017/18

North Bank Forum
Goodwin Community Hub
63-71 Anlaby Road
Hull
HU3 2LL

## Address of contractor for 2018/19

Meeting New Horizons CIC
The Strand
75 Beverley Road
Hull
HU3 1XL

If you require this report in an alternative format please contact the address above.

healthwatch

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