You Said We Did April – Sept 2016

You said	What we did	What happened?
One of our volunteers suggested some improvements to the Quality Account that Ellenor Hospice produced to make it more readable to the public.	We passed this feedback onto Ellenor.	Ellenor responded very positively. They added a summary section and put the report in chronological order following our advice.
A Health Trainer shared with us feedback from his clients about counselling services. They reported: • Long waiting times for appointments after referral • Reports of being under staffed • Long wait after initial assessment • Counselling sessions being cut short • Teething problems with newly commissioned provider	We shared all of this feedback with the provider of counselling services.	Dover Counselling gave us this response: "It is fair to say we have been absolutely inundated with referrals and there was a delay in counselling services commencing in Folkestone as it took longer to secure the building than first thought. However, UMC are up and running now and it has taken some of the pressure off. Throughout this time, we have continuously taken on more counsellors and more venues to try and meet demand. It is difficult to comment on the client who was transferred to UMC then back to us without knowing the situation but they certainly would not have to go through another assessment, instead they would be allocated to their counsellor who would have details of their assessment with UMC. Counselling sessions are 50 minutes always, unless the client feels they want a shorter session. Counsellors allow an hour between appointments. Assessment appointments are between 30 and 40 minutes. We did have a lengthy waiting list but have now reduced this significantly and I can advise we are now aiming to offer therapy within 6 weeks of referral. However, there are a number of clients whose availability

		for counselling is quite restricted or they want to see a specific named therapist or want a specific venue. In these cases, it may take a little longer but we do make them aware of this. We are working hard to keep within the timeframes laid down and I am always happy for clients to phone me direct if they have any issues."
One of our volunteers was actively involved in the development of a new ward at Tunbridge Wells Hospital. They raised some direct questions about dignity and privacy.	Our volunteer raised their concerns within the meeting. We also followed up and wrote formally to the Trust.	Changes were made to the plans for the new ward as a result of our feedback. This included privacy curtains and relocation of thank you cards from the sympathy area.
One of our volunteers had heard concerns about family members not being involved in mortality reviews.	We raised this concern with the Care Quality Commission and they told us they were doing a review into how families were involved in the process and a copy of the report will be shared with Healthwatch Kent.	The report concluded: Learning from deaths needs much greater priority within the NHS to avoid missing opportunities to improve care. Bereaved relatives and carers must receive an honest and caring response from health and social care providers and the NHS should support their right to be meaningfully involved. Healthcare providers should have a consistent approach to identifying and reporting the deaths of people using their services and share this information with other services involved in a patient's care. There needs to be a clear approach to support healthcare professionals' decisions to review and/or investigate a death, informed by timely access to information. Reviews and investigations need to be high quality and focus on system analysis rather than individual errors. Staff should have specialist training and protected time to undertake investigations. Greater clarity is needed to support agencies working together to investigate deaths and to identify improvements needed across services

		and commissioning. Learning from reviews and investigations needs to be better disseminated across trusts and other health and social care agencies, ensuring that appropriate actions are implemented and reviewed. More work is needed to ensure the deaths of people with a mental health or learning disability diagnosis receive the attention they need.

How have we influenced improvements to services?

Patients told us about concerns they had about night staff response times at East Kent Hospitals.	We talked to East Kent Hospitals about the concerns	The Trust told us that response times are being timed during in-house ward visits. These tests currently only happen during the day. The Trust is considering how they can test the response times at night as well. .