North Kirklees Clinical Commissioning Group

Francis Report Discussion Group Notes

24th April 2013

Present: Deborah Turner (Head of Quality and Safety, NKCCG), Richard Palmer, Christine Hyde, Rochelle Hall, Pauline Cooper, Malcolm Hirst, Eileen Wilkinson, Ebrahim Raja, Kirsty Wayman (Engagement lead, WSYBCSU), David Kelly (Chair, NKCCG), Zubair Mayet (Engagement, WSYBCSU)

Deborah welcomed everyone to the session and gave a brief overview of the purpose of the session. Francis Report 1 was published in 2010 based on the failing of Mid Staffordshire as over four years, 1,200 patients died needlessly. Francis Report 2 was published in 2013 and the Governments response is that patients should be first and foremost.

North Kirklees Clinical Commissioning Group (NKCCG) would like to know from a patient / relative perspective, how would you know that services are safe?

What hasn't worked? What are your concerns?

Staffing on wards

- Ward 6 has a low number of nursing staff. The nursing staff are very good but due to low ratio of patients to nurses this drastically affects the quality of care that they can give. One night during a patients stay there was over 26 patients and only two nursing staff.
- Dewsbury District Hospital (DDH) does not have a very good reputation as patients feel that staff are busy doing paperwork as there are no ward clerks to do admin tasks. The problem seems to be caused by the management of hospitals and not the ward staff. There is difference between Wards in allocation of clinical staff.
- Staff morale is very low in DDH, they do not have time to give the expected level of care to patients.
- Having few staff on the wards makes you feel vulnerable and angry when you observe other patients not getting quality of care that they are entitled to. This results in patients having to look after each other on the word to compensate for the lack of staffing.
- A member of public talked about their stay in hospital, where they felt helpless when another patient was stranded in the toilets and they were told not to assist them.
- Raised a concern regarding staffing on Children's ward and was told 'can't knit nurses'. Doesn't encourage people to raise concerns. Staff morale on ward is very low, had 3 health care assistants / interpreters now have 1, so now using family members to translate to patients, this is not appropriate.

Quality of care

- Patients get incomplete information; many want to understand how they can self-manage better. But this can only be achieved if Consultants and GP's are open and honest and help patients understand their symptoms. Keeping patients informed is critical.
- Families are not always aware what their loved one is undergoing and patients themselves do not necessarily have the confidence to articulate their views.
- Many patients talked about having to bring their own meal to have the correct nutrition and a balanced diet. Concern was raised about patients not being monitored to ensure they were eating.
- There needs to be smoother flow of patients between the three sites of Mid Yorkshire. Seeing the right person at the right time and providing a seamless level of care.

Raising concerns

- How can we encourage nurses to raise their concerns to management?
- Many patients feel if they do flag an issue their quality of care would be affected.
- Complaints are not dealt with and more scrutiny should be given to all Providers that CCG's commission.

Communication

There is lack of communication between GP, hospitals and Specialist Consultants. There is usually a delay in information being cascaded between all the parties which causes concern for patients, how do we know we are getting the correct treatment / advice?

Appointments

- Appointment system for rheumatology is not working. There are none available, it is very difficult to get through on the phone to make an appointment, and people are being missed. The team are very good but due to IT problems it is creating real problems for staff and patients.
- Systems / processes are not working which worries patients, especially when they are being told that appointments have been missed.

Location of services

- If you want to make services safe for children, DDH should not lose its Paediatric Ward. The distance between DDH and Pinderfields is over 45 minute. This is critical when time is the difference between life and death.
- From feedback of Older Peoples Network members, the most crucial aspect for them is to have a hospital that is close by and within good proximity for family and friends. This also speeds up recuperation.

Discharge process

- Delays in medication / papers
- Lack of communication

- Lack of co-ordination
- Coronary care unit – fantastic discharge, felt looked after and confident that there would always be someone to talk to should any concerns / worries arise.
- Someone else talked about the good care their mother had received and how everything had been done for them by the social worker and how it was great not to have to worry about any of it.

Travel / transport

In DDH foyer there should be more accessible information for public transport.

Community Matrons

In North Kirklees the Community Matrons are excellent; they are always available and have the knowledge to help you.

Have you seen anything that works?

- High staff ratio leads to confidence and reassurance to patients.
- Should be able to access the right care, right time in the right place. Be admitted to the right ward first time, continuity of service / staffing.
- An ideal scenario would be there is one point of contact that would be aware of all your conditions and had a log of all the medication.
- Want to be located close to home to enable family to visit.
- Having someone to talk to that knows about your condition gives you confidence and reassurance.
- COPD Expert Patient Programme was very successful why has this not continued?
- University students being taught by patients how to treat patients.
- Newly diagnosed diabetic children have open access to children's ward and have access to community nurse at anytime to do home visits.

If you could ask nursing staff one question what would that be?

- Would like to know – what do you like about where you work? What causes you concern?
- Trust is very important and needs to be incorporated in all aspects of care. How do we develop that trust?
- Positive difference can be made by patients feeling safe, having a trusting environment and staff that are knowledgeable and compassionate.

What should NKCCG put in place to make a positive difference?

- Get information to GPs post discharge quicker
- Create an environment where patients feel safe, knowledgeable, have trust and communication
- Knowing that will be told what is happening, trust in where the treatment will be received, looked after, easy to be visited, good food
- Single point of access

- Process to enable people to raise concerns without having to submit a formal complaint
- Volunteers to help patients eat
- Healthwatch could be part of patient safety walks. Look at visiting ward 6.

Deborah thanked everyone for coming and participating in the discussion. She agreed to send the notes from the session to all attendees. In addition to the notes, Deborah will send the draft action plan, for comment, that she is developing in response to the Francis Report 2.