healthwatch Rutland

Paper 3

To: **LLR CCG commissioning and transformation leads for Urgent Care**

Cc: **Oakham Medical Practice**
Latham House Medical Practice
DHU Healthcare

Urgent Care stories: Rutland

Three stories have been brought to the attention of Healthwatch Rutland (HWR) by the public recently that create a concerning picture of Rutland patient experiences with urgent care services (see appendix). These stories relate to services that variously included NHS 111, Oakham Minor Injuries Unit, Oadby Urgent Care Centre, GP practices at Latham House Melton Mowbray and Oakham Medical Practice as well as Emergency departments at Leicester Royal Infirmary and Peterborough City Hospitals.

In each case the patient and carer have received confusing and/or inaccurate information, leading to their stated views that they had to make unnecessary journeys that wasted time and in one case significantly heightened anxiety.

We draw attention to the following issues highlighted by these patient stories:

Issue	Service provider
Case 1: NHS111, Oakham Minor Injuries Unit, Peterborough City Emergency Department 4 March 2022	
NHS 111 operator was poorly informed of urgent care options realistically available to this Rutland patient. A suspected broken finger was referred to Oakham MIU that did not have X-ray facilities at the time of the incident.	Derbyshire Health United Healthcare (DHU)
NHS 111 seemed unclear on the location and address of the MIU.	DHU
Advice from NHS 111 operator that walk-in service was available with no prior appointment was found to be correct in practice but conflicted with the family's own online search result.	LLR CCG
Requirement to register as a temporary Oakham Medical Practice patient before accessing care at the MIU was not understood by the family and in fact was unsuccessful as the registration was not logged on the system; no patient notes were therefore available to the MIU practitioner.	OMP
Case 2: Latham House Medical Practice, Oadby Urgent Care Centre, EMAS, Leicester Royal Infirmary ED 21 March 2022	
Administrative error by practice receptionist sent a patient bleeding heavily to OUCC with no appointment that day.	LHMP
Reception and Doctor "unnecessarily very hostile and rude" although the family member of the patient "begged the doctor to see my daughter". Receiving no help from OUCC the patient was self-conveyed by family to LRI on the advice of EMAS.	DHU
Case 3: NHS 111, Oakham Medical Practice 28 April 2022	
NHS 111 operator booked a face-to-face appointment with the GP practice and confirmed that it was indeed face-to-face when the	DHU

patient asked the operator specifically to check. The appointment came through as a telephone triage call at the GP practice.	
GP receptionist initially offered little flexibility to accommodate the patient in view of the error, until specifically asked to escalate to the practice manager - after which arrangements were made to see the patient at the associated MIU.	OMP
Patient commented that the lack of flexibility to make good after a booking error seemingly placed the receptionist in a vulnerable position.	OMP

HWR feels that these individual items of feedback highlight indicate areas along urgent care pathways that require strengthening:

- Improved information/training for NHS 111 operators who are poorly informed of the urgent care options available to Rutland patients; the processes, the clinical offer, and in one case the actual location of the urgent care provider site.
- Clear communication of urgent care offer for Rutland, to improve patients' understanding of the services and what clinical diagnosis/care they can expect from which urgent care sites and when.
- More flexibility available to receptionists/care navigators to accommodate patient's needs when booking/referral errors have been made.

We note that in two of these cases, additional pressure was put onto busy Emergency Departments when the patients could/should have been cared for in urgent care settings.

We therefore ask that you share these stories with transformation leads and communicate back to us what changes to training, processes, and public communications activities will be made to ensure such situations do not continue to occur.

Healthwatch Rutland
4 May 2022

Appendix

Case 1: Visit to Rutland Minor Injuries Unit Friday 4th March

My daughter recently had a suspected broken finger so I rang 111 at about 4 pm on Friday night to find out what I should do.

They suggested I see someone. There seemed to be some confusion as to whether I should be going to the Oakham Medical Practice or the Rutland Memorial Hospital. The lady then seemed to have some difficulty locating the address but did in the end. 111 told me that I did not need an appointment just to go along (although when I looked at other information about RMH online it said you needed an appointment, so I was a bit confused) however we drove up to Oakham and I just dropped into RMH without an appointment, which seemed fine.

In the hospital I needed to fill out a temporary form to register with Oakham Medical Practice, I then had to walk over to the surgery and wait for them to answer the door, drop the form in, then walk back to the hospital and then we could sit and wait to be seen. We were seen promptly by a very nice, efficient and caring Doctor. Unfortunately, my temporary form was not added to the computer so the Doctor did not have any of our information, he couldn't write anything down as it still didn't come through by the end of the examination, he thought my daughter's finger was broken and that she needed an Xray. He then said that the x-ray machine wasn't available which seemed a bit strange for a

minor injuries unit. It would be good if there was communication to direct you to where you needed to go for your ailment, i.e., when you tell 111 you have a broken finger and get sent somewhere the x-ray machine was not available.

The doctor told me I would need to attend another unit. I didn't want to drive anywhere again and be told that they didn't have an X-ray machine so I asked what to do, the doctor said to ring Corby's urgent care X-ray dept. they said they were open until 8 p.m. but it was best not to come down as they had long queues unless I had a doctor's referral, I said I can't have a referral as my doctor cant access his computer and records and I asked if they could talk to the doctor on the phone which they agreed to but still wouldn't accept his verbal referral. I was unable to have a referral appointment as I had no written information.

I then did not know where to go or where would be the least busy place on a Friday night. I had been to Peterborough walk-in centre before and had very good service so I drove to Peterborough from Oakman which took about 30 minutes. When we arrived at the A and E and minor injuries unit (they are adjoining) they were so busy and full of very sick people my daughter started crying and wanted to go home as she was in pain and upset by seeing everyone else so ill. We decided to stay as the Doctor at RMH had said it was best to get it seen straight away in case it started healing in the wrong way. We waited for three and a half hours to be seen, it was understandable as there were people much sicker than my daughter but a bit frustrating to know if the RMH x-ray machine was working/or we went to Peterborough straight away the process would have been much easier. We had good service from the nurse practitioner and nurse that eventually saw us and got an X-ray that confirmed my daughter had broken her finger, they applied a dressing to keep her fingers together. We arrived home at 10 p.m. Afterwards someone mentioned that I should have tried the Stamford Minor Injuries unit which is closer and possibly less busy but this was never suggested to me. The process felt a lot more complicated than it needed to be.

Case 2: Experiences of NHS with my daughter

My daughter had a gynaecological procedure at Leicester General Hospital on 21st March. She was advised to contact her GP in the event of excessive bleeding. She returned to work.

During the afternoon she began to feel unwell and decided she should return home. When she stood up, blood gushed from her to the extent that it was all over her, her chair and her office carpet. She managed to get home but the heavy bleeding persisted. She tried to ring her GP practice, Latham House, Melton Mowbray as per the instructions. It took her the best part of an hour to get through to Latham House and she was told there were no appointments available. The call handler booked her into the Oadby Urgent Care Centre – telling her the appointment was for 8.30pm that evening.

My daughter is a single parent with two young children. She did not feel well enough to drive. She asked me and my husband to help out. We drove to her house and my husband stayed with the children while I drove our daughter to the Oadby UCC. By the time we had got from the car to the waiting area my daughter was on the point of collapse. I went to book her in and understood that the patient who had arrived just before her had been told to attend Oadby UCC but Latham House had actually booked him into the Oakham out of hours facility. The doctor refused to see him.

When I tried to book my daughter in they told me Latham House had booked her in for 8.30am the next day and not 8.30 pm that evening. I explained that my daughter was bleeding heavily and on the point of collapse and needed to be seen by a doctor urgently. The doctor came out of his room and said it was not 'his remit' to

see her. We both felt that the receptionist and doctor at Oadby UCC were unnecessarily very hostile and rude (neither of us were being aggressive or abusive. I actually begged the doctor to see to my daughter!).

We went out to my car and I tried phoning NHS111 for help. The recorded message informed me that NHS111 was too busy to take my call and to look on line for self-help. I have never felt so vulnerable in any of my dealings with the NHS as I did at that point.

In desperation I telephoned 999. The call handler was pleasant and advised me to take my daughter to ED. She said they were so busy that I could get my daughter to LRI quicker than they could but, if the situation got worse, to stop the car and dial 999 again.

We arrived at a packed LRI ED at about 9.15pm. As my daughter wanted, I left her and went back to her house to pick up my husband and grandchildren to take back to our own home for the night. My daughter's observations were done regularly but she sat the whole night on a plastic chair in ED before being transferred to a gynaecology ward sometime between 6 and 7 am in the morning. My daughter said the staff in ED were totally overwhelmed by the workload but were pleasant with her at all times.

While in ED my daughter told a nurse about her experience at Oadby UCC. The nurse told her that they were getting a lot of people arriving from there without receiving care and treatment and she did not know what was going wrong.

My daughter has agreed these facts and given her verbal consent for me to share ….

Case 3: My experiences of NHS111 and Oakham Medical Practice (OMP)

On Thursday 28th April at about 9pm I noticed the beginning of a rash on my forehead, close to my hairline. This was accompanied by a sensation similar to being consistently stung by a wasp. I suspected shingle as I had felt 'headachey' and tired for a few days.

I woke in pain at 3am on Friday 29th April. I noted that there were three blotches/spots in close proximity to my eye. As a former registered nurse, I knew that shingles around the eye needs treating quickly with antiviral medication. But – I also knew that:

- We were coming up to a bank holiday weekend so access to medical care would be potentially more difficult
- It is almost impossible to get through on the telephone to OMP first thing in the morning and difficult to get a same day appointment if contact is made later in the day
- I would be asked to send in a digital photograph. This was a problem because a) I felt too unwell to be bothered to try to sort out the technology to do this and b) the majority of the blotches and spots would not have been captured as they were at my hairline or on my head.

Therefore, I telephoned NHS111 at 3.am (approx.) as I reasoned I would be most likely to get a quicker response at that time than in the morning. I was comprehensively triaged by the call handler and he booked a face to face (f2f) appointment with a doctor for 9.30am at OMP. Because of a previous miscommunication, I double checked this appointment was f2f and at OMP. He confirmed this.

I felt too unwell to drive so my husband took me to OMP. We arrived at 9.22. I walked into the foyer but the check-in machine would not accept my details. The receptionist told me that I had been booked in for a telephone triage and so could not enter the premises and could not see a doctor. I was to go home for my telephone triage at 9.30. I explained that I would not be able to get home within some 5 minutes. I live about 15 minutes' drive away from the surgery! To compound this, there were traffic-controlled delays on the road due to roadworks.

The receptionist insisted that the rules meant that I could not be seen until I had been triaged by telephone - despite my pleas to be seen and my expressed need for a prescription that day. I could not wait until after the Bank Holiday to get the antivirals for fear of eye and sight complications. I asked for some flexibility in the

rules but this was refused. I asked to see the practice manager. The receptionist went off to speak with the practice manager. She returned to tell me they were trying to contact the doctor to ask her to see me. I was invited to sit inside.

The receptionist returned a few minutes later to say the doctor would see me at the Rutland Memorial Hospital minor injuries unit. I waited just a few minutes before being seen. The doctor took one look at my forehead and confirmed shingles. She handed me a prescription for the antivirals and advised me about pain control. I think I was with the doctor for about 2 minutes in total. I got the prescription dispensed at the nearby Boots pharmacy. While my prescription was being dispensed, I returned to the surgery to thank the receptionist for her assistance. She informed me that OMP were submitting a formal report to NHS111 as I was not the first patient to be incorrectly told to turn up for f2f appointment.

My questions and comments are:

- Why are NHS111 incorrectly booking f2f appointments?
- Why do OMP need to do a telephone triage when it has already done by NHS111? A duplication, surely?
- Why, when a patient states an urgent prescription is needed, is this disregarded?
- Why should I have to plead to be seen in a foyer with other patients present – ie where has patient confidentiality gone?
- Why is the system organised such that there was an expectation that I should return home when I would have already missed the phone call and facing the potential to have to return later for a f2f appointment ie 2 journeys instead of 1? This increases costs, an unnecessary delay in commencing treatment, unnecessary further discomfort for someone who is feeling decidedly unwell etc
- Although I would like to thank the receptionist, the practice manager and the doctor for finally agreeing to provide the medical attention I was seeking, I would suggest that compassion and discretion to be flexible with rules might not have been forthcoming had I not escalated the matter. So, what happens to people who do not have the wherewithal to escalate an issue?
- Although I recognise that the receptionist was doing her job as instructed, I understood that, as a perceived 'gatekeeper', she was particularly vulnerable. Any patient feeling poorly and frustrated could have become aggressive towards her at any time. Her own personal safety and welfare were not being adequately considered.