Influence Panel report from Thursday 6 June 2019

Emergency village/critical care capital development project

Attendees

Dan Clough – CCG
Lyndsey Shorrock – CCG
Amanda Bate – CCG
Chris Clark – BTH
Howard Ballard
Karen Birchall
Kenneth Carroll
Maxine Chew
Maurice Christian
Elaine Christian
June Deveney
Ian Gibson
Russell Hodskinson
Jeanie King
Nick Milne
Jen Olivine
Peter Osborne
Jim Proctor
Norma Rodgers
Allan Slater
Wendy Stevenson
Richard Thornburgh
Steve Tingle
Lisa Westoby

Dan Clough opened the meeting and introduced Chris Clark, associate director of planning and strategy from Blackpool Teaching Hospitals NHS Foundation Trust, who would deliver the presentation. Prior to the presentation, Panel members agreed the terms of reference which had been circulated prior to the meeting and these were signed off for the next 12 months.

At the end of the meeting, Dan Clough thanked Panel members for their input into the annual reports for Blackpool CCG and Fylde and Wyre CCG, which have now been completed and published.

Chris Clark gave a presentation on the project to redesign the A&E and critical care services using £12.9m recently acquired from NHS England. He explained that public engagement will form a key part of the development of a business case, which will be submitted in early 2020.

Panel members were split into three groups and asked to give their views on three topics based on their experiences of current services at the hospital. Boards were placed around the room and discussions took place while members were able to make notes and put them These were estates/buildings, patient and public experience and service performance (operations and process).

The Panel's key recommendations were as follows

1. Move ICU to create extra space
2. Keep the public, and particularly the Influence Panel, involved throughout the project
3. Ensure continuity of services during any building work
4. Ensure there is sufficient staff so improvements to the building are worth it

Comments made throughout the meeting were as follows:

Buildings/estates

- There is a lot of walking around from one place to another and A&E is too far from the surgical block.
- Concerns were raised about where services such as A&E would go on an interim basis if construction work was to be carried out.
- Linking it all together is great but it will be important to make sure the communication between teams and departments is right to avoid people working in silos or as individual teams.
- The primary care side works really well and has been very successful.
- The x-ray department is too far away.
- Intensive care does not seem to need to be where it is. Moving that somewhere eels would provide lots of space for other things to improve A&E.
- Need to review the courtyard areas and outside spaces. Are these necessary or could they be utilised to increase the available space?
- Dropping someone off when they need a wheelchair can be very problematic as there just isn't the space to park for a short period of time.
- Some corridors are not wide enough for equipment to fit side by side – this is an opportunity to increase the space.
- There are no facilities for relatives to buy food apart from a couple of vending machines selling sweets and crisps. This is not ideal when people are sat in the waiting room for extended periods of time.
- Waiting areas are too small and quickly become crowded and full.
    - Could utilise drop-down seats in waiting areas which fold away to make room for wheelchair users.
- It is very drafty when you come out of the main exit. This could cause someone to fall and injure themselves.
- Everything done as part of this work needs to be future proofed as you don't want to be doing this exercise regularly.
- Consider doing some fundraising to buy new equipment that you can't afford with this capital investment, for things such as a new CT scanner.
- A more open planned approach could improve communication.
- There are security provision issues for staff and patients.

Patient and public engagement

Note: Most Panel members had not experience of critical care services currently and so gave more general comments, rather than comments relating to personal experiences. Comments have been themed for ease of interpretation.

<u>Staff/communication</u>

- Good communication from staff
    - Be realistic
    - Manage people's expectations
- Staff to be mindful of how long people have been waiting
    - Have they eaten or had a drink – or should they not be eating or drinking (depending on what treatment they may be about to receive? Paying particular attention to more vulnerable patients
    - Staff also need to mindful of carers/family members

- Friendlier staff
- Staff need to listen to patients
    - Staff must listen to patients/family members/carers properly
    - If somebody is brought in unconscious, staff need to speak and listen to a family member/carer (if possible) about their needs
- TV screens need to give accurate information about waiting times etc

Environment

- Basic facilities to work eg lighting, water machines/vending machines/coffee machines
- Better vending machines ie healthier choices, or something with more substantial foods eg sandwiches, not just chocolate bars
- Have a coffee shop/café/food outlet at the site – could also create some income generation
- Better privacy – curtains don't provide enough privacy, you can hear everything
- Have segregated areas for different types of patients eg children and young people/frail and elderly/potentially violent patients (or for these patients to be better managed, can be concerning for other patients), quiet areas for people with autism, dementia friendly
- Well-lit outdoors for those arriving at night
- Some form of security to better manage difficult patients

Triage

- Better triage facilities
- Assessment and triage – critical → emergency → non-emergency
- Patients to have a traffic light system – be put into red, amber or green – people will feel more comfortable waiting if they realise there is someone in greater need
- Following triage do not be returned to the same waiting room – this will help people better understand where they are in the system

Access

- More wheelchairs need to be available
- Need to have easy access to wheelchairs at reception
- Better assistance for people who may need it eg lone carers/family members with an elderly relative or a young baby, or someone who isn't mobile
- Waiting taxis can currently cause problems when trying to drop someone off – needs to be better managed
- Better access to departments for patients
- Better signposting
- Coloured pathways
- Disability friendly
- More drop off spaces
- Better car parking facilities – free or cheaper parking, more car park pay machines

Other comments

- Is there bed blocking with people not being discharged over the weekend?
- The ED should have its own x ray/MRI area
- The ED should have specialist/clinical teams that work as multi-disciplinary
- Use best practice to develop the ED
- Do not reinvent the wheel

Challenges/issues/opportunities

Challenges

- Challenge of having the right clinical staff with the right expertise.
- Anticipate and plan for teething problems – do a number of trial runs with volunteers/immersive rehearsal.
- Account for additional construction staff and materials – vehicles impact on parking and ambulance access.
- Sustainability.
- Anticipating need.
- Ongoing funding.
- Staffing levels.
- Lack of consultants.
- 'Tell us once' doesn't work – people are still having to tell their story multiple times (Salford example is a good one where their system works well).
- Discharge letters need to be done immediately – notes can be inadequate.
- Management of staff and processes needs improving as in the CQC report.
- Security in A&E needs to be improved.

Issues

- Will primary care be part of it the facility? Clinical specialists are not in situ in A&E and this slows down patient flow. Pathways can be improved by having the relevant specialist knowledge in the unit.
- Issues getting an appointment with a GP is a contributing factor – people default to A&E.
    - What happens in services outside of the emergency village will impact on its efficiency
- Ambulance waiting times are poor.
- Triage takes a long time – up to two hours or even longer.
    - Why is it taking too long to triage? There should be sufficient staff at the front door.
- Frequently changing the system and options so people are unclear of where to go so good communication about appropriate use of services is essential.
- Long waits for x-rays.
- Totally inconsistent patient flow.

Opportunities

- Will the unit include a specialist service for children? At present they have to go to Manchester.

- MDTs in the department – assessed by the right person.
- Colour-coded tunics so staff (eg nurses, consultants) are recognisable.
- Better facilities for mental health patients.
- More space for patients.
- Patient records: Carry with patient/patient passport? Or wristband with barcode?
- The new unit could benefit staff recruitment.
- All disciplines and support services should be in situ within the emergency village.
- Triage should include the ability to reroute people who don't need to be in A&E to reduce waiting times.
- Initial assessment crucial.
- Keep patients informed about waiting times.
- Does the hospital use the same type of system as GPs so this information could be shared?
    - Extend summary care record.
- Separate triage for ambulatory and ambulance admissions.