Ashford and St. Peter's Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS
7th March 2018

TITLE	**Patient Experience Group Report**
EXECUTIVE SUMMARY	The minutes of the meeting of the Patient Experience Group held on 12th February 2018 are attached. Matters discussed in the meeting included: • Quality Report – Patient Experience • Feedback from Patient Panel Meeting • Feedback from Group Members on Recent Visits and Meetings • Feedback from Members to Governors Relating to Patient Experience • Visit to the A&E Department
The Council is asked to:	Note the minutes of the meeting of the Patient Experience Group held on 12th February 2018
Submitted by:	Keith Bradley, Chair of the Patient Experience Group and Public Governor for Woking and Guildford
Date:	March 2018
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS Foundation Trust

Council of Governors

Minutes of the Patient Experience Group
12th February 2018

Room 1, Postgraduate Education Centre, St Peter's Hospital
14:00 – 16:00 hours

PRESENT:	Keith Bradley (Chair)	Public Governor, Woking and Guildford
	Brian Catt	Public Governor, Spelthorne
	Maurice Cohen	Public Governor, Woking and Guildford
	Godfrey Freemantle	Public Governor, Hounslow, Kingston upon Thames and Richmond upon Thames
	Chris Howorth	Appointed Governor, Royal Holloway University of London
	Danny Sparkes	Public Governor, Runnymede, Windsor and Maidenhead
	Bertie Swan	Public Governor, Elmbridge
IN ATTENDANCE:		
	Erica Heppleston	Associate Director of Quality
	Anu Sehdev	Membership and Engagement Manager
	Marty Williams	Assistant Director of Patient Safety
APOLOGIES:	Maureen Attewell	Appointed Governor, Spelthorne Borough Council
	Sue Harris	Staff Governor, Nursing and Midwifery
	Judith Moore	Public Governor, Woking and Guildford

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PEG-01/18 Minutes of Previous Meeting

The minutes of the meeting held on 20th November 2017 were agreed as a correct record.

The updated Action Log was noted.

REGULAR ITEMS

PEG-02/18 Feedback from Patient Panel Meeting

Danny Sparkes advised that one meeting had taken place and three of the seven members mentioned concerns relating to the iMSK service. Bertie Swan advised that she had met with the Associate Director of Operations for iMSK and Trauma recently who had listened to her concerns. He advised that he had recently come into post and that he was aware of concerns and would be looking into them. He was clear that repeat cancellations would not continue to occur. Danny confirmed that the Patient Panel would continue to monitor the situation.

Danny advised that in its efforts to recruit new members, eight people had expressed an interest to join the group. Interviews would be taking place in a

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couple of weeks to ensure people were selected who were interested in the care of patients in general and did not have personal grievances.

Finally, Danny advised that the Director of Operations for Planned Care had conducted a presentation on winter pressures.

The Assistant Director of Patient Safety queried the occurrence of complaints relating to iMSK and the Associate Director of Quality advised that relatively few complaints were received. She had met with the Associate Director of Operations for iMSK and Trauma a few months ago due to problems being raised via PALS (Patient Advice and Liaison Service) in relation to appointments. The PALS Team was tracking concerns and the situation was now in hand.

PEG-03/18 Quality Report – Patient Experience

The Associate Director of Quality welcomed any questions or requests for further detail on the harms section of the report. She advised that improvement actions were in hand apart from in non-elective readmissions. Some deep dives were being conducted and specialty readmission rates were largely static despite winter pressures. Keith Bradly queried whether care homes could be encouraged to make efforts to avoid readmissions and it was advised that recommendations in relation to medical pathways had been made when multiple patients from the same source had been taken to the hospital. This included responsiveness of care homes taking their patients back. It was explained that care homes had their own assessments to undertake and Maurice Cohen reflected on the delays experienced with getting care home staff to come and assess patients.

Godfrey Freemantle queried which readmissions were avoidable and which unavoidable and it was advised that a piece of work had been conducted about two years ago looking at this and improvements had been made. It was clear that patients often returned because they did not know what to do when they were discharged home and it was important to communicate what to look out for and what care to take at home. Maurice Cohen queried whether there was scope for a clinician to visit care homes and the Associate Director of Quality advised that there had been a similar initiative in New Zealand. Community in-reach had been discussed as an option here previously, but capacity and travel time did not support this at that time. However, the Bedser Locality Hub which had been located at Woking Community Hospital had been designed to allow people to access a range of health, social care and community services; all in one place in order to assist with preventing readmissions also.

In response to Chris Howorth, the Associate Director of Quality advised that readmissions counted even if these were for a different condition than previously admitted. The Group considered this unreasonable and it was agreed that this would be double-checked. It was further advised that to analyse each case would require a lot of work. The range of readmissions was similar to other trusts although national data had not been available for some time. **EH**

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In response to Chris it was advised that the vast majority of patients fell into the General Medicine specialty. Whilst the Trust was taking actions to reduce readmissions, time would tell whether these actions were sustainable. The Assistant Director of Patient Safety advised that daily CAT meetings took place where patients fit for discharge were discussed. A red bag went with patient upon discharge which contained all the necessary information for care homes as well as the Trust should the patient return. Danny Sparkes spoke about her attendance at two ward rounds when she had noticed that no one was taking notes and queried whose responsibility it was to take the actions discussed. Brian Catt relayed his personal experience of being a patient on a ward and how he noted the same but that everything was undertaken that was suggested. It was advised the junior doctors took the actions and nurses should be taking notes. It was agreed to check with ward managers what the process was. **EH**

The Associate Director of Quality moved onto the Friends and Family test (FFT) and advised that response rates in some areas were low. There was an improvement project in place to improve response times, ownership of complaints and allow learning from complaints.

The Group then discussed SIRIs and how there were 11 reported in December. This number included four historical cases that had not been reported previously. Delays were often experienced when they were coroner/Police cases. The Assistant Director of Patient Safety advised that efforts were being made to improve attendance at weekly Quality panel meetings where potential SIRIs were discussed.

Keith Bradley welcomed the recent inquest reports that had been shared with the Governors.

FEEDBACK

PEG-04/18 Feedback from Group Members on Recent Visits and Meetings

As mentioned previously, Danny Sparkes advised that she had taken part in two ward rounds accompanying management trainees.

PEG-05/18 Feedback from Members to Governors Relating to Patient Experience

The Group members had nothing to feedback.

PEG-06/18 Any Other Business

Bertie Swan mentioned an initiative whereby a dog would visit wards so that patients could be allowed to engage with the dog. It was agreed that the Deputy Chief Nurse would be asked whether this was an initiative that could take place at Ashford and St Peter's. **AS**

PEG-07/18 Tour of A&E

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The Associate Director of Operations for Emergency Medicine welcomed the Group at the entrance to A&E.

The Associate Director of Operations for Emergency Medicine advised that the Urgent Care Centre (UCC) which was opposite the A&E Department opened its doors between 08:00 and 21:30 hours and outside these hours minor patients were seen at the front of the A&E Department.

The Associate Director of Operations for Emergency Medicine advised that patients that were brought in by ambulance were escorted to the main A&E Department on a stretcher. If patients came in of their own accord then they were directed to the UCC. It was advised that the UCC would soon be changing its name to the UTC (Urgent Treatment Centre).

In the UCC, patients were greeted by the screening nurse who asked a few questions regarding their symptoms, took some general observations and made a decision whether the patient should be seen by an Emergency Department (ED) doctor or GP. Very ill patients were moved to the main A&E Department. In response to Maurice Cohen the Associate Director of Operations for Emergency Medicine advised that the 3 GPs employed all worked part-time in the department to cover the rota 7 days a week. The Associate Director of Operations for Emergency Medicine advised that the UCC saw over 100 patients per day and attendances were up this year to be over 100,000 for the year.

The Associate Director of Operations for Emergency Medicine moved the Group inside the UCC and advised that the streaming nurse completed a streaming form when first reviewing a patient which was then given to the patient to book in with the receptionist. The receptionist would then direct the patient to either the main UCC waiting area, to see the GP, or the main A&E Department. It was advised that the Trust was still experiencing winter pressures and no day was quiet. The Associate Director of Operations for Emergency Medicine advised that 40 patients were in the UCC that day and Mondays were generally the busiest day.

Maurice queried what proportion of patients was referred by GPs and it was advised that this was around 30%. Also 30% of patients were transferred from the UCC to be seen in the main A&E Department. Paediatrics had a separate area.

The Group was directed to where ambulances parked up by a special entrance to A&E. Critical patients were moved to the Resus area. On arrival 2 paramedics accompanied a patient, with one staying with the patient and the other booking the patient in. The Associate Director of Operations for Emergency Medicine showed the Group the Psychiatric Liaison Nurse room.

The Group moved to the main area and the Associate Director of Operations for Emergency Medicine advised that several porters were based there as well as there being a separate area for specialty doctors. The Group was shown the

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Resus area which housed 4 beds and a paediatric bay. This area had its own entrance. When a call was received from the ambulance service that a very ill patient was being brought in, staff would prepare the area and receive the patient. After resus the patient would move to the majors area which had 5 spaces. More nurses were made available to look after the very ill patients.

Ambulance trolleys were able to move through the area to the pit stop area which had 7 spaces where a handover between the paramedics and nurses took place and where patients would get ready to be seen by the doctors. If more patients arrived than could be accommodated in the pit stop area then the department corridor was used to queue patients. After this the main hospital corridor was used and screens were put up to ensure a level of privacy and dignity. There were nurses that covered the two immediate corridors. When patients were waiting in the main corridor, paramedics stayed with their patients until a handover from the nurse occurred. The room that was previously the multi-faith centre was now the Clinical Decision Unit.

The Associate Director of Operations for Emergency Medicine highlighted that there were capacity problems currently being experienced in the hospital with delays with patients deemed fit for discharge still in a hospital bed.

The Group was informed that ED staff had a maximum of 15 minutes to complete a patient handover with the ambulance crew otherwise the Trust was fined. The 4 hour target to see a patient, make a decision and move them to the right place passed very quickly. Brian Catt queried how much longer was needed, on average, to complete this process and it was advised in winter pressures with high attendances to achieve the 4 hour target was a real challenge with an extra hour being the norm.

The Associate Director of Operations for Emergency Medicine advised that it was considered that very sick patients that could not be moved within the 4 hour target were cared for in the A&E department until clinically stable to move and these were termed as clinical breaches.

The Associate Director of Operations for Emergency Medicine reminded the Group that the Trust was experiencing winter pressures and that from Spring onwards there would be less queuing. Also when there was clear "flow", in the department and hospital, ie when patients were able to leave punctually when discharged, the Trust performed very well on the 4 hour target, achieving 95% compliance.

The Group was shown the cubicles for trolleys which could accommodate 15 patients.

It was confirmed that A&E specimens were prioritised by Pathology and containers for specimens were coloured yellow. Radiology provision was very good with two x-ray areas in the department and the availability of a CT scanner nearby.

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The Associate Director of Operations for Emergency Medicine advised that patients that were brought in dead were taken to the Resus area initially and then transferred to the body viewing room. It was confirmed that the incidence of nursing homes sending their patients to hospital to die had been noted and comments fed back to the nursing homes concerned.

The Associate Director of Operations for Emergency Medicine talked about the Same Day Emergency Care (SDEC) service which was for ambulatory patients seen in the UCC and brought in by ambulance that required treatment that would be over the 4 hours but not needing to be admitted.

The Associate Director of Operations for Emergency Medicine spoke a little about the proposed new build which would include an assessment area and how this would be very useful when the Trust was under pressure. The new build would be where the existing A&E car park was and would have three floors. The first floor would be the UTC, the second floor would be the Integrated Assessment Unit and the third floor was undecided at present.

The Associate Director of Operations for Emergency Medicine told the Group a little about her previous experience when she had been in the army and a member of the Queen Alexandra's Royal Army Nursing Corps where she got to the rank of full Colonel but took the decision to move to the NHS to allow for better family stability. She had worked with Chief Executive previously and it was through discussions and time spent with her how she became attracted to the NHS. This was not a decision she had regretted.

The Group members thanked the Associate Director of Operations for Emergency Medicine for showing them around the department.

Date and Time of Next Meeting

Monday 9th April 2018, Room 1, Postgraduate Education Centre, St Peter's Hospital

Further Dates for 2018

Monday 2 July
Monday 10 September
Monday 19 November

All 2-4 pm in Room 1, Postgraduate Education Centre, St Peter's Hospital

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Action Log

Meeting Date	Minute Ref	Topic	Action	Lead	Due Date	Update	Completed
20.11.17	**PEG-42/17**	**Dementia Care Update**	Invite Dave Sills to update the Group in 2018	AS	Nov 2018	ND	
12.4.18	**PEG-03/18**	**Quality Report – Patient Experience**	Check the conditions applicable when patients readmitted within 30 days resulting in fines being issued	ER	9.4.18		
12.4.18	**PEG-03/18**	**Quality Report – Patient Experience**	Check process during ward rounds with ward managers	ER	9.4.18		
12.4.18	**PEG-06/18**	**Any Other Business**	Speak to the Deputy Chief Nurse about the possibility of allowing dogs on the wards for “patting”.	AS	9.4.18		