Enter & View Queen's Hospital, Romford: Ophthalmology Outpatients' Department

24 November 2015

One of a series of connected
Enter & View visits to Queen's Hospital in 2015

Healthwatch Havering is the operating name of
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What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

Healthwatch Havering had taken the decision to conduct an Enter and View (E&V) of the Ophthalmology Unit at Queens as they had heard a number of concerns from patients regarding the service provided at the Ophthalmology clinics and the Eye Casualty at Queens Hospital.

- Some concerns centred around patients being evaluated at Queens but sent to Moorfields for surgery rather than receiving

treatment at Queens despite Queens Ophthalmology being one of the largest Ophthalmology units in the country. Moreover, there were concerns for patients having to travel to Moorfields, which is over 15 miles away, most of whom would need to use public transport.

- There were also suggestions in CQC reports that the Ophthalmology Unit had improved the efficiencies in clinics, with few short notice cancellations of appointments, compared with 60% of appointments being cancelled at the beginning of 2014. Despite this statement, Healthwatch had been told of a number of complaints, suggesting that there were still issues with cancellation of appointments.
- Another concern was that the unit suffered from space issues as there is a large number of patients attending several eye clinics and Eye Casualty each weekday. This posed issues concerning space for patients presenting with infections and areas to accommodate paediatric patients and patients with learning difficulties.

The visit

On arrival, the Healthwatch team was met by the Matron and a Senior Nurse in the reception area. The Matron is in charge of Ophthalmology, Trauma and Orthopaedics, ENT, and King George Hospital's day wards Amber A and B. Of those units, only Ophthalmology covers outpatients. The Senior Nurse is in charge of the Ophthalmology units, both ICAS and outpatient clinics: her background is in Ophthalmology and she has worked in many hospitals including Moorfields and Western.

The reception desk is inside the entrance to the unit and three receptionists cover the registration for both ICAS and for outpatient clinics. Our initial observation is that the area is very small and gets congested very quickly when a number of people arrive together.

There is a white-board notice board to the left as one enters the reception area, which gives details of the doctors associated with the outpatient clinics and the ICAS information. The reception desk is straight ahead and the general waiting room is to the right of the entrance. Just to one side of the area going into the waiting room is another white-board with the same details repeated. In addition, on this board there is information identifying the length of delay for each clinic. At 3.45pm on the day of the visit, the time-delays for three clinics were listed as: 1 hours 20minutes, 45 minutes and 60 minutes, respectively. Although this is useful information, its relevance to individual patients was less than it might have been as there was no way for patients to see how many people were in front of them in the queue for each clinic. Another issue was that the white-board is often leaned against and some of the information can be erased. It would be better if this board was situated around the corner in the waiting room where patients would be able to see it while they wait to be called to the clinics: the team was told that there were plans to move this board in the near future. A television on the wall in the waiting area, to provide information about clinics waiting times, etc., was not functional at the time of the visit.

The team asked if the ICAS was referred to as Eye Casualty (EC). They were told that the name and the processes were currently under review as there is a need to respond to patients' needs and GP and optician referrals. Recently two new primary care staff have been appointed.

The team asked what qualifications the reception staff required to do their jobs. Neither the Matron nor the Senior Nurse was aware of any special requirements beyond the standard Queen's Hospital training as their roles were to register the patients for either Eye Casualty or for the specific clinics. With regard to EC, any critical emergencies would be triaged immediately. There are two triage nurses on duty all the time and most nurses in the unit can cover the triage process. Staff are rotated so that cover can be provided in case of illness or staff leave.

One of the triage nurses acts as the coordinator whilst the other forms part of the emergency or chemical injury team. Generally, the triage nurse prefers to be on duty in this role all day rather than be rotated morning and afternoon.

Only patients requiring surgery for retinal detachment are referred to Moorfields Hospital because Queen's does not have the facilities or staffing for these operations. When a patient presents with retinal detachment, Moorfields is called and often they are given an appointment there the next day. Patients make their own way to Moorfields.

The nurses said that they are well supported by the doctors in EC. The team was told that 35 or more patients regularly present at EC each day and, of this number, more than 24 are treated. The area for treating EC patients is very small. The nurses said that they have been working with Beta Mansouri to see if they can improve the space for both EC and the clinic and support area.

The team was told that there are 12 slit lamps in the unit. All doctors and three nurses are qualified to use the slit lamps. All patients in EC and outpatient clinics have a slit lamp test done at some point. After registering at the reception, patients are given slit lamp tests. Ideally these tests should be done by a nurse practitioner. Slit lamp tests are not difficult to interpret and are used in conjunction with the eye problem history. The slit lamp shows up conditions such as raised pressure or scratches on the eye. Patient's notes are recorded on Symphony. The notes are hand drawn and are not computerised as they show the area of the eye that is affected. As far as the Senior Nurse knows there is no system in operation in the UK using computerised electronic systems for recording this information.

In answer to a question about the number of patients seen in EC in a year, the Senior Nurse said that 24 or more patients are seen every day, 5 days a week. As about thirty-five patients present each day at reception and are triaged, at least nine or ten patients presenting at

EC are not emergency cases. The area used for triage is very small and is in a room shared by two doctors giving treatment to patients. The three cubicles open onto a central area and are cubicles rather than separate rooms, so privacy is an issue and as the cubicles are close together it may be difficult to hear what is being said as other peoples' conversations impinge. The EC operates from 9am to 4.30pm but patients are treated much after this time. There is no on call service at Queens. This is being looked into at the moment.

Owing to the limited space available in the department, there is no room to have a separate children's area for EC. Children are generally dealt with quickly and at reception if a child presents they will be given priority. Although there is no separate area for children in EC in the clinic waiting area, when the paediatric clinic is held on Mondays and Wednesdays a screen which has colourful tropical fish on it separates the adults' area from the paediatric area with signage identifying the area as the children's waiting area. There are two paediatric consultants.

With respect to adults or children with learning difficulties, nurses generally know them and endeavour to get them treated straight away. For new LD patients they have to rely initially on the notes that accompany them but once the staff are aware of the patient's condition they try to treat them first. Patients' notes are on Medway now and the notes follow the patient around.

There is no helpline for EC patients at Queen's. The Senior Nurse is looking into setting up a telephone triage system and in fact a new recruit to the team has had experience of the telephone triage system in their previous post. The Senior Nurse is aware that patients say it is very difficult to get through to the Eye Unit at Queens hospital and this causes problems for patients.

The EC unit adheres to the hospital policy on infection control. Rooms are cleaned regularly. If a patient presents with a suspected infection,

they are taken away from the area where other patients are waiting. When treating patient with infections the nurses gown-up in green scrubs. The masks and other infection control materials are held on resusc. trolleys.

General Questions

In general, the main issues for the department centre around the limited space available. It would be good to have a separate paediatric area within the unit but this is unlikely. Another issue for the unit is lack of storage space. Changing the colour of chairs from grey to a bright colour would provide more contrast for visually impaired patients. The staff felt that they are working closely as a team and looking at ways to improve.

The numbers of patients on a day-to-day basis varies considerably, as there are four or five separate consultant clinics as well as laser and orthoptists of two different types.

The waiting list at Queens for ophthalmology outpatient operations at the time of the visits was 3,518 and for admitted theatre operations 310. The waiting time for Cataract operations was until first week in January 2016, for Children's operations (such as squints) first/second week in February 2016, for Cornea/External eye operations the third week in December 2015, for retina operation the first week in December 2015 and for Oculoplastics the first week of January 2016.

The only eye operation outsourced to other hospitals is retinal detachment surgery, which is carried out at Moorfields.

1The staff were aware of Sight Support services and said that they provide a vital service for patients. Members of staff inform patients of their presence in the unit and also give patients leaflets on Sight Support. Sight Support representatives are based in the Ophthalmology unit in a bright yellow area in the room, which doubles as the Laser treatment room. They disseminate leaflets and CDs to patients as well

as provide advice on a one to one basis. The team were aware of cases where relatives accompanying patients had not been told of the Sight Support services. This highlighted an issue of patient confidentiality if they are not with the patient when the information is disseminated.

In the clinics' waiting area, leaflets on AMD, diabetic macular oedema, glaucoma and many other conditions were available on a wall mounted display stand. However, some of the information on services and conditions is too large for the wall racks and these are placed on a table in the corner. However, we were told that the nurse planned to set up a bigger leaflet rack that would provide space for displaying all the literature available in a more visible and accessible way. This would go some way towards patients and relatives being able to access useful information on conditions and services available. Asked if the staff had heard of Mike Brace and his support group charity – they had not. The nurse also said that The Royal National Institute of Blind people (RNIB) is a very good source of information for patients and families although when patients are told about it they think it is not for them as they may only have slight sight impairment. An interesting comment was that RNIB should consider being re-named, as it does not convey the message that it is open to people with sight impairment.

Laser treatments are used for patients who have received cataract surgery, acute raise in eye pressure, diabetic patients for sealing vessels in the eye and retinal problems.

In answer to the question do consultants recommend the issuing of a Certificate of Visual Impairment (CVI) very often if the patient is diagnosed with visual impairment we were told that this was the usual procedure. Sight Support really helps patients understand what is available for patients with sight impairment and how to approach getting help.

Patients who have been to Queens before with sight problems will have their notes on Medisoft and this information will be available to the EC triage nurse.

Only one patient who presented with an eye problem has been admitted to a ward in the last six months or more.

A HWH representative pointed out that 60% of stroke patients have some level of sight impairment and asked if referral of stroke patients to the eye clinics was common practice. The nurse said that they have stroke patients referred to the eye clinics but was not aware whether this is standard for all stroke patients.

There are five clinics in the morning and five in the afternoon Monday to Thursday and five clinics in the morning on Friday. Staff training is carried out on Friday afternoons but there is also a Laser clinic. On the day of the E&V Mr Kahir has approximately 8-10 patients morning and afternoon. Different consultants will have a different mix of new and follow-up patients and this will dictate how many patients require slit lamp tests.

In answer to the question can you explain what the "one stop shop" as mentioned in the CQC report means, we were told that when a patient who needs surgery sees the consultant, they will have their pre-assessment and then will be given a date for the surgery. In this way, the consultant manages their own operations list. In the case of patients who have wet AMD, patients will have the full range of tests and will be given an injection on the day. Patients are given a choice whether they want to have the injection the same day. Similarly, patients who have diabetic macular oedema may have their first injection under the one-stop setting and will get appointments for the follow-up injection at a clinic 4-6 weeks later.

The main concern for staff is the lack of space, which prevents initiatives being implemented, which could help to improve the efficiency of the unit. At the moment there are only two vision assessment lanes. If there were two more lanes this would improve the throughput. For instance, there are five consultant clinics with only two vision lanes, at 8.30 am in the morning all eight patients need vision assessment thus staff are playing catch up right from the start.

Four vision lanes would mean that vision assessment would not slow up the pace that patients can be treated at the clinics.

Another nurse HWH representatives interviewed, also voiced the need for at least four vision lanes, as this in their opinion would lead to much quicker throughput of patients and patients would spend a lot less time waiting for tests.

The orthoptic assessment area doubles up as the laser treatment unit. This is not an ideal situation. Laser treatment is used for follow-up after cataract surgery, acute rise in ocular pressure, used for diabetic patients to seal vessels in the eye and for retinal problems.

The nurse said that they felt valued and listened to and there is a good culture of being listened to. However, the lack of space to set up new initiatives to improve the flow of the clinics was a constant problem. One initiative of doing an audit of the eight patients who present at clinic at 8.30 am to follow what the situation would be for them by 10.30 am would be quite revealing and would provide opportunities to see how processes could be changed to improve patient flow.

Speaking to patients

The team spoke to patients waiting in the waiting room and unfortunately a number of patients had been waiting a long time.

One patient who had an eye ulcer came to the EC at 11.45 am and was seen for 5 minutes and was told to wait in the waiting room. They had been triaged at 2.45pm and was still waiting at 4.15pm. The HWH representative spoke to the optometrist to see if the patient could be seen right away as they had been waiting a long time and the light was causing the patient discomfort. A darkened room for the patient to wait in would have caused the patient less discomfort.

Another patient had presented at King Georges at 6.35am and seen by a doctor who said they should go to the EC at Queens and the EC would be told they were coming as the person had a chemical in their eye.

They should come before 3pm as the eye clinic closes at 4.30pm. The patient did not know that they needed to book in at reception hence was not in the system as they did not book in at reception. Misinformation from ringing to make an appointment meant they were still waiting at 4.30pm.

Recommendations

- There is a need for more space in a number of areas of the Ophthalmology Unit – the reception area and waiting area get congested really quickly when a number of patients present at EC
- In particular, consideration should be given to improving the number and accommodation for using slit lamps. Staff were observed during the visit looking for rooms and lamps to use, which is not suggestive of good organisation
- The triage room for EC is very small and is not very private it is recommended that the triage room is larger and more private
- It is recommended that there are at least two more slit lamp lanes for visual assessment, which would reduce the delays in waiting for assessments
- Setting up a telephone line for EC patients would help with potentially reducing the number of patients presenting at EC who do not need emergency treatment and also improve the communication between GPs and EC staff
- Having rooms which don't double up as laser treatment rooms and eye support area would be better for patients and staff
- An audit of all patients attending the five clinics and laser clinics each day for a period of time would be a valuable exercise to see what are the main hold ups in the dealing with patients and identify what changes could be made to improve the experience and the times

- Providing a darkened room for patients to sit if they have ulcers or other painful and light sensitive conditions while they wait for treatment would be recommended.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on [date] and is representative only of those residents, carers and staff who participated. It does not seek to be representative of all service users and/or staff.

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
enquiries@healthwatchhavering.co.uk

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