



North Bristol NHS Trust (NBT) Event – 6th October 2010

Bristol Local Involvement Network (LINK), South Gloucestershire LINK and The Care Forum Voluntary Sector Networks (South Glos and Bristol) organised an event in partnership with NBT on 6th October 2010 at BAWA from 2pm – 4pm. The aims of the event were for people to hear presentations from NBT staff and to ask questions on:

- Update on Patient Experience work (including the development of NBT Carers' Strategy)
- Changes to NBT PALS (Patient Advice & Liaison Service) and Complaints' service
- The latest on the new Southmead Hospital development

Talk on Patient & Public Involvement and Patient Experiences and the Carers Strategy – Juliet Winter, Patient & Community Engagement Manager and Corinna Casey, Building our Futures

http://www.thecareforum.org/publication_uploads/6%20Oct%20-%20Advice%20and%20Complaints.pdf

Corinna Casey spoke about the Building Our Futures Programme. She spoke about the Medical Admissions Unit and the benefits of an integrated unit at the new Southmead development. She outlined these as patient care and patient experience. At the new hospital, people should have more expert advice and be discharged faster.

Update on Southmead Hospital – David Powell, Director of Capital Projects

http://www.thecareforum.org/publication_uploads/6%20Oct%20-%20Patient%20Experience.pdf

Changes to Complaints and Patient Advice & Liaison Services (PALS) – Juliet Winter and Sue Needs, Deputy Advice & Complaints Team Manager

http://www.thecareforum.org/publication_uploads/Southmead%20Hospital.pdf

There was a market style format, where speakers sat at tables, and people were invited to move over to a table of their choice to ask the three speakers questions. People were



also able to change tables. Here are some of the questions and answers from these sessions.

Southmead Hospital Developments

Q. Will services currently at Frenchay Hospital be continued on the new site?

A. A decision to centralise most of the services at Southmead has been taken. There is an issue of travel to Southmead instead of Frenchay which affects many people. £1.5 million has been invested into transport for the new hospital site and working with the local Bus company. There will be a bus network which is focussed on linking with the main population centres. North Bristol NHS Trust (NBT) are sharing ideas with the University of the West of England (UWE). The transport system will take 2 years to shape and NBT are talking to local bus companies about having 3 routes into the site; which is attractive to the bus companies.

Q. There is a concern that the surplus land on the Frenchay site will be used for redevelopment – is this likely?

A. Once the plans for the services that will exist on the Frenchay site are finalised the remaining land will be disposed of.

Q. My husband was in hospital recently and the room he was in had to have a 'deep clean', but the windows were not cleaned because the cleaners said it was not their job. Who will clean all the windows and glass in the new hospital?

A. Window cleaning has been built into the contracts – so a certain amount of window cleaning is guaranteed for the first 30 years. This covers a proportion of the windows that will require cleaning. The budgets for window cleaning are reduced and the contract is for the basic level of cleaning.

Q. You talked about there being 75% single occupancy rooms in the new hospital. Would any of these have an extra bed for a Personal Assistant (PA) to stay in?

A. There will be space in every room for a reclining chair for a PA or relative to stay on.

Q. What training will staff have about Disabled People and PA's?



A. The detail on that is not known by me. A plan will be put together of which this will be one part, it will then be publicised and will involve public consultation – when and how has not yet been decided. There is a user access group which is good for user involvement and dissemination of this information.

Q. Is there enough room to get emergency equipment around the beds?

A. Yes there is. There have been mocked up rooms in the new development and these have shown that there is room to bring emergency equipment around the beds; e.g. ultrasound machines and extra wide wheelchairs. A lot of thinking that has gone into that.

Q. Has storage been built in?

A. We have had the benefit of looking at other developments where storage has been lower and consequently we have put in bays with enough space for machines to be plugged in, placing storage where people need it most and want to use it. But it has to then be managed effectively.

Q. Transport is an issue for many people trying to get to Southmead – the area needs decent transport.

A. Transport has to be a lot better, a network that is linked up or a circular network that allows people to come off it and into the hospital. This is being planned with experts and with some funding - £1.5M is going to be spent to try and ensure that there is a bus coming into the hospital every five minutes.

Q. What about a 999 call in Kingswood – will that person still get to hospital in the same time?

A. It is a concern. However, ambulances are more able to manage patients in the ambulance and then move them once they are stabilised. It is better to have an emergency department in one place.

Q. What services will there be at night? Currently, there is no non emergency transport for discharge at night.

A. The Patient Transport Service is a service that could take people home; but there are some criteria for accessing it.



Q. Will the number of acute hospital beds within NBT be less than it is now? With the increase in older people and people taking longer to be discharged, there could be problems with bed blocking.

A. There could be problems but it is difficult to get the number right. It is important to work out what the growth in population is likely to be; Bristol and South Gloucestershire, with new housing and the increase in older people. There is a need to get the size of the services right and to have some transfer of care where it's appropriate. For example, all children will go to the Bristol Children's Hospital when the new Southmead hospital opens. The length of time people are staying in hospital is decreasing and the NHS bed base is also decreasing despite an increase in demand on services year on year.

Q. Older People tend to go into hospital for medical care and end up staying in for longer. What will there be for long term care?

A. There are now primary care services that help to keep people at home. There are now 100 beds for long stay older people and planning suggests that 200 are needed.

Q. What about the provision of appropriate food for Black and Minority Ethnic (BME) Communities?

A. This came up in the planning of the hospital and will be included in the new hospital. Information is yet to be collected for operational policies.

Q. Hospitals should have clear guidance on asylum seekers – someone who had applied for asylum was admitted to the emergency department and has just been given a bill for £6000.

A. This is government policy and so NBT must apply properly according to government policy. But people should be told that this is the case when they are admitted; but the situation can be complex if someone is requiring emergency care or surgery.

Q. Training – urge you strongly to integrate this with front line staff

A. There is training for front line staff at the moment but it can always be improved

Q. What is the length of the Private Funding Initiative (PFI) contract?

A. 30 years



Q. What percentage of turnover is paid back under the PFI agreement?

A. 7% is paid back – an annual payment of 7% if paid back to the government for PFI for the first 30 years.

Q. What are the provisions for changes in the retail price index? And what are the provisions for not being able to match it?

A. If the retail price index goes up NBT is tied into it. NBT has to make the payments but it will generally be lower than NHS inflation. NBT has the same contract as every hospital.

Q. Bristol is very good for transport compared with South Gloucestershire but there are very few buses in rural areas. The system for discharge without back up for transport is poor.

A. NBT is spending £1.5M on buses and road improvements to optimise transport to the new site – if attitudes shift then market forces may work to that advantage. Acute services have to be backed up with other services. If you can get buses into the site on regular times so that then people tend to use them.

Q. I understand from the information here that there will be en-suite facilities for the rooms. If you have done your consultation and research right then they will be low level accessible facilities. How accessible are the bathrooms, are they fully accessible for wheelchair users?

A. The question was whether to make them individually or assisted accessible. All the en-suites have showers but are not individually accessible. Ward bathrooms are accessible in both ways. You need to be able to get a nurse on either side of someone in the bathroom so the person wouldn't be close enough to the sick for it to be individually accessible.

Q. 25% of the rooms are not single occupancy? This could be an issue of isolation for an older person.

A. There are two four- bedded bays on each ward; so a 32 bedded ward has eight beds in bays and the rest in single occupancy rooms. It is difficult for people who may wish to be alone and for those who do not, but the single occupancy rooms are within site of the Nurses station and so people will be able to see activities and others coming and going.



Q. Are the wards specialty or gender based?

A. Both could have been done with the ward design but it was decided to make them specialty based, but the four-bedded bays are split so that they are single sex and at either end of the ward

Q. It is important to have dual purpose rooms that can be used by more than one therapist in the rehabilitation services

A. There will be general areas with standardised larger treatment rooms that will be multi purpose.

Q. I have seen the new Pathology building – it is quite a distance from the main hospital site; even with the vacuum transfer system will this be OK?

A. It is more than adequate. The main service building is not big enough for all the pathology disciplines, but is excellent for microbiology so that will stay there and the others move to the new building. Its location is dictated by having to move it early in the new build project. Pathology service could then be consolidated across the city.

Changes to Complaints and Patient Advice & Liaison Services (PALS)

Round Table – Changes to PALS

Sue Needs, Deputy Advice and Complaints Manager

Number of complaints are reducing; number of concerns are increasing which is an indicator of success in that PALS is making itself known and available to patients.

Q: One LINK member tried to find the office. Is it signposted?

A: I will ensure that it is but it will be named Advice & Complaints (A&C).

Q: Awareness training is needed with staff as to where to access the service at Trust HQ.

A: This is on going.

Q: Many staff will not know where HQ are.



A: We will look into this.

Q: Is the new system going to be more proactive in giving advice, general and clinical?
It is a problem now that individuals go home earlier, they need clear information on medical needs and for carers.

A: We would signpost to the ward for advice or call the ward ourselves to get the advice.

Q: It is a big problem. If patients leave ward without advice, the patient might not know they needed it.

A: A&C would not know either; this is a clinical responsibility.

Q: What is the size of your department?

A: Six, four of whom are full time, 1 part-time and 1 admin officer.

Q: Is that adequate for a larger hospital?

Q: I think it will be. We will be able to make more ward visits when the whole team is based all under one roof.

Q: UHB have got only 2 staff.

A: But this is because PALS and complaints are still separate.

Q: I am concerned when a complaints procedure is under the control of the organisation being complained about and is not independent; there is a danger that complaints are downgraded in magnitude, significance or even numbers.

A: ICAS (Independent Complaints and Advocacy Service) is independent and supports the patient. But the complaint would still go through the NBT process. We are reviewed by the independent ombudsperson. We negotiate with each client as to whether it goes to complaint or remains a concern, but both are treated equally seriously. Learning from mistakes is a main objective. All issues that are raised are recorded. If it is a complaint it is signed off by CEO. If it is a concern, it is signed off within the A&C.

Q: Are concerns identified as potential issues?



A: Yes, enquiries, concerns, complaints and compliments are reported on and analysed. Trends analysis is passed to the Trust's board for action planning. Communications are always an ongoing issue but there is now a real chance to change.

Q: How do you find the attitude of staff when you go to them with a complaint?

A: It can be defensive, because it is often a shock to them. Sometimes it is the patient or carer that is awkward, but staff need to be able to deal with this.

Q: Does A&C deal with it if someone complains about treatment?

A: I am concerned that most patients do not have expert advocates who will know if there may be an issue, who can ensure appropriate treatment.

A/P: It is a nurse; the named nurse should know.

A/P: Or an independent advocate.

A/P: Nurses no longer attend ward rounds.

A/P: Should not need an independent person.

A/P: Deference is built into elderly people's view of the hierarchy.

A/P: People don't recognise/don't admit/don't know how to/frightened of recrimination.

A: If we had a pattern of complaints on a ward, we would investigate.

Q: Do you publish the information?

A: It goes to the Trust board. I don't know if it is published. I will find out.

A: We determine the reasonable time to complete a case. We renegotiate with a patient if it is moving more slowly. Ruth Brunt, the Trust's Chief Executive, is very focussed on complaints and the learning arising from them.

Q: It worries me that if someone has been trained by someone they are less likely to whistle blow.

A: Independent advice is now available for clinical issues if they cannot be resolved locally. A&C would seek this if need be.



Q: Now the patients' human rights mean that relatives are not communicated with if the patient him/herself has not communicated.

A: He/she may have had reason not to communicate.

Q/P: Yes, but that does not seem right.

A: I encourage you to report it to ACT and we can help.

A/P: Training is needed for nurses on human rights and common sense judgment calls.

Workshop on Public and Patient Involvement, Patient Experience and Carers Strategy

with Juliet Winter, **Patient & Community Engagement Manager, North Bristol Trust,**

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Corinna Casey, Building our Futures.

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Issues and Comments from the Workshop

Feedback

- Complaints – after a complaint about hospital discharge which was upheld the complainant felt that he then got no further information or feedback. He wanted to know if the actions had been implemented, lessons learnt and to see evidence of it.
- Lack of feedback – this was a general complaint about consultations. That people who went to meetings, commented on consultations got no information about what had happened as a result.

Hospital Discharge

- Care packages are not always put together before discharge from hospital.
 - Voluntary sector can help . Carers centre has discharge officer.
- The clinical discharge from hospital may be brilliant but not health and social care.
- People are left waiting for community services when they could be discharged.
 - Clinicians need to think ahead so they can discharge on time.
 - Better training on discharge is needed.



- In North Somerset there was a project on discharge from Weston hospital- there was a coalition of voluntary organisations at discharge unit.
- A lot of staff don't know what is involved - they are very insular
- Ward staff get pressure to discharge. The Discharge nurse should not be speaking to the family – should go through social worker. Working together and consistency needed.
- A person may need training to help them come out of hospital. Support in hospital environment is different from support at home.

Working with the voluntary sector

- What role does the carers strategy envisage for organisations outside the NHS in hospital discharge eg Care and Repair who can check that a home is safe before discharge.
- Home from hospital service also wants to work with NHS
- The NHS likes to work within in its own bubble. Voluntary organisations want to work with you.
- People have to wait for home adaptations – affects quality of life and safety. The NHS may not have capacity to do this work but voluntary organisations like Care and Repair can do – they need to be known to NHS.
- Hospitals need to work more closely with Voluntary sector.
- There are a lot of organisations who want to help address personal issues. The NHS needs to have an idea of who is out there and how to tap into it. Needs better networks.
- Social workers from Southmead do use my service. Social workers are quite proactive with the voluntary sector.
- Where you have planned admission to hospital there needs to be a clear discharge plan at the beginning.

Carers

- It can be very tough on carers if the person they are caring for refuses support.
- A lot of carers don't identify themselves as such.
- Carers opinion is not taken into account – there are not proper meetings with carers particularly on hospital discharge

Dementia

- Moving people with dementia from ward to ward does not help.
- Need more awareness about dementia in NHS



- I send my staff (from voluntary organisation) onto ward to support person with dementia. Need person centred input into the medical model.

Transport

- Hospital transport is an issue
- Community transport doesn't take visitors/carers to hospital.

Information

- Need to redevelop NHS websites so we can make sense of the NHS – who is who etc -
- The different services within NHS.
- Website should be more accessible and make initial contact with hospital easier.
- Well Aware, the open access database can be used to find information on services.

Accessibility

- Clinics at Frenchay are not always accessible.
- There are no chairs with arms for disabled people.
- Doorways are not always accessible for wheelchairs
- Some chairs need to be bigger
- Water fountains should be available at outpatients.

Other

- Advanced directives – the NHS needs to be more open about advanced directives. If it is my decision not to have treatment - that should be my choice. I feel NHS is worried about undermining medical training if people want less treatment.
- Better joint working is required- people are often moved inappropriately from ward to ward- communication issue.
- 70% of people in hospital are older. Trust's will slot people into wards rather than taking into account individual's needs.
- Dignity Champions – everyone should be thinking about dignity.
- Nurses are trained to deal with acute issues but personal issues are the key to getting it right.



People were offered the chance to write comments and questions about NBT on flip-chart paper during the afternoon. This is what people wrote, followed up by a response from NBT.

Further Comments/ Questions

- In terms of improving the experience of patients – what is being done in relation to the Mental Capacity act and Consent to Treatment?
- A trust-wide policy on the use of restraint and the deprivation of liberty Safeguards needs to be more available for staff/patients/carers, etc.
- How many/what % of North Bristol Trust staff have had basic safeguarding vulnerable adults training?
- Is every clinical room power wheelchair accessible?
- The very first slide listed the expectations of the patient. The list was almost comprehensive, but there was one vital omission – the patient wants the correct treatment. This should always be the case, but it is important always to remember this!
- However, the correct treatment should have regard to the patient as a whole – not just the immediately presenting problem. Patients and carers should be listened to.