A.13 - Scheme evolution as a result of consultation comments

Brighton 3Ts. Design development from early design options to current proposal. 26.01.11
A.13 - Scheme evolution as a result of consultation comments
A.14 - Annotated plan from clinical consultation
A.15 - Patient and Public Consultation Feedback report August 2010

Introduction

This paper provides an update on the work which has been undertaken with patients and members of the public since the last update to Programme Board in August/September 2009. The paper demonstrates the success of patient and public involvement within 3Ts and provides a useful design baseline benchmark from which to measure improvements in the environment at Royal Sussex County Hospital once the hospital development is complete. Programme Board is asked to note this report.

Executive summary

Patient and public consultation within 3Ts has always been seen as extremely important. The use of the website where minutes and papers are frequently updated, and the various events for members of the public have been a feature of the 3Ts since inception. For instance during August/September 2008 over 50 people were consulted within four specific design workshops and one benefits criteria workshop. The data from this phase of consultation was analysed and presented to Programme Board in August 2009.

Perhaps more significantly, the suggestions made were fed back to clinical and operational leads so that they could either act on them, or explain why those suggestions could not be taken forward. Therefore the data presented below continues this process. All the suggestions contained in the appendices will be sent to identified leads, as before, together with last year’s suggestions for a progress update. There is therefore a trail of accountability at a very senior level which is recognised as best practice within patient and public engagement.

The data included in this paper paints a vivid picture of the issues which are important to the members of the public who were consulted. In general there is a strong focus on disability and access, which illustrates how buildings themselves can serve to enable or disable the people who use them. The papers finish by recommending that consultation takes place with the wider general public, if possible, so that we can ascertain whether these views are representative of our patient population in a broader sense.

Data sources

There are several different cohorts of respondents who gave information:

1. Two groups of patients or visitors who filled in the patient experience tracker (175 in total) in February and May 2010.
2. A group of patients or carers who attended the “Flagship Room workshop” (47 people)
3. Focus groups which were undertaken with specific disability or other special interest groups (approximately 90 people)
4. The Patient Public Design Panel (18 people) which has been meeting monthly since January and is made up of members of the public who have been either patients of B deadlines or have experience of design/construction. This group also includes link representatives and reports to Core Teams.
5. Letters and emails which were unsolicited, from members of the public who had been patients or carers (6).

In total approximately 300 people have participated by offering their views for the benefit of the design process, although there was some overlap between 1, 2, 3 and 5.

Quantitative data

The Patient Experience Team assisted patients visiting the RSCH between January and May 2010 to complete the Patient Experience tracker in two quarterly surveys. This yielded data from 175 patients or visitors. 44% of the respondents were men and 46% female. It is also of note that 46% of respondents classed themselves as having some form of disability which affected their everyday life.

The Patient Experience Tracker asked questions specifically about way finding, and access. This was because 3Ts is working on the hypothesis that these areas will be improved through the hospital redevelopment, and we used the patient experience tracker to set the baseline. The results of these questions are shown below:

Getting to the hospital

The chart below shows that PPH compared favourably to RSCH for ease of access, although the sample size was smaller (60 compared to 115 for RSCH) with 89% saying it was easy or fairly easy at PPH and 63% saying the same for RSCH.

Navigating and way finding at RSCH

55% people found the RSCH site difficult to find their way around compared to only 10% saying the same at PPH.
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or analysis of qualitative data

initially segregated into the main patient areas which were:

- Waiting areas
- Treatment areas
- Catering facilities
- Examination rooms
- Hygiene
- Noise and environment
- Of comments

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Waiting areas</td>
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</tr>
<tr>
<td>Treatment areas</td>
<td>117</td>
</tr>
<tr>
<td>Catering facilities</td>
<td>92</td>
</tr>
<tr>
<td>Examination rooms</td>
<td>66</td>
</tr>
<tr>
<td>Hygiene</td>
<td>41</td>
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<tr>
<td>Noise and environment</td>
<td>37</td>
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<tr>
<td>Of comments</td>
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<td>10</td>
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</table>

Summary of data

- Wayfinding
- Reception and waiting
- Ward design/treatment
- Clinical Care
- Improved customer care
- Consulting and examination rooms
- Toilets
- Changing facilities

This data contains a lot of very useful information which will be further interrogated for the purposes of benefits realisation. However, within the content of this paper, the data presented above shows conclusively that RSCH compares unfavourably with PIHR for both physical access and way finding on site, although the town centre location does appear to be popular with respondents. The next section explores these issues in depth and is based on qualitative data collected within focus group settings.

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The next section looks at these areas individually, before an analysis of the overarching themes.

Wayfinding

Wayfinding was found to be particularly difficult at BSCH and cited as a problem by 31% of those questioned. Trying, by contrast was easier for people to negotiate. As expected, parking was mentioned as particularly difficult and people found the current campus difficult for a variety of reasons, such as its slope, the numerous levels and the confusing signage.

“The site is just so convoluted and it is difficult to follow instructions to get to your destination. Most people cannot remember all instructions”

• “It’s just too complicated”
• “I used to get hopelessly lost...it’s like a maze.”
• “I didn’t know where to go.”

Significantly, whilst people were enthusiastic about the benefits of information technology, several people were anxious that the advances should not take the place of human contact:

“Whatever new technology is introduced must not replace personal touch and human contact, people need options...who is going to help people start the journey?”

It was of interest that the good location of the site was mentioned 15 times (12%), as it is easy to get to by bus and is within the City.

As can be seen the issue of disability and inclusion was the main focus of the comments with 26% of those questioned wanting to see reception and waiting areas which were fully accessible with a range of aids for people with disabilities, such as people who are partially sighted or people with mobility problems.

In general those questioned were very keen to embrace technological improvements which would make being a patient or visitor an easier, more comfortable experience. People compared the busy environment to being in an airport or shopping centre where there are many facilities which make navigating large groups of people easier. They cited examples of aids which could improve the waiting/visitor experience such as banners which they could take with them whilst waiting in outpatients.

“One-patients need to be light and airy with different height chairs, I recently accompanied my wife to the breast unit in Preston Park. There the waiting area is great, it would be improved if the coffee bar opens all the time since we are operating. Similarly, reception should be manned throughout clinics.”

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However, several comments about design in this area were focused on the need to minimise infection (particularly for immune-compromised patients), and whether this would make sounds for people who were hard of hearing difficult, or surfaces for people with dementia/little less too reflective and confusing.

“If we get booked together to see the doctors” time can we have buzzers? a system to let us go off around the site until we can be called to see we don’t like hanging around for hours, especially with the general public who might be infectious... We need smaller cubicles where we can keep away from children/people with coughs and colds.”

Some comments also raised the issue of whether people should have to wait at all. However people also had a lot of contributions to make about the ambulance and environment in the waiting and reception areas. There was a clear division between people who wanted TV/music and diversion, and those who did not. One group suggested that perhaps waiting areas should be subdivided into areas with diversions and areas which were more tranquil/few stimulating. In general, comments about art were that it should be soothing, and tranquil, if present at all.

Once again, people thought volunteers and staff could help to humanise the new, technological sophisticated patient waiting experience:

“We would like to have “grazers” as well as self check-ins in reception, also warm people.”

Ward design and treatment areas

There was a range of responses about wards and treatment areas, with people very interested about what the provision of single rooms would mean in terms of changes to patient care. Whilst people supported the concept of single rooms because of the associated improvements in privacy and dignity, there were concerns about nursling care being adversely affected. It was interesting to note that women were in favour of being nursed in bays of four than men.

Many people took the opportunity to describe the facilities they would like to see in treatment areas, a selection is shown below:

“Can we have soaks which are at waist height, and toilets you can get a drip stand into? When you are having chemo for a couple of hours you have to drink a lot of water to flush it through and then when you need to use the toilet, it can be hard to get it the drip unpegged if it’s at floor level behind the chair.”

Another Cancer patient:

“Why are we shoved out the back, almost as if we are secret? Areas have no outside rooms. We understand that privacy is important but we think sometimes people see cancer as something to be hidden away... Not sure the area should look very clinical, more domestic and homely.”

Another theme was that increased facilities should be made available for people with carers, such as fold down beds, or cozy chairs next to people having chemotherapy. People also made comments about the need for water. The main thrust of these comments was that light, snacky food should be made available, as well as calorie-rich food like ice cream for people with poor appetites.

The theme of the need for the new design not to make human contact obsolete was a recurrent one.

Clinical care

Whilst this was not a prompted question, it came up in every interview or focus group, so was considered separately because those questioned used this opportunity to describe the nursing/care they had received in hospital, some of which had been unsatisfactory. Others had praise for the staff. The ratio of favourable to unfavourable comments is shown below:

“Can you get someone with the right skill level to take the blood... Several stories of nurses being people with only venous or a challenge, 1) Even though the patient knows from experience that they won’t be able to find the vein unless they are a specialist phlebotomist and they will keep trying until it hurts”

Compared to:

“The staff were marvellous; the clinical care was second to none”

Once again, the importance of better facilities for people with disabilities and the importance of human contact unprompted as did the issue of infection control. One facilitator said that older people “were scared of hospital” because of their worries about picking up a life-threatening infection.

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Improved customer facilities

To some extent this category was implicit in many others, such as the reception and waiting areas, however it was given its own analytic category because it is considered an important area of patient feedback as the NHS modernises and embraces the concepts of competition and choice. It is moving away from the "grateful recipient" patient towards the discerning consumer. Moreover, in all the meetings with patients, this came up as consistently important. So whilst clinical skill is the most important aspect of care, improving the customer experience and making people feel valued and cared seemed to contribute to both the patient experience and the recovery process.

"There was some discussion about patient entertainment and telephone systems. The group expressed some dissatisfaction with the current arrangements in providing these services stating that the service was over priced and difficult to use. It was suggested that as portable entertainment systems were becoming increasingly common the design should be developed with this in mind (patients able to access Wi-Fi, charging points)."

Examination and consulting rooms

This area of feedback was mainly practical advice to the 3Ts about how the examination suit could be made more user friendly. However, there were some useful comments about the process of consultation too:

"Would like a consultation before being examined i.e. an equal exchange one-to-one, rather than a consultation when you are lying on an examination couch (I)."

And

"Should be just patient and the consultant - limit people coming in and out of rooms when they don't need to be there - don't make exam rooms sound like an airport."

"Leave the desk - there was a fair amount of consensus that desks are a barrier to proper communication and interaction. Desks where doctors have to turn their back to you to write or type were considered just as bad... Private practice was cited as an example where there is no desk between the patient and doctor."

Toilets

Toilets were an important category for patients with disabilities. Those questioned also emphasised the challenge of space utilisation and accepted the idea of changeable male/female toilets. However, there was unanimous rejection of unisex toilets of toilets.

The disability issue prompted thoughtful and authentic suggestions which were born out of the lived patient experience, from areas such as the lack of shelving for items patients, through to the need for paediatric sides which are hand operated for patients in wheelchairs who cannot use foot operated waste bins.

Changing areas

This was a narrow, specialist area for discussion which was prompted by the 3T team wanting to know how to design changing areas in the most space efficient yet patient-friendly way. The Flagship Rooms workshop ran a session specifically in this subject with 3 variants being discussed as follows:

1. Change and wait in communal area
2. Change and wait in an area with other people who are also changing
3. Change and wait in a self-contained cubicle.

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There followed a useful discussion about the advantages and disadvantages of these variants. There was concern about the patient examination and treatment rooms being sound proofed if people were waiting next to them.

One issue mentioned was that consulting rooms are next to busy waiting areas as it can be hard if you have had bad news to step out into the busy milieu with people waiting about.

People were asked to vote on the preferred option using the diagrams and sticky labels provided. Variant 3 was narrowly the favourite. This provided useful feedback to the design team.

“Prefer to wait with other people who are changed, shouldn’t have to wait with fully clothed people”

“Can we have lockers for our staff?”

“If we have to wait once changed can you keep us informed about how long we will be waiting especially if we are going to be on our own?”

An additional issue which became apparent through feedback was the additional requirements of people with disabilities; several groups added that changing rooms should have sufficient space for people to be assisted whilst changing and for wheelchairs. Whilst this requirement will have space implications; these can be mitigated by the provision of the requisite number of larger assisted change areas.

Temperature, light and the environment

This was the smallest category for analysis but nevertheless provided some interesting insights into issues which were important for patients and their visitors. For instance single rooms were welcomed by some because they could give people the chance to alter the temperature and light to suit themselves.

The issue of disability also came through as partially sighted people favoured natural light whenever possible. There were also concerns that people with hearing loss would have difficulties if the surfaces were all reflective and non absorbent; as sound bounces off them and causes problems in crowded places. It is hoped that the design team can work out a technical solution to this problem.
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Therefore it felt appropriate to collapse the categories and summarise the thematic areas into more manageable categories as follows:

<table>
<thead>
<tr>
<th>Collapsed Themes</th>
<th>Number of times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestions for an improved customer experience</td>
<td>113</td>
</tr>
<tr>
<td>Suggested design improvements</td>
<td>102</td>
</tr>
<tr>
<td>Inadequacy of current environment</td>
<td>70</td>
</tr>
<tr>
<td>Disability and access</td>
<td>57</td>
</tr>
<tr>
<td>Vents on single rooms</td>
<td>29</td>
</tr>
<tr>
<td>Poor clinical care / Coordination of services</td>
<td>16</td>
</tr>
<tr>
<td>The importance of human contact</td>
<td>27</td>
</tr>
<tr>
<td>Good clinical care / Location</td>
<td>18</td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>16</td>
</tr>
<tr>
<td>Facilities for carers</td>
<td>7</td>
</tr>
<tr>
<td>Issues about infection control</td>
<td>5</td>
</tr>
<tr>
<td>Vents for patients / Medical Students</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>334</td>
</tr>
</tbody>
</table>

This did not seem very meaningful and was very repetitive. However it did allow issues which were important to patients to emerge such as the following:

- Disability and access
- Facilities for carers
- Infection control
- The importance of human contact
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Thus, leaving aside the “promoted” responses such as design improvements, it can be seen that patients/care are asking us to design a facility which is allows them to be treated with increased privacy and dignity and which is essentially a caring, modern and therapeutic environment as well as a clinically excellent one.

Comparison with 2008-2009 data

This compares well with the data which was collected over the previous two years which was previously presented to the Programme Board. As would be expected, there was some overlap in the membership of those consulted from a 2008 perspective, but the more recent exercise contains a much larger sample (from circa 50 people to circa 125 excluding people consulted via the questionnaire).

Whilst the previous categorisation was analyzed differently, the largest categories were broadly equivalent although design improvements are a larger category than clinical staff issues in the current year than during the previous data collection exercise. This should be seen as a natural development as many of those consulted are now more fully engaged in the design process than the previous year when they used the opportunity to give their views about their previous experiences in hospital, thus the comparison demonstrates the consistency of patient/public concerns over time in the types of issues raised.

Conclusion

This analysis has shown that patients and their carers/visitors are willing to engage in a debate about the way the hospital should be designed. Their views are an additional, rich source of data which can be included within the design information, as it has generated some insights which are only possible when someone has actually been a patient, that is feeling vulnerable, anxious, in unfamiliar surroundings and with additional requirements because of their illness or disability. In this sense the design should facilitate and enable the patient to “get past” the disability and confidently negotiate throughout the hospital in order to access the services which they require. This is where hospitals differ from other public buildings; they are used by a larger proportion of sick people and their significant others, who may themselves be feeling stressed and anxious. It is therefore welcome that BSUIH has this additional resource to draw on, both for the current design and during the remainder of the design process which will continue to provide an important window into the patient experience, once people have had the chance to process their experience and draw on it, for the benefit of others. Comments in appendix two will now be forwarded onto the responsible leads for action and responses. These leads are also being asked to update their responses to last year's paper.

Further work

The data presented above is to be complemented by a web-based questionnaire which will be on the BSUIH web site which has been designed for anyone to use, but it is hoped that patients or members of the public who do not find it easy to attend meetings or visit the hospital in person may find it a helpful feedback mechanism. In this sense BSUIH will attempt to reach people who represent other sections of the community as well as those with a long term disability.

Anna Barnes
5th August 2010
With special thanks to Mariusz Przybylak who assisted with the data categorisation and segmentation

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