Healthwatch Stoke-on-Trent Independent Strategic Advisory Board

Wed 01 May 2024 10am

Virtaul session

Agenda

	Item	Enclosure *(Paper, Verbal etc)*	Outcome *(Noting, Decision etc)*	Presenter
1	**Welcome and Apologies**			Chair
2	**Declaration of Interests**			All
3	**Notes and Action Log from last meeting 2024 02 27**	Enc 1 Enc 2	Approval	Chair
4	**Work Programme Project Updates**	Verbal	Noting	CE
5	**Meeting feedback reports by HAB members/ staff/ CE**	Verbal	Noting	CE
6	**Intelligence/Feedback update – public issues**	Verbal	Noting	CE
7	**Decisions to be made by the Advisory Board**	Verbal	Noting	CE
	A Escalation to HW England/ CQC			
	B Publish a report / agree a recommendation made in a report: Maternity Enter and View Report Visual Impairment report	 Enc 3 Enc 8	Approval	
	C Request information from commissioners/ providers			
	D Which premises to Enter and View and when (Completion of the Enter and View visit checklist is required)			
	E Decision about subcontracting/ commissioned work			
	F Whether to report a matter concerning your activities to another person- e.g. CCG, Voluntary Sector, another Healthwatch, Advocacy services			
	G Which health and social care services HW is looking at for priority project • **Enc 04 HWSoT DMP - Annual Priority Checklist - Maternity Services** • **Enc 05 HWSoT DMP - Annual Priority Checklist - Carers Virtual Forum** • **Enc 06 HWSoT DMP - Annual Priority Checklist - Community Offer** • **Enc 07 HWSoT DMP - Annual Priority Checklist - Coproduction strategy**		Approval	
	H Refer a matter to Overview and Scrutiny committee			
	I Breach/s of the decision-making process			
8	Health and Social Care Issues from the public	Verbal	Noting	CE
9	ISAB (Independent Strategic Advisory Board) – New framework	Enc 08	Adoption	CE
9	**AOB**			Chair

	Item	Enclosure *(Paper, Verbal etc)*	Outcome *(Noting, Decision etc)*	Presenter
10	**Date and Time of Next Meetings:** **Need to set dates through year** Formal Public ISAB: (May), Oct, Jan - all face to face APM (Annual Public Meeting): Jul 04 Informal private ISAB: Jun, Sep, Nov, Feb, Mar - virtual and face to face			

Chair – Healthwatch Advisory Board Chair

CE - Chief Executive

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Healthwatch Stoke-on-Trent Advisory Board
Thursday 07 September 2023 – Virtual meeting
Public Board Meeting Minutes

	Item
1	**Welcome and Apologies** Present Simon Fogell (SF – CEO) Lloyd Cooke (LC – HAB Chair) Mike Dixon (MD – HAB) Marilyn Marathe (MM – Volunteer) Casper Pulling (CP – Volunteer) Sophia Leese (SL – Staff) No apologies received.
2	**Declaration of Interests** None stated.
3	**Minutes and Action log from Public Board Meeting held on Thursday 27 April 2023.** Collectively agreed last minutes were a correct record.
4	**Work Programme Project Updates** - SF reports that the work on Parkinson's has now finished, with a report attached in the HAB documents. Shares that the carers survey has now closed with a total of 135 responses. Responses to the carers survey were collected both online and through the team attending various carers groups in person, this was also supported by the ECS research team as they had capacity. In the sensory impairment work, the team had only received a response from visually impaired groups and so are moving focus to work with those groups on visual impairment. - MD asks if able to reconsider the work with hearing impairment due to the day-to-day impacts of having a hearing impairment, however, understands the team's difficulties in getting responses from local organisations and close contract term. SL and MD to meet up to discuss further.
5	**Meeting feedback reports by HAB members / staff / CEO** - SF shares that Stoke have been proactive in preparing for their new round of CQC assessments through holding workshops whether they put forward the patient point of view and make sure to involve the voice of the people in decisions. Significant contributions to the meeting were made collectively with Expert Citizens and VAST, and they are looking to further build relationships with the voluntary and independent sectors. - SF attended another meeting where they were looking at the voice of young people and how that fits into the wider systems. SF pointed out that he feels that children's and young people's services often perceive Healthwatch as an adult-only service and reminded them that Healthwatch is a "cradle to grave service". Feels that with more promotion and involvement in younger people's services that Healthwatch services could add to their work. - SF highlighted concerns surrounding infant mortality rates in the Stoke-on-Trent areas and how it also has many areas of deprivation. Would like to work with these services to find data on if they are having significant impacts on each other. MM added that health visitors have 'disappeared' and does not know of a health visitor that visits in-person. Yet they play an important role in the community in educating and supporting mothers, but also to generally look at the babies and young children's health and wellbeing. SF agrees that there is so much more intelligence that can be picked up by visiting the home rather than the remote approach.

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	- LC attending meetings that echoed the concerns regarding children's services and social care. The City Council shared their new corporate strategy, where many plans related to health issues particularly children's services and social care. Shares that their first priority is 'Healthier', as Stoke is worse than the national average in many aspects. Added that the City Council are financially stretched and combined with the social care and its knock-on effects with health – there hasn't been a more demanding and difficult time. - SF recognised that Health and Wellbeing Board Meetings had got increasingly shorter, with an added 15-minute pre-meet where decisions could be pre-planned. SF found this concerning and waits to see if a refresh of the administration and chair of the board will scrutinise health and wellbeing in the city and ask the awkward questions.
6	**Intelligence/Feedback update – public issues** - SL shares that most intelligence received has been in relation to ongoing projects, however, has noticed an 'ebb and flow' of NHS dentistry intelligence. NHS dentistry has been one of the most prominent issues over the last couple of years and had quietened down in recent months, except for the last month where 50% of intelligence received, excluding any project-based intelligence, was regarding NHS dentistry. SL is unaware of any movement in NHS dentistry other than that they are trying to continually increase the amount of appointments. - Other rising concerns are that people are unclear on whether or not they're receiving NHS treatment or private healthcare. Particularly in some NHS apps and dentistry, where people are agreeing to 'jump queue', not realising that this is them agreeing to go to private and then being met with private healthcare charges.
7	**Decisions to be made by the Advisory Board**
7a	**Escalation to HW England/ CQC** – none
7b	**Publish a report/ agree a recommendation made in a report** - Annual Report 22/23 and Parkinson's report have been approved. - MD found the layout, wording, information, content, and use of data in the Parkinson's report was "absolutely fabulous". Aldo found the comments from MPFT added more weight to the report, especially as they were from the Parkinson's service within MPFT rather than the wider MPFT. Would like to see this standard continue in future reports.
7c	**Request information from commissioners/ providers** - none
7d	**Which premises to Enter and View and when (Completion of the Enter and View visit checklist is required)** - SF shares that the team have been offered the opportunity to do a joint visit with Healthwatch Staffordshire at UHNM on the maternity services. This enter and view was initially planned for an earlier date in the week however needs to be rescheduled. Adds that Tracy is pulling together and Enter and View programme for the last months of the current contract.
7e	**Decision about subcontracting/commissioned work** - none
7f	**Whether to report a matter concerning your activities to another person- e.g. CCG, Voluntary Sector, another Healthwatch, Advocacy services** – none
7g	**Which health and social care services HW is looking at for priority** – none
7h	**Refer a matter to Overview and Scrutiny committee** – none
7i	**Breach/s of the decision-making process** – none
8	**Health and Social Care Issues from the public** - MM concerned about the pace of primary care and community services bringing people to an 'IT world' who do not have the IT knowledge to access some services. SF adds that digital is great and needed, however continues to challenge services on how they are going to give equal access to services and resources if people can't, won't or don't have

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	the means to use digital. MD shares Digital Skills Workshop poster and adds how there are so many services and benefits that could create a decent lifestyle for people but are tied up with being digital, and so people are being made to get the hang of technology to access services. - CP noticed there it takes a long-time for people with IBD to start long-term treatment from being medicated short-term with steroid treatment. Questions that had been forwarded to the IBD team regarding treatment had been left unanswered, as they responded with a booking for a telephone appointment in a months' time. Recognises that the team is small which could be a factor in delay. SF confirms it would impact it, however if IBD is left unmanaged there is a risk of severe flare-up which would need hospital admissions and could lead to further health issues, which as well as being a problem for someone with IBD it would also be more costly to the NHS.			
9	**Any other business** – none.			
10	**Date and Time of Next Meetings:** • 7 December 2023, 11am – 1pm.			

Chair – Healthwatch Advisory Board Chair
CEO - Chief Executive Officer

Public Independent Strategic Advisory Board
Action Record 2024 – 2025

Enc 02 Public ISAB 01 05 2024

Date / Ref	Action	Owner	Update	RAG Status
2024/5}001				

healthwatch Staffordshire

healthwatch Stoke on Trent

Enter and View Report

Maternity at Royal Stoke Hospital

20th November 2023

Report on Joint Enter and View Visit to Maternity Unit University Hospital North Midlands, Undertaken by Healthwatch Staffordshire & Healthwatch Stoke-on-Trent on 20th November 2023 9 am-3 pm

Service Provider: University Hospital North Midlands

Premises Visited: Maternity Services UHNM

Royal Stoke Maternity Hospital,

Address: Newcastle Road, Stoke on Trent ST4 6QG

Tel: 01782 715444

Authorised Representatives:

Emma Ford, Christine Sherwood (Healthwatch Staffordshire) Jackie Owen, Sophia Leese (observer) (Healthwatch Stoke-on-Trent). Representatives have undertaken Enter and View training and are DBS checked.

The maternity service based at Royal Stoke Hospital is delivered over 3 floors and is made up of postnatal and antenatal wards, a midwifery birth centre, a daycare assessment area, and a maternity assessment unit (MAU). The service also provides specialist substance misuse clinics, perinatal mental health and lifestyle clinics, foetal medicine, and maternal medicine services. The community midwifery team is also based in the maternity unit and works closely with the midwifery team. These services are available to all pregnant individuals from across Stoke-on-Trent and Staffordshire.

Purpose of the visit:

This visit, a joint visit by Staffordshire and Stoke-on-Trent Healthwatch follows the publication of the Care Quality Commission (CQC) report on maternity services at Royal Stoke Hospital in June 2023 having undertaken an inspection visit in March 2023. The CQC inspection focused only on the safe and well-led key questions.

The outcome of the inspection was that the service was judged to require improvement overall. Following this inspection, under Section 29A of the Health and Social Care Act 2008, the Trust was served a warning notice requiring them to make significant improvements to the safety of the service. The two main areas of concern were:

The maternity assessment unit and the implementation of the BSOTS model of triage (Birmingham Symptom Specific Obstetric Triage System).

The induction of labour process including the system for prioritisation of risk and delays.

Therefore, the purpose of this visit was to look at how the Trust has developed and implemented measures to address the 'must do' actions as set out by the CQC in their final report and what impact this has had on the experience of women/birthing people and families attending the unit to give birth. We aimed to engage with women/birthing people and families to explore their overall experience of the service received when delivering their baby under the care of Royal Stoke Hospital.

We also wanted to engage with a range of staff working in maternity care to find out how any actions taken and plans in place had impacted upon their ability to undertake their role and have the skills and tools to do the job in a supportive and safe environment.

Methodology

This was an announced visit carried out by 2 Authorised Representatives from Healthwatch Staffordshire and 2 from Healthwatch Stoke-on-Trent, one of whom was in training and was an observer on this visit. The team arranged to meet senior staff at the entrance to the maternity unit. Signage from the car park to the unit was mostly clear to follow, other than in one area where there were two signs in close proximity pointing in opposing directions which was confusing. Signage upon entering the maternity unit in the entrance reception area was very clear as to where the various departments were located.

We were met in the reception area by the senior leadership team who identified themselves as the Director of Midwifery and her two Deputies. Also joining us was the Deputy Chief Nurse and the inpatient Midwifery matron. They were accompanied by a student midwife on placement from Staffordshire University, participating in a leadership and governance programme. The leadership team spent time with us helping to set the context for the visit and were extremely helpful taking time to explain the plans and strategies in place to address the issues leading to the CQC judgement. We were informed that before

the CQC visit the department was fully aware of their problem areas which subsequently led to the section 29a notice being issued and had already put an improvement plan and implementation programme in place prior to the visit which was shared with CQC at the time of the inspection.

Setting the context, the Director of Midwifery explained that Royal Stoke Hospital had approximately 6,200 births in the previous 12 months many of which were and still are of an extremely complex case mix deemed 'high-risk'. High risk can be preexisting health conditions, lifestyle factors such as diet, smoking, drug & alcohol misuse, pregnant individuals aged over 35 or under 17 and pregnancy-related health conditions. Royal Stoke Hospital is in the top 2% category nationally for high-risk births. To this end, every contact with the unit is risk-assessed through a 24/7 assessment and triage service at the Maternity Assessment Unit. This unit has around 14,500 admissions per year due to the number of women/birthing people attending with pregnancy-related health conditions or concerns. Pregnant individuals can self-refer if they have any concerns about their pregnancy.

The Director of Midwifery has been in post for the past two years but has previously worked in a range of diverse maternity settings including nationally developing an end-to-end maternity information system. Her priorities upon taking up an appointment and gaining a full understanding of the maternity service in practice at Royal Stoke Hospital was to develop an action plan focusing on 3 main areas for development and improvement.

- Workforce
- Governance
- Culture

We were told that these are key areas underpinning the action and implementation plan addressing the must-do improvements required by the CQC. We were provided with an overview of some of the specific actions that have been taken to improve on these areas and were later sent copies of reports presented to the System Maternity Oversight and Assurance Group, the latest dated the 31st of October as evidence of the work being undertaken. The first report focused on setting the scene, an update on Maternity services the Maternity Quality Improvement Plan and the Risk Log. The latter report provides an update on how the actions from the s29a CQC notice are being addressed and the progress made. In summary, we were informed that.

Workforce- A long-term recruitment and retention workforce plan has been developed in conjunction with NHS England (NHSE) both

regionally and nationally. £850,000 of external funding has been secured as well as £509,000 in LMNS (Local Maternity and Neonatal Systems) funding which has enabled the recruitment of 30 specialist roles and an additional 22 midwifery roles. Some of these are new in post and going through the induction process currently.

There are 5 Maternity Support Workers undertaking midwifery degree apprenticeships, and student nurses are offered roles upon successful completion of their training and have the added incentive of development in leadership and governance opportunities.

The service has recruited 3 of 5 midwives through international recruitment with the remaining two in progress. All new midwives are offered preceptorship packages which are bespoke and flexible and offer a very personal welcome to all new staff.

There is investment in staff training, other than the mandatory training required there are also opportunities for leadership and development training which is focused on succession development and includes shadowing. There is also the Vitality development programme which is based around organisational culture and behaviours offered to most staff.

Governance – The service has in place a range of governance arrangements which oversee the quality and safety of the services, and the outcomes of action and implementation of improvement plans and targets. The Maternity service feeds into a hierarchy of 8 quality and safety assurance groups both internal and external and oversight is also provided through the Integrated Care Board (ICB) and the Local Maternity and Neonatal Systems (LMNS). We were told that the leadership team have a good and honest relationship with the Executive Board and Non-Executive Directors who are described as a listening, supportive and open board that provides an open, transparent, and mature governance structure which holds the service to account and ensures compliance in duty of candour. The team have a monthly 2-hour voice with the executive and non-executive board and an open and good relationship with the Chief Executive Officer.

Culture – The Midwifery service has a Cultural improvement plan that is focused on creating a "kind and respectful workplace." The leadership team have put in place a whole range of actions aimed at cultural change. We were informed of some of the achievements over the past 12 months including.

- Strengthening leadership (new structures)
- Perinatal Culture & Leadership Development Programme (NHSE/I) (April 23)
- SCORE survey

- Vitality Team Building and Leadership Behaviours Programme (46 midwifery leaders)
- Vitality Team Building and Leadership Behaviours Programme (roll out for band 5's & 6's) (250+ band 5&6 midwives)
- ENABLE Training for all maternity, neonatal and gynaecology teams.
- Kindness into Action – Trust-wide
- INSIGHTS Training for all maternity, neonatal and gynaecology teams
- FRIDAY FOCUS
- Freedom to Speak Up – responses.
- NHS England/Improvement Insight Visits – Maternity and Neonatal
- Engagement with student midwifery workforce
- Leadership Toolkit - Maternity and Neonatal
- Daily safety huddles

The results of these and other actions and ongoing plans, the evidence outlined in documents to the System Maternity Oversight and Assurance Group (SMOAG) and shared with us indicate an improvement in all areas of concern outlined in the CQC's Section 29a notice. The figures indicate that there is still work to be done but the actions taken are heading in the right direction. For example, of the 1487 people who attended the MAU in September 2023, 87% were triaged within 15 minutes, as opposed to 75% triaged within 30 minutes highlighted in the CQC report.

Similarly, within the same document (SMOAG), 240 women/birthing people commenced their induction of labour within the specific guidelines & reached 88% in September 2023 against a target set out at 95%.

Training is still an area that requires improvement, but the evidence suggests that this is being monitored closely with plans in place to address the shortfalls and improve the outcomes of these targets.

We were informed that because of the measures put in place around recruitment and retention of staff, the expected vacancy level was expected to hit the target of 10 vacancies by December 2023. We were told that all the student nurses recruited in the past 12 months are still in the post due in part to the very good preceptor package and the level of support that is offered to new staff. We were informed

that the staff turnover is generally one of the lowest in the country at 6.9%.

The leadership team came across as open and transparent about the strengths and weaknesses of the service and the steps being taken to achieve the vision for the service as well as the steps, still needed to achieve this. They presented as very passionate and enthusiastic about the service, and this was very evident in the way they spoke about the work they were doing and their determination to make the vision a reality. Following this session, we were given a guided tour of the whole maternity department and were then left to go freely around all areas to speak with patients and staff.

Staff Experience.

We visited all wards and maternity areas and spoke to staff from across the board from senior managers, ward managers, staff of all levels, ward clerks and domestic staff. We spoke to at least one member of staff on each ward and often more. Although it was evident from observation that the staff were busy, there was quiet and calm throughout all areas we visited and a sense that everything was under control.

The busiest unit was the MAU and although there appeared to be a lot of staff around, we were told by the ward manager that there were staff shortages on that day. There should have been 14 core staff, 8 floating Staff + 1 new staff member who was not yet fully operational. However, on duty, there were 8 core staff, 2 floating staff + 3 new staff. We were told that there are days when the unit is extremely short of staff and the Flow Coordinator must move staff around to fill emerging gaps. We were informed that there is a high use of bank staff at present but most of these are their staff, so this works well in terms of employing appropriately trained staff with the right ethos. Talking to some of the staff working on the MAU there was a perception that they were still very short-staffed, this was later clarified by managers who told us that this is largely because a lot of new staff were not yet fully operational due to going through the induction and training process, and this perception may change over the next few weeks.

All the staff we approached to speak to us were very friendly and very willing to give us time and answer our questions and it felt that they were doing this openly and freely. Even the negative comments were made openly, and it was clear that staff felt able to speak without fear of reprisals.

There was a feeling that staff felt they were a part of a close-knit unit with close relationships and a strong level of trust among their colleagues. Most staff other than new staff told us they had been in

post for periods of between 5-25 years. Many told us they loved their job and loved the environment they worked in, describing it as happy. There was a very positive feel of a close-knit, mutually supportive staff team with a strong sense of unity who are proud to work in Maternity services at Royal Stoke Hospital and that came over in the welcome we were given, and the way staff spoke to us.

Not all staff felt well supported by their managers or peers, though these were the exception, not the rule. A couple of staff told us that they did not feel as valued by the rest of the team due to their role as Health Care Assistants (HCA). This was despite feeling that their role in supporting the running of the unit is vital and without which the ward would not run smoothly and there would be even greater pressure. They felt taken for granted on occasions and not always as valued as the medical and midwifery team and therefore sometimes treated differently. We spoke to staff in the same role on a different ward however and their view was very much the opposite in that they felt that their role was valued by colleagues, and they were seen as valued for their contribution to the ward.

Two staff told us they did not feel as well supported by their manager and felt that the turnover of managers over the last few years made it very difficult to gain any continuity and consistency in the way things are done. One HCA mentioned that managers come and go so quickly that it is hard to get adjusted to their ways and then must get used to a new manager who has their own ways of doing things and it is all change again. These staff did not feel that they really got any recognition in the Friday Focus newsletter which was surprising as the latest one dated November which we had sight of particularly recognised the role and contribution of the Maternity and Health Care Support Workers and celebrated the work they do. These views reinforce the ongoing need to address the culture of the organisation so that every member feels valued for the important role they play as part of the wider team.

We spoke to one member of the domestic staff who told us that they had worked on the unit for over 15 years and could never imagine leaving. They had told us that although their manager was fantastic, and they felt respected and treated well by the senior managers, they sometimes felt 'looked down on' by some of the staff on the ward and not seen or treated with dignity and respect. However, they love their job and the patients and therefore would never contemplate leaving because of this and thought generally it was a great place to work.

Several staff told us that they don't always get their breaks due to the pressure of work on occasion. A few told us this was a regular occurrence as there was so much going on that it wasn't possible to take a break. We were told that breaks are the responsibility of the individual to take them when they can. The shifts are 12½ hours long,

so breaks are important to take sustenance and recharge batteries. It was repeated a few times by staff that the MAU is a very busy ward with a fast turnover of patients and little to no control over the flow of patients. We were told that the ward could have over 1000 patients a month and there are times when it feels very manic working on MAU. However, staff we spoke to appreciate initiatives like the daily huddle which they saw as an opportunity to share concerns and raise issues of pressure. Most staff also appreciated the Friday Focus as a means of keeping updated and celebrating the good work being done.

We spoke to the Flow Coordinator whose role is to do 2 hourly checks in the whole dept to see where the hotspots are and to move staff around accordingly. They told us that the role brings with it a lot of pressure and is a very visible role, but they have been in the post for 5 years and feel very well supported by their colleagues and manager.

Most staff we spoke with told us that managers and the leadership team were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons and were given good opportunities for training and development. Most told us they felt respected, supported, and valued.

Many of the staff we spoke with came over as compassionate and caring and were focused on the needs of patients and their babies. We were told of the actions that had been taken to make the experience of the parent and baby more pleasant by little things that they could do to enhance the comfort of the rooms or comfort for parents and babies. This was communicated to us in a way that demonstrated care and compassion and put the needs of the patient first. This was more evident in wards 205 and 206, the Midwifery birth centre and the delivery suite. For example, the High-risk delivery suite is now adjacent to the Neonatal unit, and this allows parents to stay with their babies. This is not to say that the MAU staff were not compassionate or caring just that the pace of care and the nature of the unit seemed to be more focused on dealing with immediate problems resolving issues and throughput.

Service User Experiences:

During our visit, we engaged with a total of 12 women/birthing people and people/family members supporting them.

We saw 5 women/birthing people within the Antenatal Department, 3 in the Maternity Assessment Unit, 1 in the Low delivery Suite, 1 in ward 205 and 2 in Ward 206. Our numbers reflected the time we had within the unit after our tour by the deputy midwives and this was just a snapshot of each department.

Demographics

3 aged between 18–24

8 aged between 25-49

1 age unknown

10 White/British

1 Asian/Asian British Pakistani

1 Asian/Asian British-any other Asian/Asian British background

Positive Findings:

We were told many times during our conversation with women/birthing people and families about the caring attitudes of staff and most people felt they had been treated with dignity and respect.

The twelve women/birthing people we spoke with were either seen quickly following the referral from their GP once a positive pregnancy was confirmed or given a link to complete themselves from the GP to the community midwife.

The twelve women/birthing people we spoke with all said they saw the same community midwife, and this helped with the continuity, trust & reassurance. It appeared that the community midwife tends to talk about feeding, birth planning, mental health, Domestic violence, safeguarding, and any other support needs.

Wards 205, 206 and the Midwife Birthing Centre all received only positive feedback. Some of the most pertinent comments are stated on Pages 11 & 12 of the report.

People said that they didn't feel pressured to breastfeed and that the choices around alternatives were adhered to & listened to, including pain relief & birthing plans.

Three of the women/birthing people we spoke with also attended the outpatient facilities at the County hospital for Antenatal care and gave positive feedback about their experiences. We did not meet anyone who had recently attended the postnatal facilities either at County or Royal Stoke hospitals or within the community services. Currently, women/birthing people are not given the option for home delivery or births at Free-standing Midwifery Birthing Units as these have currently been suspended. (Reviews are currently taking place regarding FMBU's).

The Royal Stoke Hospital Maternity Unit did offer a facility to use a birthing pool and had theatres for elective C-Sections or emergencies. Some women/birthing people had stated they had requested a tour of the facilities before giving birth and this has been accommodated, another woman/birthing person stated they weren't aware they could tour the facilities. However, there is a virtual tour of the facilities at Royal Stoke Hospital maternity on the hospital website.

Most people said that birth plans were followed where it was safe and practical to do so. This helps to reinforce to the patients that their voice had been heard.

Patients said that on the wards & birthing suites staff would accommodate partners to stay overnight and were prompt when answering buzzer calls.

We asked the patient on the ward "What has been the best aspect of the service?" These are some of the comments:

"The best aspect is the nurturing I felt from the midwives".

During Labour "The team at the hospital are very good and kept checking in on me and my partner".

"My partner was included in everything, and we felt respected".

"The best aspect for me was how involved my partner was and how well he was looked after. My partner was allowed to stay with me and stayed on the ward".

"Every handover on the ward the staff would pop in and introduce themselves on each shift and I had a named nurse

per shift. Even the cleaner would pop in and see how we were doing".

Healthwatch asked women/birthing people & the people/family members supporting them. "If there was one thing you could change what would this be?"

These are some of the comments:

"Size of the rooms"

"The food, but I am picky but there are plenty of options."

"Some staff attitudes"

"Culture & process on MAU"

"Time it takes after your scan in Antenatal to see the midwife."

"Would like a facility to bring siblings in during my antenatal appointments as not all of us have support externally, I feel this would reduce my anxiety and stress levels."

Strengths:

The Royal Stoke Maternity has made some positive changes.

- Access to our records: This is a service which electronically allows patients to translate their notes into a particular language.
- Alternatives for people with Learning Disabilities or Sensory Impairments (a member of staff is the National Representative for Digital Lead midwifery) and sits on the All-Things Digital National Table.
- Every Contact Risk Status: From the contact for pregnancy booking this is looked at.
- Good to see images of uniforms so that patients can recognize the staff's roles.

- Examples of the maternity units' Values and Promises on notice boards across all departments.
- Areas to get fresh water from and vending machines on most of the floors with a café located on the ground floor adjacent to the Antenatal unit.
- Patients can access the Maternity and Neonatal Patients Voice & give feedback regarding their experiences.
- The Maternity Assessment Unit now has a waiting room with a 24-hour reception area and a triage midwife. This service is working on getting women/birthing people seen within 15 minutes.

Environment

The building is situated away from the main entrance but shares car parking with the main hospital. The signage to the hospital was mainly clear but confusing in one area with two signs pointing in different directions.

The maternity unit is well laid out over 3 floors with a large entrance lobby that contains a reception desk. The entrance was light, spacious and clean with clear signage to all the main areas. There are vending machines on the entrance levels that are accessible to all visitors. The antenatal service and ultrasound are located on the ground floor.

Each floor we went on was spotlessly clean and well-maintained with a lot of colourful pictures on the walls. The walls on each floor also had noticeboards containing information on various topics helpful to new parents, but these all appeared to be in English only. There was no indication that these were available in alternative formats for people whose main language was not English and those who may have sensory or other impairments.

It was very heartening to see outside the neonatal unit, the walls full of what we were told were previously premature babies' photos who had gone through the unit and were now thriving babies and toddlers. This seemed to be such a morale booster and perhaps seeing them brought a sense of relief and comfort to patients.

Hand sanitisers were located at each ward/unit entry, and we only found one that did not contain sanitiser. We observed that the "Hand-wash only"/ “No drinking water” signs above the taps were often too faded to read.

The rooms in all parts of the unit were well presented, clean, generously resourced, and had plenty of space. There were several specialised rooms - including water birth, twin and bariatric rooms,

and the facilities of the bereavement suite were excellent, offering support to the needs of the parents.

The equipment that we saw was clean and looked well maintained from a layman's perspective and we saw domestic staff in most areas and no evidence of clutter or litter anywhere in the unit.

Overall, the maternity unit presented as a warm and welcoming environment with cleanliness and maintenance at a high standard.

Recommendations

- Review external signage to ensure patients can find their way to the unit easily.
- Review the information available to patients and families on notice boards and in waiting areas ensuring that patients who have different needs to access information know that this is available and how to access it.
- Think about language - a lot of posters are very wordy, think about simple language and pictorials, think about coloured backgrounds and contrasting print.
- Ensure that staff can access a break in line with working time regulations to support safe and effective working.
- Consider what actions can be taken to ensure that staff at all levels can feel valued and involved in the running of the service as an integral part of the team.
- Wi-Fi access needs to be in alternative languages.
- Some of the seating in waiting areas in both the Triage on the MAU and Antenatal are of a foam box construction with a low triangular backrest. They are low to the floor and offer no support with arms. These could be uncomfortable if seated for long periods. Heavily pregnant individuals or people with mobility issues may struggle to mobilise.
- Consider having a notice that explains the Triage process at MAU and why you may have to wait. A small number of people who have spoken to Healthwatch about maternity services have been unclear on the Triage process.
- Consider a pager/text system if women/birthing people must wait for long periods in the Triage or Antenatal areas so at least they can walk about or go outside for a break.
- Communication is key: For example, recent guidance recommends Induction of Labour (IOL) is offered at 7 days past due date (40

weeks plus 7 days). Women/birthing people may be booked for an IOL, but if another woman/birthing person presents in labour they will take priority. There will be times when Induction of Labour's are delayed, resulting in the recommendations not being met. Healthwatch would recommend that if the situation was explained to women/birthing people this could prevent some of the frustrations.

- Improvements need to be made within the MAU, including the waiting times as these can still be problematic.
- A few patients felt some staff appeared negative towards them.
- Some of the staff's terminology needs improving as it comes across as unsympathetic.
- Several patients we spoke with felt that they had not been listened to, within the MAU department. One patient also felt there was a breakdown in communication between the call handler and those telling the women/birthing people to come into MAU to be induced, but the receptionist on MAU didn't appear to have been made aware of this on arrival.

  "I get here no-one seems to know why I am here and what I have come for."

- Another patient felt the electronic system with patient records needs updating. "If you come under a different trust for the community midwife, she cannot read the Royal Stoke Hospital Notes and Royal Stoke Hospital cannot read my Birthing Plan or community notes, so I have to relay all the information".
- Some women/birthing people stated they found their own Antenatal classes and must pay for the service. They do not think they are provided free in the area since Covid.

The Royal Stoke Maternity Hospital also offers other services such as:

- Bereavement rooms with sofa beds and kitchenette, and TV and stereo to give a more homely feel. This allows families to spend as much time as they need with their child and gives them the dignity and respect that is needed during this time. There is also access to specialist-trained staff on hand for the patients and families.
- Royal Stoke Hospital Forget-Me-Not Support Group-STILL was launched in 2017 and currently has 245 members. It offers a support group for after discharge in both face to face and online forums to help with bereavement. This has expanded recently into a separate group for families needing support during subsequent pregnancy.
- We were made aware of the Palliative Care Service that was offered onsite. This is when a life limiting/life shortening condition of an unborn baby is diagnosed during pregnancy. This service allows families to consider options that can then be discussed in a calm, controlled & realistic manner.
- An Advance Care Plan is created where all discussions are recorded & shared within the appropriate teams to prevent repeated conversations surrounding difficult decisions. The planning helps in memory building during the antenatal period, appointments, and during delivery and postnatal periods to give better continuity. After delivery women/birthing people & families can access “cold cots” which allow more time with the baby and can be used to take the baby home for a short length of time.

Summary

On speaking with patients and their support, feedback was largely positive with some patients wishing to compliment the staff. Negative feedback was related to service within the MAU department & general waiting times in MAU & antenatal.

Contact Details for the Public:

Maternity Assessment at Royal Stoke Contact Details.

- Royal Stoke Delivery Suite on 01782 672333
- Royal Stoke Midwife Birth Centre on 01782 672200
- Royal Stoke Maternity Assessment Unit on 01782 672300
- Freestanding Birthing Unit County Hospital on 01785 230059
- For all enquiries relating to maternity-related bereavement services the contact is: nos-tr.bereavementmidwife@nhs.net

Please contact Healthwatch with any further feedback

Staffordshire (Excluding Stoke-on-Trent)

enquiries@healthwatchstaffordshire.co.uk

https://healthwatchstaffordshire.co.uk/contact/

https://www.smartsurvey.co.uk/s/G84ZDT/

Stoke-on-Trent

info@healthwatchstoke.co.uk

www.healthwatchstokeontrent.co.uk

Maternity and Neonatal Voices Partnership (MNVP)

MNVP's primary objective is to gather feedback from women/birthing people and their families about their experiences with maternity and/or neonatal services. This information is then utilised to help shape the future of local maternity and neonatal services and to drive forward improvements in the care offered and provided.

Visit their website here.

Related Healthwatch Staffordshire report:

You may also be interested to read our report "Maternal Mental Health Matters Survey Staffordshire". This looks at a small sample of feedback on maternal mental health for Staffordshire births between April 2020 and Autumn 2022.

“Healthwatch would like to thank all the staff for making us feel welcome and showing us around the departments and all the feedback from patients and family/support, we hope this report will be useful”.

Next Steps

The report will now be published on Healthwatch websites.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all patients and staff, only an account of what was observed and contributed at the time of this visit.

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Committed to quality

We are committed to the quality of our information. Every three years we perform an in-depth audit so that we can be certain of this.

Healthwatch Priority Project Decision Checklist

Name of Healthwatch	Healthwatch Stoke-on-Trent		
Proposer: (Project lead)		Date proposed:	1 May 2024
Decision to be made on which Health and Social Care services should HW agree as priority projects.			

Summary of decision to be made:

A decision is required on whether **maternity services - neo natal and perinatal** should be a priority project for Healthwatch Stoke-on-Trent this year because of the following evidence.

The focus of the project will be to look at mental health issues that arise and the support provision.

How much evidence is available about the issue? (*1 being limited evidence from limited sources, 4 being well researched with a range of evidence from a range of robust sources*)

Infant mortality and risk factors

In the Stoke-on-Trent City Council's draft Corporate Strategy 2024-28 data shared found that the infant mortality rate (per 1,000 live births) in Stoke-on-Trent (6.5) was 1.67x higher than the national average (3.9). The Child health in 2030 in England: comparisons with other wealthy countries report, published by Royal College of Paediatrics and Child Health (RCPCH) in October 2018, found that the national average of 3.9 per 1,000 live births is 30% higher than median mortality across EU15+.* This puts Stoke-on-Trent 116.67% higher than the median mortality across EU15+.

**This research used EU15+ as its comparison group. This includes the 15 countries of the EU in 2004 plus Australia, Canada, and Norway. Totalling 18 countries datasets.*

However, 2022 data from Eurostat shows that around 12,872 children died before reaching the age of one in the European Union (EU), which is equivalent to an infant mortality rate of 3.3 (per 1,000 live births).** Comparatively Stoke-on-Trent's infant mortality rate is 96.97% higher.

***This dataset includes all 27 EU Member States infant mortality rates to reach the 3.3 median rate.*

The 2018 RCPCH report also found that key risk factors for a higher infant mortality rate in England/the UK compared to other countries is that England/the UK has higher proportions of young mothers and higher proportions of smoking during pregnancy than most EU15+ countries. According to supporting data provided in the Stoke-on-Trent City Council's draft Corporate Strategy 2024-28, 25.7% of adults in Stoke-on-Trent smoke regularly. The national average for adults who regularly smoke is 14.5%.

Maternity services

In March 2023, the Care Quality Commission (CQC) carried out an inspection on The Royal Stoke University Hospital. In their inspection report, CQC share that University Hospitals of

North Midlands NHS Trust was served a warning notice under Section 29A with the maternity services receiving an overall rating of "requires improvement". The reasons for the rating were because:

- People were not always able to access the service when they needed it without having to wait longer than the trust targets and as recommended in national guidance. There was a lack of embedded processes to triage and prioritise care and treatment for women and birthing people who attended the service.
- Staff did not always have training in key skills, to ensure safe treatment of women and birthing people. However, staff we spoke with could describe how to escalate safeguarding concerns. Staff took every opportunity to protect women and birthing people from abuse.
- The design and equipment were not always suitable to meet the needs of women and birthing people. Equipment was not always available for use leading to delays in treatment for women and birthing people.
- Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service used systems to monitor performance and risks. However, staff did not always follow trust guidance to identify and escalate associated risks to women and birthing people. Leaders did not have effective oversight and there was a risk improvements were not always identified or made when needed. In addition the service did not provide a local business continuity plan. We were unable to determine what the arrangements were should an unexpected major event occur.
- Leaders had the skills and abilities to run the service. Leaders had identified and implemented systems to address and improve services in order to better manage priorities and issues the service faced. There were however, areas where the leadership could develop further. In particular, inconsistent incident reporting processes reduced effective oversight and reduced the ability to identify themes and trends. Staff mandatory training did not meet trust targets, and staff did not always follow processes as outlined in guidance.

Following the CQC's inspection and retrospective report, we arranged a joint Enter and View visit to The Royal Stoke University Hospital maternity services with Healthwatch Staffordshire in November 2023. During our initial meeting with the senior leadership team, they assured us that there were improvement plans and strategies in place to address the concerns highlighted in CQC's report. They also shared with us that in the previous 12 months, they had approximately 6,200 births, many of which were deemed 'high-risk'. A pregnancy or birth is considered to be high-risk due to complexities such as: pre-existing health conditions, lifestyle factors (such as diet, smoking, drugs and/or alcohol), age (over 35 or under 17), and pregnancy related health conditions. The Royal Stoke University Hospital is in the top 2% nationally for high-risk births.

On the day of our visit, our teams found similar issues as highlighted in the CQC report in regard to safe staffing levels across some departments, particularly the Maternity Assessment Unit (MAU). We also found that overall, patients and supporting visitors feedback was largely positive, with some wishing to compliment the staff. The negative feedback received from patients and relatives were often in relation to the MAU and waiting times in the MAU & antenatal department. Long waiting times in the MAU have been a reoccurring theme as a patient attending during the teams Enter and View visit to the MAU in March 2020.

Maternal Mental Health

In 2019, Healthwatch England shared the experiences of 1,738 people with their Mental health and the journey to parenthood report. Many reported a good experience of care, however the survey findings also indicated that many were not experiencing support that met the NICE guidelines. Following this report, NHS England launched 6-week mental health checks for new mothers which aimed to ensure that they feel well and have the support needed if struggling with their mental health. However, a more recent review from Healthwatch England looking at a further 2,500 people's experiences found that maternity care is worsening across the country. The Left unchecked – why maternal mental health matters report found that the 6-to-8-week postnatal consultations were not working well for everyone, with many struggling to access timely support and others not receiving any support.

Local charity Mothers Mind supports approximately 10 new mothers per group every 4 months. The charity has picked up a range of stories and experiences of mothers' using local maternity services including concerns around a general lack of support and services available, particularly for younger new mothers, which can negatively impact their mental health and wellbeing.

/4

Reason for score:

Is the issue going to impact on lots of people? (*1 being relatively little, 4 being community wide and likely to affect large numbers of people)*

Staff at the University Hospitals of North Midlands NHS Trust's (UHNM) The Royal Stoke University Hospital maternity services informed us that they had approximately 6,200 births in the past 12 months. The Royal Stoke University Hospital not only supports all residents in Stoke-on-Trent, but also those across the Staffordshire County and in other surrounding areas.

In addition to those births, there are close relatives and friends who also require advice, guidance, and/or support from perinatal and maternity services to confidently take care of the baby.

/4

Reason for score:

What is the impact on people on community groups who experience health inequalities and who feel their voice is seldom heard? (*1 being relatively little, 4 likely to affect large numbers of those seldom heard*)

Through this project we will reach young mothers and mothers who have or had a high-risk pregnancy.

/4

Reason for score:

Does the issue help Healthwatch Stoke-on-Trent to have a positive influence on health and social care services? (*1 being unlikely to, 4 being highly likely to*)

This project will provide a local narrative and data to existing national projects. It will amplify the voices, stories, and experiences of those using perinatal and maternity services. Furthermore, any improvements to these services that can be achieved through this project will have significant impact.

/4

Reason for score:

Does the issue align with local strategies and needs assessments? (*1 being little alignment, and 4 being significant alignment*)

The Stoke-on-Trent City Council's draft Corporate Strategy 2024-28 has 'A Healthier City' as its first of 5 priorities. Under this priority, the Council shares how they intend to work with the NHS and other local partners to provide effective preventative approaches to key challenges such as *poor rates of life expectancy and healthy life expectancy in the city*, to achieve target outcomes like *more children get off to a good start in life*. Supporting data used in this priority included the local infant mortality rate.

/4

Reason for score:

Is the issue already being dealt with effectively by someone else? (*1 being dealt with satisfactorily by someone else, 4 not being dealt with at all*)

Although we are aware that there are ongoing projects about different aspects of maternity both nationally and locally, they often target specific issues and are not an all-encompassing project.

/4

Reason for score:

Total score: /24

Vote of HAB members taken: Y/N Majority reached: Y/N

Decision of the HAB:

Reasons why the decision was made:

Date decision ratified:

Healthwatch Priority Project Decision Checklist

Name of Healthwatch	Healthwatch Stoke-on-Trent		
Proposer: (Project lead)	Simon Fogell	Date proposed:	01 05 2024
Decision to be made on which Health and Social Care services should HW agree as priority projects.			

Summary of decision to be made

To support the Carers Strategy by developing and hosting a Digital Carers Forum for those who can not attend face to face forum meetings to help with the development of the next city carers strategy

How much evidence is available about the issue? (*1 being limited evidence from limited sources, 4 being well researched with a range of evidence from a range of robust sources*)

Carers, unpaid carers, provide immense support to people, often loved ones enhancing their independence to remain at home.

Healthwatch England states in its 2018 report that carers are unaware of their rights to assessments and find accessing reliable information and advice about local care services challenging. Many carers only start looking for help when their need becomes urgent, and they reach a 'crisis' point. Any delay in accessing support at this point has an adverse effect on their health and wellbeing.

/4

Reason for score:

Is the issue going to impact on lots of people? (*1 being relatively little, 4 being community wide and likely to affect large numbers of people)*

There are over 27,300 informal/unpaid carers in Stoke-on-Trent and approximately 825 of these are young carers 58% of these carers are female, in line with the national trend at the census.

Stoke-on-Trent City Council has 2.971 adult carers registered as of May 2020 of which 62% (1851) are female. This is slightly higher the national trend according to the data from the 2011 Census. The largest age group of our registered adult carers is for those aged between 86 - 95 with 25% (739), with those aged 76-85 close behind with 24% (705). The data highlights that the largest proportion of our registered adult carers are over the age of 65 with 69% (2,050) adult carers registered as caring for someone.

/4

Reason for score:

What is the impact on people on community groups who experience health inequalities and who feel their voice is seldom heard? (*1 being relatively little, 4 likely to affect large numbers of those seldom heard*)

Of the 2,971 adult carers registered with Stoke-on-Trent city council 73% (2,161) are White British, 3.5% (104) are BAME and mixed race, 1% (38) are other white or Irish traveller origin and 22.5% (667) are unknown. Within Stoke-on-Trent the two areas with the highest number of registered adult carers by postcode (as with young carers above) falls within the ST3 area at 26% and ST6 area at 23%, with 29% (209) of adult carers from the ST3 area living in Longton and 21% (48) of young carers from the ST6 area living in Burslem.

/4

Reason for score:

Does the issue help Healthwatch Stoke-on-Trent to have a positive influence on health and social care services? (*1 being unlikely to, 4 being highly likely to*)

Yes it will enable people to have their voices heard by the key stakeholders in the city that will be creating the refreshed carers strategy to ensure it meets their needs.

/4

Reason for score:

Does the issue align with local strategies and needs assessments? (*1 being little alignment, and 4 being significant alignment*)

Yes it does

The current carers strategy has Five Key Priorities for Carers
Priority 1 Identification and Recognition Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in the designing local care provision and in the planning of their individual care packages
Priority 2 Realising and Releasing Potential Enabling those with caring responsibilities to realise their aspirations and fulfil their educational and employment potential
Priority 3 A life outside of caring Personalised support both for carers and those they support, enabling them to have a family and community life
Priority 4 Supporting Carers to stay healthy Supporting carers health, mental health and wellbeing to enable them to remain mentally and physically well
Priority 5 Young Carers Supporting children and young people by protecting and encouraging them to thrive

/4

Reason for score:

Is the issue already being dealt with effectively by someone else? (*1 being dealt with satisfactorily by someone else, 4 not being dealt with at all*) It will support the refreshing of the strategy through our independence ensuring people have their voices heard. /4 Reason for score:
Total score: /24 Vote of HAB members taken: Y/N Majority reached: Y/N
Decision of the HAB:
Reasons why the decision was made:
Date decision ratified:

Healthwatch Priority Project Decision Checklist

Name of Healthwatch	Healthwatch Stoke-on-Trent		
Proposer: (Project lead)	Simon Fogell	Date proposed:	01 05 2024
Decision to be made on which Health and Social Care services should HW agree as priority projects.			

Summary of decision to be made

To support the Community offer – a range of preventative and low-level services to support people in maintaining their independence avoiding statutory services. To be part of various working streams looking at developing this offer:

- Operational (Social Work Teams)
- Service Users/Carers
- Vol Sector
- Providers
- ICB/Health

How much evidence is available about the issue? (*1 being limited evidence from limited sources, 4 being well researched with a range of evidence from a range of robust sources*)

The adult social care system is in need of overall. Successive governments have not enabled. Leaving local systems buckling under the pressure and local authorities facing difficult choices in the provision of care.

/4

Reason for score:

Is the issue going to impact on lots of people? (*1 being relatively little, 4 being community wide and likely to affect large numbers of people)*

Judging by the number of unpaid carers supporting people in the city it would reciprocally indicate that there are many people whom would be affected by this new approach by the council.

/4

Reason for score:

What is the impact on people on community groups who experience health inequalities and who feel their voice is seldom heard? (*1 being relatively little, 4 likely to affect large numbers of those seldom heard*)

Carry on form above this illustrates how many people are in need of support from one perspective. Of the 2,971 adult carers registered with Stoke-on-Trent city council 73% (2,161) are White British, 3.5% (104) are BAME and mixed race, 1% (38) are other white or Irish traveller origin and 22.5% (667) are unknown. Within Stoke-on-Trent the two areas with the highest number of registered adult carers by postcode (as with young carers above) falls within

the ST3 area at 26% and ST6 area at 23%, with 29% (209) of adult carers from the ST3 area living in Longton and 21% (48) of young carers from the ST6 area living in Burslem.

/4

Reason for score:

Does the issue help Healthwatch Stoke-on-Trent to have a positive influence on health and social care services? (*1 being unlikely to, 4 being highly likely to*)

Yes it will enable people to have their voices heard by the city council whilst the community Offer is developed to ensure it meets their needs.

/4

Reason for score:

Does the issue align with local strategies and needs assessments? (*1 being little alignment, and 4 being significant alignment*)

Yes it does

The current Stoke-on-Trent Joint Health and Wellbeing Strategy 2021-2025 has key priorities:

- Start well
- Live well
- Age well
- Healthy city

/4

Reason for score:

Is the issue already being dealt with effectively by someone else? (*1 being dealt with satisfactorily by someone else, 4 not being dealt with at all*)

It will support the refreshing of the strategy through our independence ensuring people have their voices heard.

/4

Reason for score:

Total score: /24

Vote of HAB members taken: Y/N Majority reached: Y/N

Decision of the HAB:

Reasons why the decision was made:
Date decision ratified:

Healthwatch Priority Project Decision Checklist

Name of Healthwatch	Healthwatch Stoke-on-Trent		
Proposer: (Project lead)	Simon Fogell	Date proposed:	01 05 2024
Decision to be made on which Health and Social Care services should HW agree as priority projects.			
Summary of decision to be made To support the City council develop the Coproduction strategy that will underpin the Community offer and Cares Strategy			
How much evidence is available about the issue? (*1 being limited evidence from limited sources, 4 being well researched with a range of evidence from a range of robust sources*) Co-production is an important way of achieving the overarching aims of the Care Act including prevention, wellbeing and the focus on outcomes. It should be a consideration in all aspects of implementing the Act. https://www.scie.org.uk/co-production/what-how/#:~:text=Co%2Dproduction%20is%20an%20important,the%20requirements%20of%20the%20Act. The Care Act's statutory guidance says: Local authorities should, where possible, actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and the community. "Co-production" is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. /4 Reason for score:			
Is the issue going to impact on lots of people? (*1 being relatively little, 4 being community wide and likely to affect large numbers of people)*			

Measure	Local data	National avg.
Average life expectancy (years – Male/*Female*)	77.9 / *79.7*	79.4 / *83.1*
Average healthy life expectancy (years – M/*F*)	55.9 / *55.1*	63.1 / *63.9*
Infant mortality rate (per 1,000 live births)	6.5	3.9
Suicide rate (per 100,00 population)	16.4	10.4
Adults with a common mental health disorder	18.0 %	16.0 %
Percentage of adults who are overweight or obese	69 %	63.5 %
Adults doing recommended physical activity	57.5 %	65.8 %
Preventable deaths (per 100,000)	215.1	142.2
Adults who smoke regularly	25.7 %	14.5 %
Over-65s receiving long-term adult social care	5.4 %	5.3 %
Economically inactive adults who have long-term health problems	39.6 % (17,000)	25.4 % (10,900)

- Inadequate housing contributes to poor health outcomes for vulnerable residents.

/4

Reason for score:

What is the impact on people on community groups who experience health inequalities and who feel their voice is seldom heard? (*1 being relatively little, 4 likely to affect large*

Indicator	Local data	National avg.
Children living in poverty (after housing costs)	43.2 %	30.0 %
Households experiencing fuel poverty	21.8 %	13.4 %
Gross weekly pay by area of residence	£552.00	£642.20
Percentage of residents who are living in the most deprived 10 % of areas in England	32 %	-
GVA per capita (economic productivity)	£24,175	£31,138

- Stoke-on-Trent has some of the highest rates of debt and insolvency in the UK.
- Increasing levels of reliance upon emergency support.
- The city has the second highest level of fuel poverty in England.

/4

Reason for score:

Does the issue help Healthwatch Stoke-on-Trent to have a positive influence on health and social care services? (*1 being unlikely to, 4 being highly likely to*)

Yes it will enable people to have their voices heard by the city council whilst the community Offer is developed to ensure it meets their needs.

/4

Reason for score:

Does the issue align with local strategies and needs assessments? (*1 being little alignment, and 4 being significant alignment*)

Yes it does

The current Stoke-on-Trent Joint Health and Wellbeing Strategy 2021-2025 has key priorities:

- Start well
- Live well
- Age well
- Healthy city

Plus for the city prioroties

1. **Healthier:** A healthy standard of living for all
2. **Wealthier:** Enabling greater shared prosperity
3. **Safer:** Building safe, empowered communities
4. **Greener:** Environment, growth and wellbeing
5. **Cleaner:** Working together to clean up our city
6. **Fairer:** Tackling inequality to boost life chances

/4

Reason for score:

Is the issue already being dealt with effectively by someone else? (*1 being dealt with satisfactorily by someone else, 4 not being dealt with at all*)

It will support the refreshing of the strategy through our independence ensuring people have their voices heard.

/4

Reason for score:
Total score: /24 Vote of HAB members taken: Y/N Majority reached: Y/N
Decision of the HAB:
Reasons why the decision was made:
Date decision ratified:

Independent Strategic Advisory Board (ISAB) Framework and Terms of Reference

Healthwatch Stoke-on-Trent

healthwatch Stoke on Trent

Engaging Communities Solutions

April 2024

Contents

What is Healthwatch?

Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

The purpose of Healthwatch is to give people using Health and Care Services a powerful voice. By doing so, Healthwatch ensures that the public's views and experiences are heard by those who plan and deliver NHS health and social care services, giving people a real say over how their local services are run.

Healthwatch not only has the ability to influence how services are commissioned, redesigned, and delivered, but are also able to provide advice and information on local service provision and signpost those wishing to make a complaint.

Visions and Values

The vision of Healthwatch is to be the independent patient champion for local people, enabling them to improve health and social care.

Our mission is to listen to local communities and use their views to challenge providers and commissioners to bring about improved services.

Our Objectives are to:

1. Seek out opportunities for service improvement.
2. Be recognised as the independent patient champion.
3. Listen to all the communities' voices and seeking out the quieter voices.
4. Be a credible source for data collection.
5. Be accountable and hold commissioners and providers to account.
6. Be trusted and respected as a fair and professional organisation.

Our Strategy is to:

1. Build public awareness of the Healthwatch brand.
2. Obtain the views of the public.
3. Build strong, sustainable relationships with providers and commissioners.
4. Create effective partnerships with local groups and organisations.
5. Challenge organisations to improve service provision.

Functions of Healthwatch

Statutory Functions of a local Healthwatch

The legislation that has created Healthwatch can be summarised in to eight statutory activities:

1. Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.
2. Enabling local people to monitor the standard of provision of local care services and whether and how local health and social care services could and ought to be improved.
3. Obtaining the views of local people regarding their needs for, and experiences of, local health and social care services and importantly to make these views known.
4. Making reports and recommendations about how local health and social care services could or ought to be improved. These should be directed to commissioners and providers of health and social care services, and people responsible for managing or scrutinising local care services and shared with Healthwatch England.
5. Providing advice and information about access to local health and social care services so informed choices can be made about local care services.
6. Formulating views on the standard of provision and whether and how the local health and social care services could and ought to be improved; and sharing these views with Healthwatch England
7. Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC (Care Quality Commission); and to make recommendations to Healthwatch England to publish reports about issues.
8. Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

The core legislative basis for Healthwatch

The Local Government and Public Involvement in Health Act 2007, amended by the Health and Social Care Act 2012, outlines the main legal requirements for the provision of Healthwatch.

This is underpinned by many other regulations that detail activities undertaken. The law refers to the roles of:

- Local authorities are required to make provisions for Healthwatch statutory duties to be effectively fulfilled.
- Providers of Healthwatch services.

- Healthwatch England, whose main role is to provide advice and support to every local Healthwatch and to provide general recommendations to local authorities on making contractual arrangements for the delivery of Healthwatch duties.

Legislative frameworks are often complex. It is important to consider what legislation states about Healthwatch, local authorities and Healthwatch England. It says:

- What they should do (duties).
- What they may do (powers).
- What is prohibited.

Additional key legislation which Healthwatch should follow

Healthwatch is subject to a wide range of other legislation, and we have identified some of the key areas below. The Health and Care Act 2022 does not change the statutory functions of local Healthwatch but does amend the Local Government and Public Involvement Act 2007 to replace the Clinical Commissioning Group (CCG) with the Integrated Care Board regarding the duty to respond to local Healthwatch reports. Statutory guidance places a requirement on Integrated Care Systems to collaborate with local Healthwatch, e.g., guidance on the preparation of integrated care strategies. www.gov.uk

Legal powers of local Healthwatch

Having been developed under the Health and Social Care Act 2012, local Healthwatch organisations have been granted several legal powers:

1. To gather people's views on, and experiences of, the health and social care system.
2. To send trained Authorised Representatives to 'Enter and View' local services to speak to patients and service users, and observe services being delivered.
3. To make reports and recommendations and to get a response from commissioners and service providers.
4. To have influence on local commissioning decisions through membership of the statutory Health and Wellbeing Board and involvement in preparing joint health and wellbeing strategies.
5. To alert Healthwatch England, or the CQC, where appropriate, to concerns about specific care providers, health, or social care matters.

Other local Healthwatch regulations

Additional to the statutory activities, there several other requirements of a Local Healthwatch organisation:

1. To be an independent organisation.
2. To produce an Annual Report as per the guidance set by the Department of Health.
3. To apply for and hold a licence to use the Healthwatch Trademark.
4. Be accountable under the Freedom of Information Act 2000.
5. To hold meetings in public.
6. To have a decision-making procedure as per the local Healthwatch regulations.
7. For DBS checks for people undertaking volunteer roles like Enter and View to be considered by the local Healthwatch, which should be subsequently satisfied that the individual is a suitable person for the purposes of Enter and View and other volunteering roles. We use the DBS eligibility guidance from gov.uk to determine the appropriate level of check for roles.
8. To publish and maintain a list of Authorised Representatives.
9. To present clear, impartial teams and not involve ourselves in political activities.
10. To have provision for the involvement of lay persons and volunteers in governance and activities.

Governance and Accountability

Contracting and Funding of Healthwatch

The Health and Social Care Act 2012 introduced Healthwatch from 1st April 2013. Each of the 153 upper tier local authority areas in England has its own local Healthwatch organisation. Funding for local Healthwatch was devolved from the Department of Health to each local authority who were then responsible for commissioning a provider to develop an independent Healthwatch organisation in their area. Following a competitive tendering process, the local authority appointed Engaging Communities Solutions CIC (Community Interest Company) as the provider of Healthwatch Stoke-on-Trent.

Governance Model

Local Healthwatch across the country have adopted varying governance structures. Our framework has been developed from over ten years successful implementation and delivery of multiple local Healthwatch organisations within the Midlands, Northwest, and East of England.

This experience has identified that the more complex the governance structure, often the more the nature, role and responsibilities of the Board lack clarity. Our experience has also proven that, due to the contracting and accountability arrangements between Local Authority commissioners and the contracting body, a traditional Fiduciary Board structure only adds to a lack of clarity. It is for this reason therefore we have adopteda model of an Independent Strategic Advisory Body (ISAB). Such a model removes any complexities whilst at the same time provides an effective mechanism to access both external lay and professional wisdom and generate insights and ideas which can only come with distance from the day-to-day operations.

Accountability & Transparency

As holder of the contract from the Local Authority for the development and delivery of Healthwatch Stoke-on-Trent, Engaging Communities Solutions CIC will remain accountable for ensuring that Healthwatch is meeting its statutory and contractual requirements during the contract period. This will be governed by the Engaging Communities Solutions CIC Board who provide strategic leadership and promote good governance and accountability on all contractual, legal, and financial duties of Healthwatch. Overseeing the day-to-day operations of Healthwatch will be the responsibility of the Healthwatch CEO in conjunction with the Managing Director of Engaging Communities Solutions CIC. However, the ISAB will provide added independent lay insight and overview regarding delivery of the annual strategic work programme.

Delivery of the contract against the specified outcomes (KPIs) will be closely monitored by the Managing Director of Engaging Communities Solutions CIC and the Local Authority Commissioner as part of the contract management process. The ISAB will be appraised of the contractual requirements so that their strategic input complements and supports these requirements and enables them to offer effective consideration of delivery against the overarching strategic vision.

Key Features of the ISAB Model

The Healthwatch model of an ISAB differs from 'traditional' Board models as follows:

Traditional role of a Board:

Setting purpose and mission.

Why Healthwatch is different:

This has already been determined by statute – the 8 statutory functions of Healthwatch sets out the purpose. To a further extent have also been determined by the Local Authority commissioner and stipulated in the service specification.

Traditional role of a Board:

Determining the operational delivery and fulfilment of the service.

Why Healthwatch is different:

This has been determined by the provider tender response which forms part of the contract.

Traditional role of a Board:

Determining the work programme.

Why Healthwatch is different:

A high proportion of the workplan is determined in part by each of the above and from what is being raised by the public. There is however scope for the ISAB to contribute to the setting of this.

Traditional role of a Board:

Determining budget and resources.

Why Healthwatch is different:

This has been determined by the tender response, and due to the level of funding, there is limited freedom of movement. The ECS Board retain responsibility for financial management, setting a local budget and allocating resources.

Traditional role of a Board:

Monitoring performance.

Why Healthwatch is different:

Engaging Communities Solutions CIC are responsible for ensuring delivery of the contract to a high standard, and the Local Authority as the commissioner are to ensure this happens.

Traditional role of a Board:

Legal duties.

Why Healthwatch is Different:

The ISAB is created in a voluntary advisory capacity with no legal responsibility/accountability.

Purpose of the ISAB

The central purpose of the ISAB is to ensure a winning strategy for Healthwatch and be a strategic partner within senior management, enabling it to be one of the best Healthwatch services in the country. Its core work includes setting strategic priorities for Healthwatch as aligned to the statutory and contractual requirements; reviewing and modifying strategic plans; and observing the execution of work programmes. The ISAB will also have responsibility for maintaining and safeguarding the independence, probity, and transparency of Healthwatch Stoke-on-Trent, and ensuring that delivery is focused specifically on the needs of local people.

The role of the ISAB does not include:

1. Operational delivery.
2. Operational decisions.
3. A platform for personal agendas.
4. Managing or directing staff.
5. Performance management of staff or Engaging Communities Solutions CIC.

Recruitment and Composition

Membership of the ISAB will comprise of the Engaging Communities Solutions CIC Managing Director or their deputy and local Healthwatch CEO as accountable contract and operational leads, in addition to further individuals (both lay and professional) appointed based on their ability to represent specific needs or voices of local communities. The ISAB will be led by a lay Chair who will Chair all meetings. If the Chair is unavailable or absent, the Chair role will be undertaken by the ECS Managing Director or Deputy.

The recruitment of the Chair will be through open public recruitment. The Chair will receive a small remuneration and be appointed on a Service Level Agreement for a period of three years, with an option to extend the appointment for a further two terms at the discretion of the Managing Director.

ISAB members will be recruited to sit on the board for an initial period of three years, with an option to extend for a further term.

The maximum number of members for the ISAB is 14. The minimum number is 4.

The quorum for the ISAB with 4 members is 2. The quorum for the ISAB with 5,6, or 7 members is 3. The quorum for ISAB's with 8,9 or 10 members is 4. The quorum for ISAB's with 11,12,13 or 14 members is 5.

A dedicated member will be recruited from the Voluntary and Community Sector with the purpose of representing the views of grassroots voluntary and community organisations. To improve our engagement with and representation of younger people, we will seek to ensure that at least one lay member position is held by someone under the age of 30. If necessary, we will co-opt a younger person for a period of time to fulfil this role.

As a minimum the ISAB membership should include the following:

1. Engaging Communities Solutions CIC Managing Director/ Deputy
2. ISAB Chair
3. Local Healthwatch CEO
4. ISAB VSCE – Community Voice (Lay)
5. ISAB Member - Community Voice (Lay)
6. Youth HW representative – CYP (Children and Young People) Voice (Lay)

Additional lay members of the Advisory Body will be selected via an open application process for their knowledge and expertise in one or more of the following areas:

1. Patient and public engagement.
2. Children and young people.
3. Marketing and communications.
4. Health and social care.
5. Volunteer management.
6. Safeguarding.
7. Older People.
8. Strategic leadership.

All applicants will be assessed against the person specification and role description by the recruitment panel. If necessary, Healthwatch will seek out individuals with the right skills representing different areas and interests to maintain a balanced ISAB.

Roles of Individual Members

The person specification and role description for ISAB members detail specific requirements. Attributes and involvement required of individuals will include:

1. Experience – Offer advice and insights that comes from seniority and/or time served experience.
2. Specialist Knowledge – Contribute or be called upon for expert knowledge from their specialist area.
3. Horizon Scanning – To contribute to being the 'eyes and ears' of things Healthwatch needs to be aware of.
4. Local Knowledge – Share knowledge of local concerns, plans or developments.
5. Different Insight – Consider approaches to activity and offer alternative insights.
6. Ideas – Contribute ideas towards mind mapping for the strategy development session.
7. Ambassador – Utilising opportunities to promote and champion the work of Healthwatch and encouraged engagement and involvement by others.
8. Independence – contributing to safeguarding the probity and transparency of Local Healthwatch.

ISAB members, although appointed for their knowledge and/or expertise in particular areas, may also will invariably bring their own specific interest areas. This may present an opportunity with two-way benefit for ISAB members to 'sponsor' a particular area with a view to assessing the potential of inclusion on the future local Healthwatch workplan. This would involve:

1. Being the eyes and ears of development in this area.
2. Identifying potential gaps that fit within the HW remit.
3. Determining how local Healthwatch can offer specialist knowledge to partners in this area.

Requirements of the Role

Meetings

All ISAB members are expected to attend the majority of all scheduled meetings. Absence for three consecutive meetings will, at the discretion of the Chair, disqualify an individual from continuing as a member and the Chair may then request the ISAB to terminate membership, which will be notified to the individual in writing.

Members will be expected to work constructively with other ISAB members and the staff team and be required to allocate time for reading reports and preparing for ISAB Meetings.

Members will also be required to respond to requests for approval of decisions and or projects within a 7-day timeframe to ensure efficient governance and decision-making processes are adhered to.

The format of ISAB meetings will be led by the approved agenda and the business of the ISAB will, as far as possible, be conducted by consensus of members. If necessary, decisions will be made by simple majority vote. All members shall have one vote. In the event of a tied vote, the Chair will have the casting vote.

All decisions must be made in accordance with the Decision-Making Process and Procedure.

Representing Healthwatch

There may be times when there may be two-way benefits or efficiencies in ISAB members attending meetings or events under the guise of Healthwatch. Any such circumstances would be based on the following requirements:

1. It is at the request of, or agreement by, the Executive team.
2. The meeting is sufficiently prepared for, including reading papers for the meeting in advance, and liaising with the Healthwatch CEO/ Manager in advance for any pertinent updates or information.
3. The most economical means and route of transport are agreed with the Operational Leads.
4. A summary or outcomes of the meeting are fed back to the Executive team and wider ISAB.
5. Requests or decisions are not committed to by the representative but are instead fed back to the Executive team.
6. Representatives are clear in their remit for being at the meeting.
7. Individual views are not presented as being those of Healthwatch. If there is a strong desire to present a personal view, the representative is to be implicit in informing the meeting that it is their own view and not that of Healthwatch.
8. A professional image is always portrayed.

If an ISAB member is attending a meeting in another personal or professional capacity, then they should ensure that other attendees and minute taker are aware that they

are there in that capacity, and not on behalf of Healthwatch.

Communications with partners and stakeholders

It is important that all contact with partners and stakeholders is made via the Executive team. The reasons for this being:

1. It ensures information is up to date with other activity taking place.
2. It ensures there is not conflicting messaging with what has been conducted by the Executive team.
3. It allows for consistency in delivery of all activity.
4. Partners are not confused by multiple contact points to the service.
5. All activity can be recorded and followed up appropriately.
6. It ensures all parties are involved in any relevant decision-making requests.

Invariably by attending meetings in the capacity as an ISAB member, there will be the need to contribute to discussions which is encouraged, however the above impacts should be considered in doing so.

Eligibility

Anyone who is over the age of 18 and lives in, or uses health or social care services within, the Local Authority boundary is eligible to apply. However, the following exceptions may apply:

1. Current health and social care providers (Managers, Trustees, employers, and current employees) whose main function is to provide services in the Healthwatch contracted area.

2. People whose work directly involves them in commissioning health or social care services in/for the Healthwatch contracted area, or in commissioning or making strategic policy for other local authority services.

Applicants are expected to provide honest, full, and accurate information and any failure to declare relevant information, or the provision of false information could result in an application being rejected or a place on the ISAB being withdrawn. Applicants must declare any relevant personal, professional, or commercial interests in any matters which are likely to be passed before the ISAB.

A conflict may arise from financial, professional, or personal circumstances, and may include but are not limited to:

1. Direct financial gain or benefit to the member, such as:
    A. Payment to an ISAB for services provided to the Healthwatch organisation.
    B. The award of a contract to another organisation in which an ISAB member has an interest and from which an ISAB member will receive a financial benefit.
    C. The employment of an ISAB member in a separate post within the Healthwatch organisation, even when the member has resigned in order to take up the employment.
2. Indirect financial gain, such as employment by the Healthwatch organisation of a spouse or partner of an ISAB member.
3. Non-financial gain, such as when a user of Healthwatch services is also an ISAB member.
4. Conflict of loyalties, such as where an ISAB member is appointed by the local authority or by one of the funders of Healthwatch, or where a friend of an ISAB member is employed by Healthwatch.

ISAB Meetings

The ISAB will meet formally at least four times a year, with dates, venues and agendas for meetings published in advance. Apart from the annual strategy development workshop, all meetings will be in public to further enable lay involvement.

The agenda for the meetings will be set on an annual basis in order to ensure effectiveness and optimum contribution. Having a set annual schedule will also enable planned priorities to be adhered to, whilst also being able to effectively monitor capacity to respond to unexpected demands.

Standing items of the ISAB will include:

1. Declaration of Interests.

(All ISAB meetings have Declarations of Interest as a standing agenda item for all meetings. Members who may be perceived as conflicted by an interest in an item under discussion- whether personal or by association with another organisation or enterprise with which they are associated- are required to have this recorded in the notes of the meeting. At the discretion of the Chair, the individual should remain silent

or, if appropriate, withdraw from the meeting for the relevant item and this should be recorded in the notes of the meeting).

2. Apologies.
3. Minutes & Matters arising.
4. Past quarter activity and developments (for info)
5. Decision log (for info)
6. Progress against strategic plan.
7. Themes and trends reported in last quarter.
8. Risk log, including ad hoc/unexpected requests and ability to respond.
9. ISAB members feedback/horizon scanning.
10. HW Network scoping feedback.
11. Public questions.

Other key areas of business discussed over the course of the year will include:

1. Annual work planning.
2. Thematic project planning and review.
3. Annual Report collation.

Annual Workplan Setting

At the beginning of each calendar year, the ISAB will set out the strategic priorities for the 12 months ahead. The setting of priorities will be facilitated by a matrix approach that enables the ISAB members to identify and map them against the statutory and contractual requirements. Intelligence that is gathered by the Healthwatch team, including themes and trends, in addition to known system workplans and strategies, will be provided to help inform decision making. A separate decision matrix will then also be utilised to aid in identifying which specific issues Healthwatch should focus upon, that ensures the decision is equitable, avoids duplication and enables Healthwatch to make optimum impact.

Due to the cross-boundary nature with neighbouring Healthwatch, and the potential for having a shared contracted provider, there is also potential to hold future joint strategy development sessions with the fellow Healthwatch ISAB's (Independent

Strategic Advisory Board) and teams. Not only will this aid the avoidance of duplication, but it will also help maximise resources, skills, intelligence, and impact, as well as enabling l opportunities for joint pieces of work.

Following the annual strategy development, the Healthwatch team then translates this in to an operational workplan, for agreement, and commencement of delivery in the April, in time for the new financial and contractual year.

Code of Conduct

ISAB Members will be expected to abide fully with the ECS (Engaging Communities Solutions)/ Healthwatch code of conduct and the Nolan Seven Principles of Public Life thus maintaining high standards of probity. They must also present a positive image of the wider ISAB and Healthwatch at external events.

The Principles of Public Life are a template for conduct in the public domain. Healthwatch ISAB Members will follow these principles and be expected to sign up to a code of practice pertaining to:

1. **Selflessness –** Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefit for themselves, their families, or their friends.
2. **Integrity –** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
3. **Objectivity –** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
4. **Accountability –** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
5. **Openness –** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest demands.
6. **Honesty –** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
7. **Leadership –** Holders of public office should promote and support these principles by leadership and example

healthwatch
Stoke-on-Trent

An Insight Report: Access to Healthcare for People in Stoke-on-Trent Living with a Visual Impairment

January 2024

Contents

Background

Healthwatch Stoke-on-Trent is the city's independent health and social care champion. We are here to listen to the experiences of local people using local health and care services and about the issues that matter to the people of Stoke-on-Trent.

Accessible Information Standard

The Accessible Information Standard was published by NHS England, following approval as a new 'information standard' for the NHS and adult social care system, in July 2015. Officially called DCB1605 Accessible Information (and formerly SCCI1605 Accessible Information), the Accessible Information Standard ('the Standard') directs and defines a specific, consistent approach to identifying, recording, flagging, sharing, and meeting individuals' information and communication support needs, where those needs relate to a disability, impairment, or sensory loss. By law (section 250 of the Health and Social Care Act 2012), from 1st August 2016 onwards, all organisations that provide NHS care and/or publicly funded adult social care must follow the Standard in full. Organisations that commission NHS care and/or publicly funded adult social care, for example Clinical Commissioning Groups (CCGs) and local authorities, must also support implementation of the Standard by provider organisations.

The Accessible information standard is made up of 5 principles:

1. Ask - Find out if a person has any communication or information needs because of a disability or sensory loss and if so, what they are.
2. Record - Record those needs in a straightforward way that everyone agrees with. This could be done on a computer or on paper.
3. Highlight - Make sure that a person's needs stand out whenever their records are checked. This means something can be done straight away.
4. Share - Include information about a person's needs as part of data sharing and make sure it is in line with other information you have.
5. Act - Make sure that people get information which they can access and understand and get communication support if they need it.

Throughout January to March 2017, NHS England led a post-implementation review of the Standard, with the aim of assessing its impact and ensuring that it is and continues to be 'fit for purpose'. The key themes which emerged as part of review were:

- There is widespread support for the overarching aims of the Standard, and for the Standard itself, although some organisations have concerns about costs.
- Patients, service users, carers and parents are clear that receiving accessible information and communication support is essential if they are to receive safe, high-quality care, to maintain their privacy and dignity, and to be involved in decisions about their care and treatment.
- Implementation of / compliance with the Standard is variable both across and within organisations, with particular (but differing) challenges identified by both large and small organisations of all types.

The most commonly raised implementation challenges relate to difficulty in adjusting electronic patient record systems (specifically as regards to recording and flagging of needs, and producing alternative formats), lack of awareness / the need for improved communications about the Standard and competing demands on staff time.

According to Staffordshire Sight Loss Association website, there are 16,020 people living with sight loss in North Staffordshire and this figure is expected to rise to 19,070 by 2030. We contacted the organisation to find out about the experiences of people living in Stoke on Trent with sight loss accessing services.

Initial Contact

In 2022 we visited Staffordshire Sight Loss Association (SSLA) to talk about the role of Healthwatch as a local health and care champion supporting individuals and groups to have their voice heard by decision makers involved in providing health and social care services and to use feedback to improve care and services. At the initial introductory meeting we heard from people who indicated to us some of the difficulties they encountered accessing health and social care services and told us of some of the main barriers they faced. As a result of this meeting, we decided to look further at the issues people with sight loss face when accessing services in Stoke on Trent and decided initially to focus on accessibility of the Ophthalmic outpatient services based in University Hospital North Midlands (UHNM).

What we did

In September 2023, we facilitated a focus group to seek their views on their experiences of accessing services. We engaged with nine members of the community. This was a face-to-face focus group session led by a member of the Healthwatch Stoke-on-Trent team.

We also arranged an observational visit to the eye clinic at The Royal Stoke University Hospital to find out more about the experience of somebody with sight loss attending local services.

Our Findings

Focus Group with Staffordshire Sight Loss Association (SSLA)

Information and Support

Whilst everyone's story of how they lost their sight was different, the common theme that everyone expressed was that once it had happened there was no help, support or guidance provided unless you go out of your way to find it yourself. People told us that when meeting with a consultant to get a diagnosis, it is no more than a diagnosis. All the group felt that they were left in limbo and expected to 'just get on with it' as best they could and find out for themselves what was out there in terms of help.

> *"Unless you ask the consultants, and I've seen hundreds of them, they don't tell you anything. Take being registered for example – you've got to ask them if you're eligible to be registered blind or partially-sighted. They're not forthcoming at all." – Member of SSLA.*

One person shared with us that at one appointment, a consultant had informed them of the help desk and offered to take them there. However, due to the timing of the appointment, the help desk was closed.

People told us that when referrals are made on their behalf to other services, due to waiting lists and the lack of a clear pathway, people who are newly diagnosed are still left for some time without professional support or knowledge of what is happening. During this time, they are heavily reliant on others to help them in regain their independence. This can lead to strong feelings of helplessness.

> *"The consultant was lovely and was giving me the information, they had got but to me it was more of a form filling exercise. I felt they wanted to get the form done and get me out of the room as quickly as possible." – Member of SSLA.*

Treatment

A theme that emerged from the focus group was that people are generally treated the same way when attending the eye clinic whatever the condition and the cause of the impairment. They reported that they tended to go through the same routine eye tests reading the eye charts even those who had no sight left at all and people described this as being futile and humiliating. People described feeling like they were being treated as all the same and not as an individual with potentially different needs requiring different solutions.

"It's as if the eye clinic had never met anyone with sight problems before." – Member of SSLA.

Accessibility

The fifth principle of the NHS accessible information standard states that organisations should make sure that people get information which they can access and understand and get communication support if they need it. Through this focus group we heard that people attending the eye clinics were generally happy that their accessible information needs are being met via large print letters, people who require their information in braille said their needs were not being met. An individual had shared that any correspondence in braille coming from the NHS was squashed and illegible, however in comparison their bank has sent letter in braille without issue.

Confidentiality and Independence

Most of the people attending the focus group felt that NHS staff make an assumption that they will have family or friends who will step in and meet their needs to get to appointments, read letters, etc. Therefore, help is not often offered or enquired about. This again can feel very disempowering to people who do not have support available and takes away confidentiality and independence when they are forced to call upon friends or family to attend appointment with them.

"At the moment, I've got no faith in the NHS whatsoever." – Member of SSLA.

Observation Visit to University Hospitals of North Midlands NHS Trust (UHNM) Eye Clinic

The second part of this work included an observational visit to the eye clinic at UHNM on the 30th November 2023. We had planned to carry out an observational visit with 2 people involved with Staffordshire Sight Loss Association. However, this visit had to be aborted due to issues of parking at UHNM having spent over 1 hour looking for parking. The visit was therefore carried out by Healthwatch Stoke-on-Trent staff over a 3-hour period.

Access

The Ophthalmology department is located on the ground floor of the main building in UHNM. Upon entry into the main building the enquiry desk is on the far left-hand side having moved from a more central point straight ahead of the entrance and is not so evident, especially if you have a visual impairment. There are volunteers based at the main desk to help guide people to the correct location, but no one was around at the time we visited so this would not have been evident. On our initial visit to the clinic, we attended the desk to ask for directions to the eye clinic but were not asked if we needed assistance and none was obviously available as we were directed to the clinic by pointing out the direction.

There are central digital check-in desks which provides people with visual problems the option of a large print facility for checking in. The signage guiding people to ward is above, high up on the wall, which according to the helpdesk is suitable for those who are visually impaired. The signage to the eye clinics is on a yellow background with black text, which is more accessible to those with visual impairments. However, signs to all other departments are, in most cases, white text on grey background so finding your way anywhere else in the hospital could be difficult. The assumption seems to be that if you are visually impaired, you only need to visit the eye clinic, or that those who are visually impaired have other means to access anywhere else, as alone it would be difficult.

Within the clinic itself signage is not always clear, as we found when we were left to wander from area to area unescorted. Patients were often sent to different seating areas after one part of their appointment procedure was completed but didn't always understand terminology like 'sub wait 5'. Some patients told us when asked what they were waiting for next were unsure saying that they were just told to go and wait there. A patient with severe sight impairment would be likely to struggle if they were unescorted trying to find their way around the 3 different waiting areas.

Information

The information displayed on the notice boards in each waiting area was clear and mostly in a user-friendly format. It was from observations all in English with no indication that it was available in other formats. Braille is not offered as an option but can be made available if a patient asks for it. As brought to our attention through the focus groups, there are some practical problems with providing information in braille due to the postal systems use of rollers which flattens the braille, but this is overcome in other sectors such as banking so it should be available through the NHS. Most patients told us that they received information and appointments by letter. For most this is not a problem as the hospital generally send out letters in the format requested. The hospital work with a 3rd part organisation who print off all letters in the format requested and most people said that this was fine, if they couldn't read it themselves they would get family to read it for them, we did not meet anyone in clinic who had no sight so couldn't gauge how they would manage if they needed alternative forms of information.

Information about the diagnosis and treatment and support available was not always given to people at the time and it appeared a bit and miss as to whether people got any information at all and people were not all clear about where they should go for help. There was no clear pathway in place that ensured patients received information and support they needed to maintain and enhance independence. The most obvious place to direct patients seemed to be through the help desk and some patients are referred to them as a matter of course but others are not, and it is at the discretion of individual consultants and staff as to whether they think it is necessary and appropriate. A couple of people in the waiting room talked about issues around finances and knowing what help they could get because of not being able to work again and transport was raised as a concern which they would have liked help with. We were told by the helpdesk staff that telephone numbers are available but are not always given out to patients and it is often the consultant or other medical staff who makes the decision as to whether it is appropriate to tell patients depending upon their condition rather it seemed than personal circumstances.

Communication

Feedback to patients on progress of their condition was an issue that was raised several times by people we met in the waiting areas and from the group discussion. People reported that there were problems with communication upon and following diagnosis. Most people were happy with the format of the written information received but the level of information and support received following diagnosis was seen as requiring improvement. People in the waiting areas

reported that information about their treatment and their progress was not good. One patient told us that they had asked the medical practitioner at the macular clinic how their treatment was progressing and were told that they would receive a response by letter but that this was never forthcoming, and they have never been given an answer even though they ask the same question at each appointment. The issue of certification and registration was also raised as an issue in which communication was not always clear and forthcoming.

Participants also suggested that the communication between services was not great and that the transition from diagnosis, to signposting, to support services was not consistent and led to lengthy delays for some in accessing the support they required. People reported that it would be helpful to have a clear pathway in place between diagnosis and support so that it wasn't just left to the individual to search around and chase people to get the support they need.

Patients we spoke to in the waiting areas told us they would appreciate being communicated with about delays in appointments as they felt they are often left waiting for their appointment without being told that there was a delay. We learned that several appointments are made at the same time with the first being before the time the clinic starts but patients do not appear to know this which can cause some frustration when they receive no communication about delays.

Next Steps

Sight loss can be disempowering if people need to rely on others for help and support with many everyday activities. However simple, sensible, and empathetic actions can allow people with sight loss to live fuller and more independent lives.

The NHS Accessible Information Standard reflects the varied communication and accessibility needs of people with disabilities. The standard requires NHS services to identify, record, flag, share, and act on the information needs of patients. Full and widespread implementation of this standard will significantly help people with sight loss, but sustainable implementation relies on a regular review of the application of the standard to ensure it consistently meets and adapts to the needs of patients. From our findings, it appears there is a mixed picture of accessibility, information, and communication for people with sight loss and areas that could be improved quite easily in each area. This could be achieved by Ophthalmology services working closely with Staffordshire Sight Loss Association (SSLA) to identify actions that can be taken to improve the experience of patients from the perspective of those with lived experience of the service.

This small study focused on accessibility to a small area of the NHS specialist services. People with sight loss also access the whole range of services in primary and community care. It may be an area of work that could be expanded to look at how these services meet the needs of people with sight and other impairments who fall withing the Accessible Information Standard.

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We are committed to the quality of our information. Every three years we perform an in-depth audit so that we can be certain of this.

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An Insight Report: Access to Healthcare for People in Stoke-on-Trent Living with a Visual Impairment

January 2024

Large Print

Contents

Background

Healthwatch Stoke-on-Trent is the city's independent health and social care champion. We are here to listen to the experiences of local people using local health and care services and about the issues that matter to the people of Stoke-on-Trent.

Accessible Information Standard

The Accessible Information Standard was published by NHS England, following approval as a new 'information standard' for the NHS and adult social care system, in July 2015. Officially called DCB1605 Accessible Information (and formerly SCCI1605 Accessible Information), the Accessible Information Standard ('the Standard') directs and defines a specific, consistent approach to identifying, recording, flagging, sharing, and meeting individuals' information and communication support needs, where those needs relate to a disability, impairment, or sensory loss. By law (section 250 of the Health

and Social Care Act 2012), from 1st August 2016 onwards, all organisations that provide NHS care and/or publicly funded adult social care must follow the Standard in full. Organisations that commission NHS care and/or publicly funded adult social care, for example Clinical Commissioning Groups (CCGs) and local authorities, must also support implementation of the Standard by provider organisations.

The Accessible information standard is made up of 5 principles:

1. Ask - Find out if a person has any communication or information needs because of a disability or sensory loss and if so, what they are.
2. Record - Record those needs in a straightforward way that everyone agrees with. This could be done on a computer or on paper.
3. Highlight - Make sure that a person's needs stand out whenever their records are checked. This means something can be done straight away.

4. Share - Include information about a person's needs as part of data sharing and make sure it is in line with other information you have.
5. Act - Make sure that people get information which they can access and understand and get communication support if they need it.

Throughout January to March 2017, NHS England led a post-implementation review of the Standard, with the aim of assessing its impact and ensuring that it is and continues to be 'fit for purpose'. The key themes which emerged as part of review were:

- There is widespread support for the overarching aims of the Standard, and for the Standard itself, although some organisations have concerns about costs.
- Patients, service users, carers and parents are clear that receiving accessible information and communication support is essential if they are to receive safe, high-quality care, to maintain their privacy and dignity, and to be involved in decisions about their care and treatment.

- Implementation of / compliance with the Standard is variable both across and within organisations, with particular (but differing) challenges identified by both large and small organisations of all types.

The most commonly raised implementation challenges relate to difficulty in adjusting electronic patient record systems (specifically as regards to recording and flagging of needs, and producing alternative formats), lack of awareness / the need for improved communications about the Standard and competing demands on staff time.

According to Staffordshire Sight Loss Association website, there are 16,020 people living with sight loss in North Staffordshire and this figure is expected to rise to 19,070 by 2030. We contacted the organisation to find out about the experiences of people living in Stoke on Trent with sight loss accessing services.

Initial Contact

In 2022 we visited Staffordshire Sight Loss Association (SSLA) to talk about the role of Healthwatch as a local health and care champion supporting individuals and groups to have their voice heard by decision makers involved in providing health and social care services and to use feedback to improve care and services. At the initial introductory meeting we heard from people who indicated to us some of the difficulties they encountered accessing health and social care services and told us of some of the main barriers they faced. As a result of this meeting, we decided to look further at the issues people with sight loss face when accessing services in Stoke on Trent and decided initially to focus on accessibility of the Ophthalmic outpatient services based in University Hospital North Midlands (UHNM).

What we did

In September 2023, we facilitated a focus group to seek their views on their experiences of accessing services. We engaged with nine members of the

community. This was a face-to-face focus group session led by a member of the Healthwatch Stoke-on-Trent team.

We also arranged an observational visit to the eye clinic at The Royal Stoke University Hospital to find out more about the experience of somebody with sight loss attending local services.

Our Findings

Focus Group with Staffordshire Sight Loss Association (SSLA)

Information and Support

Whilst everyone's story of how they lost their sight was different, the common theme that everyone expressed was that once it had happened there was no help, support or guidance provided unless you go out of your way to find it yourself. People told us that when meeting with a consultant to get a diagnosis, it is no more than a diagnosis. All the group felt that they were left in limbo and expected to 'just get on with it' as best they could

and find out for themselves what was out there in terms of help.

> *"Unless you ask the consultants, and I've seen hundreds of them, they don't tell you anything. Take being registered for example – you've got to ask them if you're eligible to be registered blind or partially-sighted. They're not forthcoming at all." – Member of SSLA.*

One person shared with us that at one appointment, a consultant had informed them of the help desk and offered to take them there. However, due to the timing of the appointment, the help desk was closed.

People told us that when referrals are made on their behalf to other services, due to waiting lists and the lack of a clear pathway, people who are newly diagnosed are still left for some time without professional support or knowledge of what is happening. During this time, they are

heavily reliant on others to help them in regain their independence. This can lead to strong feelings of helplessness.

"The consultant was lovely and was giving me the information, they had got but to me it was more of a form filling exercise. I felt they wanted to get the form done and get me out of the room as quickly as possible." – Member of SSLA.

Treatment

A theme that emerged from the focus group was that people are generally treated the same way when attending the eye clinic whatever the condition and the cause of the impairment. They reported that they tended to go through the same routine eye tests reading the eye charts even those who had no sight left at all and people described this as being futile and humiliating. People described feeling like they were being treated as all the same and not as an individual

with potentially different needs requiring different solutions.

"It's as if the eye clinic had never met anyone with sight problems before." – Member of SSLA.

Accessibility

The fifth principle of the NHS accessible information standard states that organisations should make sure that people get information which they can access and understand and get communication support if they need it. Through this focus group we heard that people attending the eye clinics were generally happy that their accessible information needs are being met via large print letters, people who require their information in braille said their

needs were not being met. An individual had shared that any correspondence in braille coming from the NHS was squashed and illegible, however in comparison their bank has sent letter in braille without issue.

Confidentiality and Independence

Most of the people attending the focus group felt that NHS staff make an assumption that they will have family or friends who will step in and meet their needs to get to appointments, read letters, etc. Therefore, help is not often offered or enquired about. This again can feel very disempowering to people who do not have support available and takes away confidentiality and independence when they are forced to call upon friends or family to attend appointment with them.

"At the moment, I've got no faith in the NHS whatsoever." – Member of SSLA.

Observation Visit to University Hospitals of North Midlands NHS Trust (UHNM) Eye Clinic

The second part of this work included an observational visit to the eye clinic at UHNM on the 30th November 2023. We had planned to carry out an observational visit with 2 people involved with Staffordshire Sight Loss Association. However, this visit had to be aborted due to issues of parking at UHNM having spent over 1 hour looking for parking. The visit was therefore carried out by Healthwatch Stoke-on-Trent staff over a 3-hour period.

Access

The Ophthalmology department is located on the ground floor of the main building in UHNM. Upon entry into the main building the enquiry desk is on the far left-hand side having moved from a more central point straight ahead of the entrance and is not so evident, especially if you have a visual impairment. There are volunteers based at the main desk to help guide people to the correct location, but no one was around at the time we

visited so this would not have been evident. On our initial visit to the clinic, we attended the desk to ask for directions to the eye clinic but were not asked if we needed assistance and none was obviously available as we were directed to the clinic by pointing out the direction.

There are central digital check-in desks which provides people with visual problems the option of a large print facility for checking in. The signage guiding people to ward is above, high up on the wall, which according to the helpdesk is suitable for those who are visually impaired. The signage to the eye clinics is on a yellow background with black text, which is more accessible to those with visual impairments. However, signs to all other departments are, in most cases, white text on grey background so finding your way anywhere else in the hospital could be difficult. The assumption seems to be that if you are visually impaired, you only need to visit the eye clinic, or that those who are visually impaired have other means to access anywhere else, as alone it would be difficult.

Within the clinic itself signage is not always clear, as we found when we were left to wander from

area to area unescorted. Patients were often sent to different seating areas after one part of their appointment procedure was completed but didn't always understand terminology like 'sub wait 5'. Some patients told us when asked what they were waiting for next were unsure saying that they were just told to go and wait there. A patient with severe sight impairment would be likely to struggle if they were unescorted trying to find their way around the 3 different waiting areas.

Information

The information displayed on the notice boards in each waiting area was clear and mostly in a user-friendly format. It was from observations all in English with no indication that it was available in other formats. Braille is not offered as an option but can be made available if a patient asks for it. As brought to our attention through the focus groups, there are some practical problems with providing information in braille due to the postal systems use of rollers which flattens the braille, but this is overcome in other sectors such as banking so it should be available through the NHS.

Most patients told us that they received information and appointments by letter. For most this is not a problem as the hospital generally send out letters in the format requested. The hospital work with a 3rd part organisation who print off all letters in the format requested and most people said that this was fine, if they couldn't read it themselves they would get family to read it for them, we did not meet anyone in clinic who had no sight so couldn't gauge how they would manage if they needed alternative forms of information.

Information about the diagnosis and treatment and support available was not always given to people at the time and it appeared a bit and miss as to whether people got any information at all and people were not all clear about where they should go for help. There was no clear pathway in place that ensured patients received information and support they needed to maintain and enhance independence. The most obvious place to direct patients seemed to be through the help desk and some patients are referred to them as a matter of course but others are not, and it is at the discretion of individual consultants and staff

as to whether they think it is necessary and appropriate. A couple of people in the waiting room talked about issues around finances and knowing what help they could get because of not being able to work again and transport was raised as a concern which they would have liked help with. We were told by the helpdesk staff that telephone numbers are available but are not always given out to patients and it is often the consultant or other medical staff who makes the decision as to whether it is appropriate to tell patients depending upon their condition rather it seemed than personal circumstances.

Communication

Feedback to patients on progress of their condition was an issue that was raised several times by people we met in the waiting areas and from the group discussion. People reported that there were problems with communication upon and following diagnosis. Most people were happy with the format of the written information received but the level of information and support received following diagnosis was seen as requiring improvement. People in the waiting

areas reported that information about their treatment and their progress was not good. One patient told us that they had asked the medical practitioner at the macular clinic how their treatment was progressing and were told that they would receive a response by letter but that this was never forthcoming, and they have never been given an answer even though they ask the same question at each appointment. The issue of certification and registration was also raised as an issue in which communication was not always clear and forthcoming.

Participants also suggested that the communication between services was not great and that the transition from diagnosis, to signposting, to support services was not consistent and led to lengthy delays for some in accessing the support they required. People reported that it would be helpful to have a clear pathway in place between diagnosis and support so that it wasn't just left to the individual to search around and chase people to get the support they need.

Patients we spoke to in the waiting areas told us they would appreciate being communicated with

about delays in appointments as they felt they are often left waiting for their appointment without being told that there was a delay. We learned that several appointments are made at the same time with the first being before the time the clinic starts but patients do not appear to know this which can cause some frustration when they receive no communication about delays.

Next Steps

Sight loss can be disempowering if people need to rely on others for help and support with many everyday activities. However simple, sensible, and empathetic actions can allow people with sight loss to live fuller and more independent lives.

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