Enter and View Visit to Colliers Wood

Dialysis Unit provided by Fresenius Medical Care Renal Services Ltd

31st March 2017

Healthwatch Wandsworth

Acknowledgements

The Healthwatch Wandsworth Enter and View Team would like to thank the management, staff, patients, relatives and friends who made us welcome and assisted us in carrying out our visits to the Colliers Wood Unit and in preparing this report.

The Visiting Team

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Executive Summary

The aim of the Enter & View (E&V) visits undertaken by Healthwatch Wandsworth (HWW) is to obtain information from patients on their experiences of treatment and care. The strategy for 2017 is to focus on services provided at St. George's University Hospitals NHS Foundation Trust. Our first visits were to the renal services being provided at the hospital (Champneys Ward and the St. George's Dialysis Unit).* Following this, the team visited Colliers Wood Dialysis Unit on 31st March 2017. The Unit is managed by Fresenius Medical Care Renal Services Ltd. under a Service Level Agreement with St George's University Hospital NHS Foundation Trust. It has been open for six years, has 24 dialysis stations each able to offer three sessions per day, and was designed to provide dialysis for people with chronic renal conditions who do not need intensive hospital input and are fairly mobile.

Summer 2016 saw major changes in the organisation and delivery of the Trust's renal services, involving a move out of Knightsbridge Wing, the refurbishment of a former gynaecological ward (Champneys) and a reduction in the number of inpatient beds and outpatient dialysis stations at the hospital. Community-based satellite units were required to deal with the overflow of dialysis patients from St George's. Colliers Wood took 24 patients and nine nurses from St George's and expanded its service provision with three additional evening sessions. The patients who transferred were assimilated into sessions throughout the week.

On March 31st, the E&V team interviewed a total of 25 patients from morning, afternoon and evening sessions. Most were aged between 60-79 years and had been attending Colliers Wood for between 4-6 years. Six of the recent arrivals at the Unit had been receiving dialysis at St George's before the Knightsbridge Wing closure.

The team heard from the Unit manager and some patients about difficulties in the immediate aftermath of the changes. Incoming patients and staff had to be helped to adjust to the new arrangements. Some people were dissatisfied with the changes to the time and/or day of their session. The St George's nurses had to adjust to new ways of working. The reduction in capacity at the hospital meant that Unit was now expected to receive people in poorer health and with greater dependence upon nursing care than previously.

The team concluded that, by the time of its visit, the situation at Colliers Wood had settled down. This was due in large measure to the efforts of management and clinical staff. Patients, with relatively few exceptions, said that they were highly satisfied with their care and treatment. They had confidence in the team looking after them; medical and nursing staff were praised for being respectful, helpful, and kind. People appreciated the Unit's open, airy, clean and comfortable environment, and having access to Wi-Fi. They particularly valued the opportunities for socialising with each other, and appreciated the 'can do' attitude encouraged by the Unit manager and staff. Most people considered that they received adequate information and were fully involved in discussions about their care.

The E&V team invited all patients to make any suggestions for improvement, and used these and its own observations as the basis for the following recommendations:

Recommendations for Unit Management

- Ensure the provision of enough comfortable pillows and cushions for patients.
- Review the comfort of the chairs and consider renewing some of those that are worn, and whether there is a higher specification that would provide greater comfort.
- Consider how nurses might be encouraged to talk more to patients when attaching them to machines, and at other times during a session.
- Consider if the role and responsibilities of the 'named nurse' should be clarified for patients.
- Ensure that there is always a supply of information leaflets in languages other than English in the reception area.
- Review whether TVs could be sited differently, especially for those with limited sight.
- Review arrangements for organising the provision of headphones and remote controls, for the benefit of people who cannot provide their own to ensure that everyone who wishes to have them can do so.

For consideration by St George's University Hospital NHS Foundation Trust and the service commissioners:

- Ensure that the current constraints on resources does not compromise the principle of allocating patients between St George's and units such as Colliers Wood according to clinical need and, wherever possible, patient preference.
- Consider whether any additional resources can be made available to relieve the heavy demands on consultant time, in order to provide regular reviews and reassurance to patients at satellite units such as Colliers Wood.
- Consider whether the arrangements for patient transport at Colliers Wood with two separate companies can be rationalised, so giving management the discretion to deal with the Unit's regular transport company in the interest of patients.

** We recommend that this report should be read in conjunction with the earlier report on renal services at St George's Hospital, on the HWW web site: www.healthwatchwandsworth.co.uk.*

The Full Report

1.0 Introduction

1.1 About Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) is the patient and public champion in the areas of health and social care services. At the national level, we send our reports to Healthwatch England. HWW is funded by the Department of Health through the local authority, Wandsworth Borough Council. Our staff and volunteers are managed by an independent local voluntary organisation, Wandsworth Care Alliance (WCA). HWW is governed by an Executive Committee consisting of four Trustees of WCA and four members directly elected by the community. Our activities are developed in consultation with the public at our Assembly meetings.

1.2 Enter & View

Healthwatch Wandsworth has the statutory authority to visit health or social care services provided in the borough, or which cater for the local population but are located outside the borough. We can observe how services are delivered. Our main aim is to talk to patients or clients, their close relatives or carers, and senior staff responsible for managing the services. Our main focus is on the service user's experience of care.

Our Enter & View (E&V) volunteers receive full training, and are DBS (Disclosure & Barring Service) checked before they can become authorised visitors. After each visit, the team produces a report containing its findings and recommendations. The reports are then sent to the service provider for comment, and to relevant bodies such as Healthwatch England, the Care Quality Commission (CQC), and to local commissioners and providers of the service we have visited. Finally, our reports and any response from the service provider to our recommendations are posted on the Healthwatch Wandsworth website (www.healthwatchwandsworth.co.uk).

1.3 Our E&V strategy

One the main aims of our current E&V strategy is to collect feedback on the experience of patients of St. George's University Hospitals NHS Foundation Trust. As part of this work we visited renal services on the hospital site which have been reorganised since the CQC report in 2016 recommended that the building that they were occupying were not of an acceptable standard.[1] We found that the reorganisation of services had resulted in a reduction of inpatient beds as well as the fragmentation of dialysis services previously provided in Knightsbridge Wing, St George's Hospital. We also found that, despite the hurried relocation of renal services, at the hospital, patients were largely satisfied with the quality of their treatment and care. Our report on the recent visits to Champneys Ward and the dialysis services on the St George's site will be posted on the Healthwatch Wandsworth website (see above) and we recommend that this report is read in conjunction with that report.

In order to understand the complete pathway of care for patients with renal conditions, we decided to visit Colliers Wood Dialysis Unit. This is managed and run by Fresenius Medical Care Renal Services Ltd. under a Service Level Agreement (SLA) with St George's University Hospital NHS Foundation Trust. This unit has been providing care for St George's renal patients since it opened six years ago. We hoped that, as well as talking to longer-term patients about their experience of care at the Unit, we would meet some people who had been immediately affected by the closures at St George's. This would help to give us some idea of the impact of the changes on individual patients.

[1] The CQC report can be found at: http://www.cqc.org.uk/location/RJ701 This report followed an announced visit in June 2016 and an unannounced visit in July 2016.

2.0 Background

2.1 Overview of dialysis services

Before our visit, we learned about the impact of the reorganisation of services at St George's Hospital. The number of dialysis stations located at the hospital was reduced from fifty to twelve (six on Champneys Ward and six located in a mobile unit in the hospital grounds). Consequently, local community –based satellite dialysis units were asked to increase their patient numbers. The units most affected by the changes were at Colliers Wood (with 24 dialysis stations) and the North Wandsworth Dialysis Unit, Battersea (18 stations). Other satellite units in the area that take some St George's patients are: Kingston Dialysis Unit (17 stations, managed by Epsom and St Helier University Hospitals NHS Trust) and Epsom (20 stations, managed by St Helier University Hospital in partnership with Fresenius).

Fresenius Medical Care Ltd is a large international company which manufactures products mainly for use in renal services. The part of the company directly providing dialysis in England has 42 units, each of which is separately registered, currently listed on the CQC website.[2]

2.2 External sources of information about Colliers Wood Dialysis Unit

2.2.1 The Care Quality Commission (CQC)

The previous CQC inspection of the Colliers Wood Unit was on 23rd February 2013, with a report published in April 2013.[3] The 2013 visit addressed five standards: Respecting and involving people who use services; Care and welfare of people who use services; Safeguarding people who use services from abuse; Staffing and Assessing and monitoring the quality of service provision. All standards were 'met' and there were very positive comments both from the CQC inspectors and from patients. There were no negative points or recommendations for improvement. The Colliers Wood Unit is expecting a CQC visit on 30th May 2017. (We became aware of this only after deciding on our E&V visit.)

2.2.2 St George's Kidney Patients' Association

We contacted St George's Kidney Patients' Association (SGKPA) for their views and any relevant information they could give us before our visit. The SGKPA website is a valuable resource for patients and families affected by kidney disease. It gives information about services at St. George's Hospital and the satellite units at Battersea, Kingston and Colliers Wood. The website has been updated to include full information about the recent changes. It makes clear that SGKPA supports clinicians at St George's in renal services in pressing for the Trust to find a new location on site *'that will consolidate all renal services within the campus into one building'.*

Two of the people we spoke to at Colliers Wood were active members of SGKPA. As well as answering our questions, one provided a written statement about the recent service changes and future possibilities. Their views - and those of 23 other patients - are included in Section 4 ('Our Findings').

[2] http://www.cqc.org.uk/provider/1-101727389/registration-info

[3] http://www.cqc.org.uk/sites/default/files/old_reports/1-101727389_Fresenius_Medical_Care_Renal_Services_Limited_1-205667883_Colliers_Wood_Dialysis_Unit_20130426.pdf

2.3 Preparations for our visit

2.3.1 Meetings with senior managers and clinicians at St. George's and Colliers Wood

During the preparations for our first visit to St George's Hospital, we had met with senior clinicians and service managers to gain an overview of the renal services they provide in south west London. We heard how they had undertaken a hurried relocation of services following the closure of Knightsbridge Wing. We provide more detailed information in our report on renal services currently being provided at St George's Hospital.

On 23 March 2017, two members of the E&V Team met with Nick Dagasuhan, the manager of the Colliers Wood Unit. He kindly provided the comprehensive information contained in this and the following section. He also gave us a preliminary tour of the Unit.

We heard that the transfer period had not been easy for the Unit. Patient numbers had increased from 120 to 144 at relatively short notice, and nine nurses from St George's had been seconded to the Unit (since reduced to five). The Colliers Wood team had to welcome - and try to reassure – their new patients and nurses. Initially, it had proved difficult for both sets of the new arrivals to adjust to the changed environment and – in the case of some patients – to different days and times for dialysis. It had been challenging to deal with patients' unhappiness over the move, but the manager considered that that 95% of these patients were now 'reconciled' to the new arrangements.

2.3.2 Planning the full E&V visit

We arranged to visit the Unit on Friday 31st March, and to cover all three dialysis sessions. In advance, we sent posters and a letter to patients explaining the purpose of our visit, inviting any people who could not be interviewed within the time constraints to contact us by phone or email.

The objectives of our visit were to:

- Identify examples of good working practice.
- Observe patients and staff and their surroundings.
- Capture the experience of patients, and relatives and visitors and any ideas they might have for improvement.
- Ask patients who had previously used the services in Knightsbridge Wing about how the service changes had affected them.

We agreed in advance to cover some key topics, and developed interview prompts to use. As well as asking questions on specific issues, we also give plenty of room for people to comment on other issues and to elaborate their answers. We used broadly the same questions as we had used at the St George's dialysis services tailored to fit the Colliers Wood Unit. We also agreed on a list of specific issues to observe on the unit.

3.0 Colliers Wood Dialysis Unit

3.1 Purpose of the Unit

The community satellite units were planned to provide dialysis for patients with chronic renal conditions who do not require intensive hospital input and who are fairly mobile. Providing dialysis as close to where patients live as possible, as well as being less disruptive to their lives, is associated with better long term clinical outcomes. Patients come to the Unit on a long-term basis which may be for the rest of their lives or until dialysis is no longer a viable treatment for them. Some may be awaiting a kidney transplant.

Each patient attends the Unit three times a week. Before the closure of Knightsbridge Wing, the Unit provided three dialysis sessions on Mondays, Wednesdays and Fridays and two on Tuesdays,

Thursdays and Saturdays. Since the closure, three sessions are provided on all six days. Previously, Colliers Wood had received more mobile and less dependent patients from St George's. Since the Knightsbridge closure, the manager told us that the Unit was receiving more dependent patients with more co-morbidities and greater needs.

3.2 Staffing

In this report, we use the term 'nurse' refer to all nursing staff, whether they are registered nurses or dialysis assistants.

Before August 2016, the SLA required the Unit to maintain a staffing ratio of one member of staff to 4.5 patients with a skill mix of 70% qualified nurses and 30% Dialysis Assistants. Since that date, due to the influx of nurses from St George's, this ratio has been adjusted to one nurse to 3.5 patients, resulting in seven nurses on duty per shift. The manager, who is a qualified nurse with many years' experience in dialysis services, supplements this number when he is on site. The Dialysis Assistants are Health Care Assistants with additional specialist training and they can perform all of the functions of qualified nurses apart from administering medication. Several of them are in the process of qualifying as nurses through part-time training routes and the manager, who has experience as an educator, has strongly encouraged this.

Staff work a mixture of long and short shifts which fit with both the needs of the Unit and personal preferences. Recruitment is a constant process as many staff prefer to work in the NHS. The current situation is somewhat precarious as we were told that 90% of applicants come from EU countries and it is expected that recruitment will be affected by Brexit. They have built up a group of long term experienced agency workers to whom they can give block bookings and accommodate longer periods of holidays than would be permitted under direct employment; apparently this works well for both the Unit and staff.

The Unit also offers placements to student nurses (a minimum of two at a time) and the manager was formerly the lead nurse for education at Epsom and St Helier Trust. There are learning materials developed and formal feedback is sought from students.

Each patient has a 'named nurse' who is responsible carrying out assessments such as for manual handling and pressure sores (using the Waterlow scale) and ensuring that arrangements are made for reviews by the consultant. Patients normally have an allocated nurse/dialysis assistant for a whole session, who puts them on and takes them off the machine. Staff rotate through the Unit so that they all get to know all of the patients. These staff also clean the machines and change chair and bed linen between sessions as well as serving food and drinks and doing any *ad hoc* cleaning required. The main cleaning of the Unit is done by separate cleaning staff.

3.3 Referrals and ongoing links with St George's

All patients at the Unit are under the care of clinicians at St George's Hospital and the team there determines who comes to the satellite units. The contract with Fresenius requires them to accept any patients referred. Patients are assessed at St George's before referral. Dr Daniel Jones holds clinics at the Unit four times every month, and where possible will see patients at the bed side, if that is their preference, or in his office. A multi-disciplinary clinical review of patients is undertaken monthly between staff from the Unit and St George's. The Unit also has regular input from a dietician and an anaemia specialist from St George's, and can refer to the renal services psychologist and access social work input. A liaison nurse visits patients at St George's and the Unit; she helps to prepare people who are due to move out to Colliers Wood for dialysis, and tries to pick up on any concerns people may have. They do not have any physiotherapy input and patients have to be referred by the consultant or their GP to an occupational therapist for aids and adaptations to their home. Interpreting services at St George's can be accessed when required and in practice many patients have help from their family.

The manager attends a monthly governance meeting at St George's to discuss clinical and operational matters including transport. Monthly routine blood tests are sent from the Unit to LABCO (a private company); any 'ad hoc' blood samples are taken by Hospital & Transport Services (HATS) to St George's for analysis. The on-call renal services medical staff can be contacted about urgent clinical matters which occur at the Unit and if patients need to be seen they can be taken to A&E and be seen by them there. If patients have concerns at home, Unit staff try to make an assessment by phone but they often need to suggest that patients consult their GP, call 111 or call an ambulance. Occasionally a patient wants to miss a dialysis session and, again, senior staff at the Unit make an assessment of whether this is clinically possible. Some medication is prescribed by St George's on an on-going basis and other medication by the GP. There are elements of potential cost-shifting here and the service is not always smooth.

3.4 Transport

Patients' transport needs are assessed at St George's before referral and it is specified whether they need a 'one- or two-man crew' for transport. Some people come by car, typically two or three to a car and some by ambulance, with three or four patients sharing. Before the recent changes, all transport to and from Colliers Wood was provided by HATS and was organised by St George's. Initially, patients who transferred from the Knightsbridge Wing services also used HATS, but recently St George's decided to change these patients back to using G4S (who currently provide the transport to and from services at St George's Hospital). According to the Unit manager, they are finding the G4S service much less responsive and reliable for patients. Any variations in transport, even for a single trip, have to be authorised by St George's transport desk although the clinical staff at the Unit can initiate them on patients' behalf.

3.5 Layout and facilities

The Unit is sited in a single storey building on a small industrial estate in Colliers Wood. There is free parking on site which seems to be sufficient for the service needs. The building is spacious with a reception area where patients wait when they arrive, accessed securely though automatic doors. There is a receptionist to 'meet and greet' from Monday to Friday. Off this area there is a meeting room, a staff room and two consulting rooms as well as two toilets with facilities for people with disabilities. There is drinking water available. There is a photo board of staff here and information about Dr Jones' clinics and about obtaining dialysis on holiday including travelling overseas.

Access to the dialysis facilities is through doors secured with a key pad entry system. There is a nursing station and four very spacious 4-bedded bays and eight side rooms with *en-suite* facilities. The side rooms are used for patients with Hepatitis B, Hepatitis C, MRSA and HIV; patients who have been on holiday abroad (who are quarantined for 3 months), and patients who have an infection such as a heavy cold. Each dialysis station has a call bell and free radio, TV and WiFi are provided for all patients by Fresenius although this not part of the contract. Patients are asked to provide their own headphones for reasons of hygiene, and universal remote control units. (The Unit no longer provides these, as they found that they had a habit of 'going missing'.) Side rooms have individual temperature controls and the main area has a central control system. Blankets are available for anyone requiring them. Food is ordered in advance with patients choosing their sandwich and it arrives with their name on it. Halal meat is available. Biscuits and hot drinks are also provided.

3.6 How the service is provided

The Unit is open for 17 hours per day from 6.30am to 11.30pm, 6 days a week and closed on Sundays. It can accommodate 24 patients per session; there is an overall total of 144 patients. Sessions are held at the same time on either Mondays, Wednesdays and Fridays or Tuesdays, Thursdays and Saturdays. The relocation of 24 patients from St George's was achieved by providing additional evening shifts on Tuesdays, Thursdays and Saturdays. The new patients were allocated

into different sessions across the week. Sessions last for four hours and start at 7am, 12.30pm and 7pm. The evening session permits patients who work to retain their employment.

On every shift one nurse is responsible for four patients. Each patient usually goes to the same dialysis station. The Unit has introduced a system of appointments for connecting patients to their dialysis machine at the beginning of each session. Patients regularly start their session at, for example, 7.00, 7.15, 7.30 or 7.45.

The service likes to encourage patients to retain as much independence as possible and to be as involved in their treatment as much as possible. Each patient has an electronic Patient Card and ID which records the prescription and the last three dialysis sessions for easy access on assessment. Upon arrival in the reception area patients can socialise while they wait. Then they take their Patient Cards and weigh themselves (this is automatically recorded). They collect a blanket, if they require it, and go to their dialysis station and set themselves up as far as they can to await connection. All of their data during each session, especially blood pressure, is closely monitored and recorded and is displayed on screens at the nursing station which allows the staff to see at a glance early warning signs that something might not be going as expected.

We have described above the on-going links between staff at the Unit and St George's (Section 3.3.)

4.0 Our findings

On 31st March, two members of the team visited the Unit during the morning session, five in the afternoon session and one in the evening session. In reporting our findings below, we strive to maintain confidentiality and anonymity. We use the gender-neutral pronouns "they" and "their" throughout our report, and do not use any comments that could identify individuals without their prior agreement.

4.1 The environment of care

We have already described the physical layout and facilities of the Unit (section 3.5). The reception area is spacious, and did not feel overcrowded even when fully occupied by the patients waiting for their session. It provides a good opportunity for socialising, to judge by the exchange of enthusiastic greetings and lively conversations amongst people waiting for the afternoon session. Our first impression inside the Unit (morning session) was how spacious, clean and calm it was. Many patients in the morning and afternoon sessions were dozing – or more deeply asleep – while others were reading, or plugged in to headphones to listen to the TV or their own electronic devices, such as iPads. On the day of our visit, there were seven staff on duty for each shift.

4.2. Interviews with patients and relatives

4.2.1. Demographics

Gender, age and ethnicity

Men	12
Women	13

White British	13
South Asian	8
African-Caribbean	2
Other	2

20-29	0
30-39	2
40-49	1
50-59	2
60-69	8
70-79	10
80-89	2

We interviewed twenty-five patients over three sessions: eight in the morning session, fourteen in the afternoon session and three in the evening session. We aimed to interview a number of people who had been transferred recently; otherwise, our choice of interviewees was governed by

practicalities such as whether people were awake, whether they were in the same bay as someone already interviewed, and that they had indicated their keenness to speak to us.

We interviewed slightly more women than men, which does not reflect the overall figures for the Unit of 38.1% female and 61.9% males. Similarly, our interviews did not entirely reflect the overall ethnic mix of patients in the Unit, where the proportion of people of 'white British' heritage (29.1%) is closely matched by South Asians (26.1%) and African-Caribbean (23.2%). It may reflect the patient mix on that particular day, or their availability to speak to us. (We had to abandon one attempted interview with a patient of African-Caribbean heritage because their condition made it extremely difficult for them to speak.) Twenty two percent of patients at the Unit come into what we have labelled the 'other' category; this includes people from many different nationalities and ethnic backgrounds.

Some patients experience some difficulties with communication as English is not their first language. Unless family members can help out, staff have to rely on interpreters provide by the Trust. We experienced language difficulties in three of our interviews, meaning that we could not obtain all the in-depth information we would have liked.

Length of time of current attendance at the Unit

Length of time at CW	**Number of patients**
Under 1 year	6
1-3 years	6
4-6 years	13

The table above clearly confirms the role that the Unit plays in the long-term care of people needing dialysis for chronic renal conditions. It has a core of well-established patients, many of whom have been attending since it opened six years ago. (This probably helps to explain the sense of community described in some of our interviews.) Many people had been receiving regular dialysis in different centres for years before the Unit opened, some in Knightsbridge Wing but also in centres such as St Helier Hospital. Seven people told us that they had past experience of the Knightsbridge facilities; but we decided to exclude their views if there had been a significant time lapse, only taking into account comparisons based on experience of St George's services within the past year)

We spoke to six people who had been receiving dialysis at St George's when the changeover took place. Three were completely new to Colliers Wood, while three others had been regular patients at the Unit before being moved back to St George's, and then being returned back again to the Unit. On the day, we interviewed six out of the eleven people who had transferred recently from St George's Hospital. We did not plan to target 'transfers' only, but to gather the experiences of as wide a 'convenience sample' as time permitted. We had also anticipated that some long-term Colliers Wood patients would have been affected indirectly by the closures.

Borough or county of residence

The people we interviewed lived in the following London boroughs: Kingston (3 patients); Lambeth (3); Merton (8); Richmond (1); Sutton (1); Wandsworth (5). We also spoke to four 'outliers' from further afield: Surrey (3) and Middlesex (1). These were people who had chosen to continue their treatment under the St George's clinical team, and were therefore committed to making

comparatively lengthy journeys to Colliers Wood. Most of our sample lived within reasonable distance from Colliers Wood, with a few living almost on the doorstep.

4.2.2. Convenience of session times and days

We asked everyone if their dialysis schedule had been changed in the last few months and, if so, how well this suited them. We also asked if anyone was dissatisfied and would like to change their arrangements. We found that most people were satisfied with the day and time of their session; even where they had been asked to change, some preferred the new arrangements.

Three of the recent arrivals from St George's told us that they had been given no choice about their changed schedules. In the end, one person was happy with the change from a day-time appointment to the late evening session, but another would prefer to move from the late session they had been allocated. They had not made a formal request to change sessions. A third person had been told they were being moved from St George's to St Helier Hospital for treatment, but had *'held out'* for a move to Epsom Dialysis Unit and a morning session. The move to Epsom had worked well, but this patient was now attending Colliers Wood on what they assumed was a temporary basis, following emergency (non-renal) surgery at St George's.

Of the 'established' Colliers Wood patients, three told us that they had been asked to change their sessions and/or days within the last six months. Two of them had been offered a choice, and were satisfied with their new arrangements, although one had declined the evening session originally on offer. A third person had been reallocated to morning sessions at the Unit following a brief hospital admission to St George's, but was very happy with the new arrangement.

We spoke to a few people who had not been directly affected by the recent changes, but were not entirely satisfied with their session times at the Unit. A couple of other patients told us they were not completely happy, but had not made a formal request to change.

This was in contrast to instances where the manager had been able to respond positively to individual requests: one person had their days changed to fit in better with their partner's work pattern; the length of another person's sessions had been adjusted to allow them to leave dialysis early on one day to attend college. Someone who had transferred from St George's about eighteen months ago had asked to change their days and session times and, after a short wait was able to do so. We heard that one–off arrangements could be negotiated when people were going away for a day to visit their family. According to the Unit manager, there were 'angels' among the regular patients who were happy to exchange sessions with others on occasion. (All such changes have to be sanctioned by the management team.) We were told that it is more difficult for the manager to make permanent changes to a person's schedule, as this would affect other people's arrangements and could only be done with their agreement.

We picked up a sense of anxiety from two people, who told us that patients were now being made aware that if they went away on holiday they could lose their current slot on their return, and might be placed in one of the side rooms. There was now a warning to that effect on the holiday application form. In fact, this is long-standing Unit infection control policy on providing a three month quarantine for people who have been abroad. The side rooms are for this purpose. (This suggests that this information could be made clearer, to avoid generating anxiety among people who are recent arrivals.)

4.2.3. Information and advice

Twelve patients could not remember whether or not they had been given an information pack before coming to Colliers Wood. (Many of these had been at the Unit since it opened, so any

memory lapse is understandable.) Nine people said that they had received prior information and that it had been helpful, while four people said they had not been given any information, and that it would have been helpful. One person commented that, even without any advance information, as soon as patients arrived it was, '*information, information, information*.' The St George's liaison nurse was mentioned by some as providing good information and support before they were moved out to satellite units.

Most people were satisfied that staff on the Unit involved them fully in explanations about their on-going treatment. One person found the use of medical terminology unhelpful. When we asked if staff ever gave the impression of being too busy to explain things to patients, we had some mixed replies. Most people thought this was not the case, one saying that '*they are never too busy, I see the doctor at the bedside.'* The Unit manager was seen by others as particularly approachable: '*Nick's door is always open'*.

Other people had a different perception. Some nurses were seen as better than others at making time to explain things to patients. One patient commented that the nurses were good at relaying information about results of blood tests, but '*do not usually explain what they are doing when they operate machines during the sessions'.* Another thought that, '*doctors and nurses are very busy and don't have the time due to lack of staff.'*

Patients naturally looked to the consultant, Dr Jones, as a key source of information and advice. We heard many compliments paid to his skill, approachability and '*lovely bedside manner'.* We were told that it was possible for patients to request a special appointment with him in between their fixed appointments. He has an email address that patients can use to contact him and –in one case - a patient mentioned being able to phone him. On the negative side, one person said that they hadn't seen the consultant *'for ages'*; another also said that they had not seen the consultant '*for a while…I wonder where he is, as I would like to ask him some questions.'* This person had emailed the consultant, but' *nothing has happened'.* This patient (who was not a new attender) thought that, '*St George's forgets about you when you are here… here you can't speak to doctors or get dressings done.'* Another described a '*struggle with my consultant… he is good but busy and does not always reply to emails or 'deliver' what is needed.'*

We think it is important to note that these critical comments were outweighed by many positive ones about access to information and advice. However, it does appear that, in some cases, staff may be finding it difficult to respond promptly to patients' need for information and advice about their treatment, and that Dr Jones' time is stretched.

Advice on managing the condition at home

The dietician and the 'anaemia' or 'iron' nurse from St George's visit the Unit regularly to talk to people whose blood tests suggest that they need specific advice on managing their condition. We heard that patients valued their advice on such matters as diet and the management of fluid intake. The liaison nurse was mentioned as another source of advice – in one case, on the self-administration of EPO injections. The value of the individual monthly review of blood tests was mentioned by several patients.

We asked patients if they had been given clear advice on who they should contact if they have any renal problems when at home. Apart from those patients who left it to their family to obtain this information, all patients seemed clear that they should contact their GP for advice, and in emergency to ring for an ambulance, or take themselves to an A&E department. One person told us that paramedics were able to help at home when they experienced excessive bleeding after a session. It was also clear that people felt they could contact Unit staff in between their sessions for advice or signposting.

4.2.4. Staff caring and responsiveness

We asked patients whether they knew their 'named nurse', whether their care was provided by the same nurse throughout each session, whether staff introduced themselves, whether they came promptly when called and whether appropriate help was provided. We also asked all patients about whether staff had time to listen if they wanted to talk, whether they responded to concerns, whether they provided physical and emotional support, whether they respected patients' privacy and dignity and whether they seemed to work well as a team. Lastly, we asked about their confidence in the team looking after them and whether they felt satisfied with their overall care.

We were told before our visit that all patients have a 'named nurse'. When we asked patients whether they knew their named nurse, four people responded positively. Two others said that in the past, they had been given a card with the name of their allocated nurse, who had since left. Most patients were not aware that they had a named nurse. It appears that the current system involves giving nurses the responsibility for monitoring the records of an allocated group of patients and overseeing that details of patients' tests and treatment are kept up-to- date. Patients do not necessarily know about this; the emphasis seems to have shifted to making sure that, as far as possible, continuity of care by one nurse will be maintained throughout a session.

Views about staff attitudes and behaviour were generally positive. Nurses were *'polite'*, and usually good at introducing themselves. The only exception reported was that, when there was a change of shift in the afternoon session there did not seem to be a formal 'handover' which involved the patient, and so a patient might not know which nurse was responsible for them until they appeared in response to an alarm. We spoke to people who were given special help during their session, for example because they were wheelchair users, or had poor eyesight or other health problems such as diabetes or epilepsy. We were told that nurses responded promptly when patients pressed their buzzers, or otherwise asked for help: '*they [the nurses] are considerate and caring'.*

As to emotional care, many patients told us that they did not feel the need for staff to provide this, but instead looked to their family or friends. We came across one exception to this in a patient who told us that they had no close family to provide emotional support and were feeling increasingly anxious. With their agreement, this was reported to the Unit manager, who said that he would arrange an appointment with a psychologist. Another person we spoke to had already been referred for sessions with a psychologist. Other people said they were happy to share their concerns with a member of staff with whom they felt at ease: the Unit manager, the consultant, individual staff nurses and the St George's liaison nurse were mentioned by different people as being approachable and helpful. One person asked us for a special mention for the Unit's tea lady.

There was general agreement that staff respected patients' right to privacy and dignity, as reflected in these observations: *'they [the nurses] treat people kindly and with respect'* and *'Staff communicate well with older people and people with hearing problems'*. One criticism we heard was that it was sometimes possible for patients to overhear bedside discussions about private medical matters.

Asked if they had confidence in the clinical team at the Unit most people responded positively – saying, for example, *'Absolutely… I would be reluctant to go anywhere else.'* This was reinforced by those people who had chosen to continue their dialysis at Colliers Wood, in spite of having to travel long distances. The medical team lead by Dr Jones was highly praised. It was noticeable that the levels of trust and confidence people expressed in Colliers Wood were contrasted with the poor care they said they had experienced in other dialysis centres. These bad experiences meant that some patients felt highly resistant to returning to whichever centre was involved, even if it was much closer to their home. A people expressed reservations about staff. One thought that some nurses had better techniques than others for managing access to their fistula; another had asked not to be treated by agency staff, for similar reasons.

Although we did not ask directly for patients' views on staff numbers, some people volunteered their opinions. One person said, '*sometimes they are short of staff which influences the time I get home'.* Another said that the nurses '*were not always prompt [in responding] … they are short of staff sometimes'.* One long-term attender though that '*in the old days'* at the Unit, there had been more staff on duty. A fourth person told us that his confidence in staff was being undermined *'because there is a lack of staff and they are always busy with sicker patients'.* Apart from these comments, we heard no other complaints about staffing levels. It is difficult to draw any firm conclusions from a few comments. Demands on staff are likely to fluctuate from shift to shift, sudden crises might occur, and patients may experience sessions when there are people with greater needs than usual for nursing care.

Again, we should emphasise that appreciative comments about staff caring and responsiveness outweighed the critical comments we also report here.

4.2.5. The environment of care

In our interviews, the '*comfortable, pleasant and airy'* environment was volunteered by several patients as one of the best features about the Unit. The generous space between stations was also considered to be good for infection control purposes.

We asked patients whether the dialysis chairs were comfortable and easily adjustable, and whether the temperature in the Unit was acceptable. We also asked for their views on the standard of cleanliness, satisfaction with the food provided, and the availability of activities. On all of these counts, the majority of patients replied that they were perfectly satisfied. The choice and quality of the snacks was particularly praised. Most people were satisfied with the temperature in the bays, although some found it rather too cool sometimes and needed their blankets (which some people found too thin). The side rooms had their own temperature controls. Most of the dissatisfaction expressed was with the chairs: eight people out of seventeen told us that the chairs were not comfortable, but were '*a bit hard*'; '*needs a new cushion, this one is worn out*'; '*not comfy'*. One person, who had experienced trouble with pressure ulcers in the past, was disappointed that they had not been provided with a suitable air mattress by St George's.

Most people though that the standard of cleanliness in the Unit was good. One person liked the fact that the general ward cleaning was done before each session, as can happen elsewhere '*where they cleaned around you'.* Very few people we spoke to in the bays had made use of the toilets - which are located outside the treatment area and are suitable for wheelchair users - and so could not comment on their cleanliness. Two people told us these facilities were not always as clean as they could be, but they thought that this was always quickly remedied once reported. One patient described the rather complicated performance involved when they needed to use the toilet: they had to be disconnected from the machine, helped into a wheelchair to leave the ward, and then be reconnected once more.

Asked about how they avoided boredom during their session, patients' favourite activities were: watching TV reading; chatting on their mobile phones; playing games on electronic tablets; and using puzzle books. We observed that many people felt relaxed enough to sleep during their treatment. One person said that they sometimes felt 'fed up' during the session, particularly when they were feeling less well. The SGKPA had raised some money to help establish activities such as art classes (already started), computer lessons, language lessons and therapies such as foot massage. These suggestions had been well-received by patients, although people told us they were still waiting to hear which of these would be provided and whether these would be available for all sessions.

4.2.6. Transport to hospital

On our visit to the renal services at St George's Hospital, we heard many complaints about their transport, provided by G4S. Most of the complaints were about long waits for collection to and from home.

At Colliers Wood, thirteen people told us that their transport was provided by HATS; five people travelled by private car (one drove themselves, others relied on family members); two used taxis; three said they were currently with G4S; and three people were not sure who provided their transport. Journey times varied between 10 minutes and 2 hours (this from Surrey, a journey of 42 miles).

In contrast to our findings at St George's, most people seemed content with their travel arrangements. Both HATS and G4S were criticised by different people in relation to delays in collection. Because of these delays, two people had left HATS for a private arrangement with a taxi firm; another said that they had experienced long waits after the evening session, but they were now attending the afternoon shift and experienced no problems. A patient attending the evening session confirmed that the HATS service was not ideal, as drivers had to wait for up to an hour for other patients to finish their sessions. However, they did not blame HATS for this situation, and found the waiting an opportunity to chat with others. However, another patient on the late session was very unhappy with the service (provided by G4S), saying that '*the routes were badly planned …they double back on themselves…I sometimes get home at midnight…sometimes I pay for my own cab'.*

Several people who were long-term customers of the HATS service were complimentary. They liked it when they had regular drivers; in some cases, they had the same driver since the Unit opened. A wheelchair user described how the driver would take them into the house and settle them comfortably at times when their partner was out at work. Some people who were not completely happy with collection and journey times thought that busy traffic conditions at least partly responsible for delays and unpredictable journey times.

4.2.7. Feedback on quality of care and complaints procedure

On our visits, ask people if they were invited to give their feedback on the quality of care they have received, and if they have been given clear information about how to complain if they have any serious concerns that have not been dealt with by the management.

Twelve people clearly remembered responding to the annual survey on the Unit, many of them using the electronic version. Others were less certain, particularly people who acknowledged that they had difficulties with communicating in English. We were told that volunteers from the SGHKA try to help people to complete the paper forms.

The Unit manager shared information from the Unit's annual patient satisfaction surveys for 2015 and 2016 (see table below). He thought that the lower scores for 2016 reflected negative reactions to the changes, which were at their peak at the time of the survey. In the light of what we had heard from patients about the impact of change, the lower scores for good organisation and confidence in nurses were not surprising. (However, we noted that the percentage of people who would recommend the Unit to their family and friends was slightly improved.)

Question	**December 2015**	**December 2016**
Would you recommend CW to your family and friends?	84%	86%
Do you have complete confidence in the nurses?	81%	71%
Is CW well-maintained and clean?	86%	75%
Is the service at CW well organised?	81%	68%

Is the atmosphere at CW friendly and happy?	98%	92%

The answers to our question about knowledge of the formal complaints procedures were mixed. A few people told us that they did not know, or that the issue had never arisen. A few of the older patients tended to rely on family members to pick up information on their behalf. Six people were confident that they knew how to complain and two of these named the Patient Advice and Liaison Service (PALS). Two people said that they would approach the Unit manager directly, whilst two others had actually done so: one with a verbal complaint about staff issues during the transfer period, the other had *'mobilised the support of other patients'* (successfully) to make the case for keeping his regular slot. Another two patients said they had already made formal complaints to the PALS at St George's (but not in connection with treatment in the renal services) and another had complained directly to the consultant. Our overall impression was that, apart from the more assertive patients, there was little understanding of how people might go outside the Unit to complain in the event of serious concerns, even though this is clearly stated in the information pack for patients. However, people did not appear to be inhibited about directing individual complaints to the Unit manager.

4.2.8. Good experiences/points for improvement

We asked people what they particularly liked about the Unit, and whether they had any suggestions for improvement. The replies were overwhelmingly complimentary. We have already mentioned the overall appreciation for the approachability of the manager and other clinical staff. The spacious physical environment of the Unit was widely appreciated. We heard that staff helped to create a therapeutic environment by their friendly manner, and by encouraging people to be independent and not *'making you feel you are a pain'.* One patient informed us that Unit's philosophy of care was that *'you dialyse to live, not live to dialyse',* and that patients benefitted from this approach. Many people enjoyed the '*opportunity to talk to other patients'* and enjoyed the Christmas and New Year parties organised in the Unit. We heard about shared birthday celebrations amongst patients, and the *'friendly and warm environment and the strong bonds that patients are encouraged to build'.* One person found the Unit calmer than at St George's. On a more practical level, some people liked the fact that the Unit was conveniently close to their homes, while others appreciated the car parking facilities.

We also picked up some suggestions about possible improvements. The most notable suggestions were about staffing: one person thought the main improvement would be *'more staff'*, while another said they would appreciate it if the nurses '*would circulate around more, checking up on personal problems and asking if all is OK'.* (We heard from others that the manager already does this, but it must be a challenge for him to cover 24 patients per session.)

The absence of doctors at the Unit – apart from the Consultant's visits – was a particular concern for some. A recent arrival at the Unit wanted '*doctors to be here… do not want to talk to others [staff]'*. Another told us: '*there should be a doctor here all the time… what if someone had a fit… who would look after them?'* A patient who had been attending Colliers Wood for 18 months, remained concerned that there were no doctors on site. They had preferred it at St George's: '*Doctors were there and could come straightaway if there was a problem…. there are no doctors here, and I had to adjust [to this] at first.'*

One person said – not entirely seriously, as they admitted – that it would be *'nice to have a nurse each to hook us up'*. Although they were reconciled to waiting for three people to be connected up before them, this experience was a source of annoyance to another patient. A person with recent experience of the' first come first served' system at St George's Hospital thought that it was

preferable (although we had found that this 'whiteboard' system could itself disadvantage certain patients).

Another person was also critical of this aspect of the Colliers Wood system. They had been coming to Colliers Wood for some years, and had always been the last of four in a bay to be connected up. They had asked the manager for this to be changed permanently, to allow them time to attend a foot clinic, but this had not been possible and they had to rely on negotiating times with their fellow patients. (As we note on page 10, the manager would not find it easy to make permanent changes to appointment times, as this has implications for other people. He does intervene to ask other patients if they could change times on an ad hoc basis.)

One person suggested that the Unit could be '*more generous with supplies such as pillows and tape'*. The positioning of the TV screens was criticised as being too up to suit some patients, and several mentioned that headphones and remote controls were not provided. We understood that these had been provided in the past, but so many 'went missing' that the Unit now asked people to provide their own. As a result, we spoke to some people who were watching TV without sound or without being able to change channel.

4.2.9. Issues about the transfer from St George's services

Reviewing the comments we heard from different people about the recent transfer of services from St George's, they seem to fall into four main themes.

The potential vulnerability of people on dialysis

The majority of people we interviewed gave the impression that they had come to terms with what, to an outsider, seems a daunting and life-changing experience. They were definitely not seeking our sympathy, but it was clear that they are obliged to give up a considerable amount of time each week to receive a life-giving treatment, with all the underlying anxiety that this must entail for individuals and their families. It is extremely important for them to have confidence and trust in the team caring for them. It takes time and effort to gain such confidence, and it can easily be damaged. The reassurance gained from being treated by familiar nurses in a familiar setting was clear. One recent transfer from St George's illustrated how attached people can become to a particular dialysis centre: *'Nick [the manager] is very good, and staff are very polite, but I would prefer to be back at St George's'*.

Information and communication

It is widely accepted that giving timely and clear information to people about plans for their care helps to reduce their anxiety and improve their response to treatment. We were given an insight into the generalised anxiety that can be caused by the prospect of transferring dialysis locations by someone who had moved from St George's two years ago. They described feeling '*extremely apprehensive'* about the move, as they had become '*very dependent on the team at the hospital'.* They described the time it took to work through their concerns and to build up trust and confidence in Unit team. The manager and staff had spent a lot of time listening to this person and their family. As a result, the patient had settled in well and was extremely complimentary about the care they had received at Colliers Wood over the past two years.

The sudden changes to St George's dialysis service had intensified patients' feelings of anxiety. This was compounded further by the abrupt way in which some were informed about the changes. A patient receiving dialysis on Buckland Ward and the mobile St George's Dialysis Unit, described being handed a letter at the end of a dialysis session telling them that they were being transferred the following week to another, hospital-based unit for sessions at a different time of day. Their comment on this manner of communicating was that it was '*not very diplomatic'*. It was only by '*strongly resisting'* that the patient had been able to negotiate a more acceptable satellite unit and session time.

Management of sudden organisational change

One of the long-term patients at Colliers Wood had been a close observer of the rapid changes. We were impressed with their views, as they had twelve years' experience of dialysis before coming to the Unit six years ago and considered it provided the best care they had experienced. They considered that the influx of patients and nine nurses from St George's initially had the effect of reducing a *'well-run and relaxed unit'* to a state of confusion. Staff were '*rushing around…some were not suitable for this type of work, many had not chosen to come to this unit and so were rather unmotivated.*' The move seemed to increase the amount of paperwork required, '*resulting in less focus on patient care'*. Following this difficult 'adjustment period, the Unit manager '*took resolute action'* in dealing with the staffing situation. Things had now settled down again, with a welcome return to previous standards of cleanliness and care at the Unit. We understood that some of the difficulties were because of working practices such as nurses being responsible for cleaning the dialysis machines themselves at Colliers Wood, but that these were now resolved with everyone working to Fresenius' protocols.

Appropriate services for different levels of need

Early on, we were made aware that the condition of patients on long-term dialysis will fluctuate over time. They may need short-term spells on inpatient dialysis, either because their condition has become more acute or because they have been admitted to hospital for another health problem and require additional support. Previously, the services at St George's and its satellite units was able to cater for the whole spectrum on dialysis care: acute and supported care was provided by the hospital-based units while the community units such as Colliers Wood provided long-term care for people with greater mobility and better general health. Following the 2016 closures, the hospital is less able to accommodate dialysis patients who no longer need acute care, but still need significant levels of nursing care.

We were told by one person that the Unit was now taking people *'who are extremely unwell, and in my opinion, are in need of hospital care'.* This was '*putting increasing pressure on staff and patients alike*'. In the afternoon session, we observed two examples of bed-bound patients who were clearly in poor states of health and who needed close attention from the nurses. We also heard about a patient who had a cardiac arrest during one session and another who had an epileptic fit.

We had been told before our visit that the reduction in the number of outpatient dialysis stations meant that the local system is operating close to full capacity. This clearly allows less flexibility in placing patients appropriately to health status and their needs for care, producing a 'domino effect' so that people with chronic renal problems who are considered to be mobile and in better general health (such as those allocated in the past to Colliers Wood) might be displaced to other centres outside the local area in favour of sicker patients. This could compromise the idea of patients' choice about their location for care. It also raises questions about the system's capacity to take on new patients.

5.0 Conclusions and recommendations

Healthwatch Wandsworth is not currently in a position to have an official view about any strategic options being developed for the longer-term future of renal services. We are aware that the members of St George's KPA strongly support the continuation of the dialysis service provided at Colliers Wood, along with the restoration of the old Knightsbridge Wing services in a new location on the St Georges Hospital' site. They are lobbying hard for this. It is to be hoped that the process of strategic decision-making will not be unduly prolonged. In Section 4.2.9. above, based on our interviews with patients, we suggest some key considerations that policy-makers might bear in mind.

Following our visits, the E&V team has been left with little doubt that clinicians and staff at Colliers Wood and St George's Hospital were placed under considerable strain by the abrupt decision to close Knightsbridge Wing services in the summer of 2016. The impact of the new arrangements was also felt by dialysis patients, not only by those who were transferred out to Colliers Wood but by established patients at the Unit who had to adjust to new schedules and new staff. Both the manager and professional staff have worked hard to make the new arrangements work as well as possible.

We do not want our findings about the negative impacts of this change to overshadow the overwhelmingly positive reports we heard from patients about their experience of treatment and care at Colliers Wood. The overall message from our interviews was that patients were very satisfied with the standards of care in the Unit. They valued the helpful attitude and behaviour of Unit manager and other professional staff. Nurses were generally considered to be prompt at responding to patient needs and to be polite and respectful – particularly towards older people or those with some disability. Staff were seen as good at encouraging people to be as independent as possible, despite being dependent on their regular dialysis sessions. People appreciated the spacious and airy environment in the Unit, and welcomed the opportunities for socialising with others.

Our report can only provide a snapshot of the work of Colliers Wood on a particular day, and we do not want to make any sweeping statements based on our interviews and observations alone. However, we would like to make the following recommendations to management on behalf of patients at Colliers Wood:

- Ensure the provision of enough, comfortable pillows and cushions for patients.

- Review the comfort of the chairs and consider renewing some of those that are worn, and whether there is a higher specification that would provide greater comfort.

- Consider how nurses might be encouraged to talk more to patients when attaching them to machines, and at other times during a session.

- Consider if the role and responsibilities of the 'named nurse' should be clarified for patients.

- Ensure that there is always a supply of information leaflets in languages other than English in the reception area.

- Review whether TVs could be sited differently, especially for those with limited sight.

- Review the arrangements for organising the provision of headphones and remote controls, to ensure that everyone who wishes to have them can do so.

The following recommendations are for consideration by St George's University Hospital NHS Foundation Trust and the service commissioners:

- Ensure that the current constraints on resources does not compromise the principle of allocating patients between St George's and units such as Colliers Wood according to clinical need and, wherever possible, patient preference.

- Consider whether any additional resources can be made available to relieve the heavy demands on consultant time, in order to provide regular reviews and reassurance to patients at satellite units such as Colliers Wood.

- Consider whether the two separate arrangements for patient transport at Colliers Wood can be rationalised, so giving management the discretion to deal with the Unit's regular transport company in the interest of patients.