Better Health Programme Joint Health Scrutiny Committee

Meeting on Thursday 7 July 2016 at 2.00 pm in Committee Room B, Civic Centre, Hartlepool

Agenda

1. **Appointment of Chair**
2. **Appointment of Vice-Chair**
3. **Apologies for Absence**
4. **To receive any Declarations of Interest by Members**
5. **Better Health Programme Joint Health Scrutiny Committee - Proposed Protocol, Terms of Reference and Project Plan (Pages 1 - 16)**

   Report of the Principal Overview and Scrutiny Officer, Durham County Council
6. **Better Health Programme (Pages 17 - 182)**

   (a) Presentation – Representatives of the Better Health Programme will give a presentation to the Joint Committee setting out the background to the Better Health Programme

   (b) Report of the Better Health Programme Project Executive
7. **Chairman's Urgent Items**
8. **Any Other Business**
9. **Date and Time of the Next Meeting**

   Thursday, 21 July 2016 at 2.00pm.

Published:

29 June 2016

Contact Officer: Stephen Gwillym, Principal Overview and Scrutiny Officer, Durham County Council **Tel:** 03000 268 140

Membership:

DARLINGTON BOROUGH COUNCIL
Councillor Wendy Newall
Councillor Jan Taylor
Councillor Heather Scott

DURHAM COUNTY COUNCIL
Councillor John Robinson
Councillor Jan Blakey
Councillor Watts Stelling

HARTLEPOOL BOROUGH COUNCIL
Councillor Ray Martin-Wells
Councillor Stephen Akers-Belcher
Councillor Rob Cook

MIDDLESBROUGH COUNCIL
Councillor Eddie Dryden
Councillor Bob Brady
Councillor Jeanette Walker

NORTH YORKSHIRE COUNTY COUNCIL
Councillor Jim Clark

REDCAR AND CLEVELAND BOROUGH COUNCIL
Councillor Ray Goddard
Councillor Mary Ovens
Councillor Norah Cooney

STOCKTON-ON-TEES BOROUGH COUNCIL
Councillor Sonia Bailey
Councillor Allan Mitchell
Councillor Lynn Hall

Better Health Programme Joint Health Scrutiny Committee

Better Health Programme Joint Health Scrutiny Committee

7 July 2016

Better Health Programme – Proposed protocol, Terms of Reference and Project Plan

Report of Principal Overview and Scrutiny Officer, Durham County Council

Purpose of the Report

1 This report provides members with details of the proposed Protocol, Terms of Reference and Project Plan for the establishment of a Joint Health Scrutiny Committee under the provisions of the Health and Social Care Act 2012 involving all local authorities affected by the Better Health Programme and any associated service review proposals.

Better Health Programme

2 The Better Health programme is about meeting patient needs now and in the future with constantly improving health and social care delivered in the best place. Commissioners want to make sure that:

- We improve results for patients;
- Care is of the same high standard wherever, and whenever it is provided;
- Services have the resources to be sustainable for the next 10 -15 years;
- We can provide services across 7 days a week where necessary;
- We make services easier for patients to understand and use;
- We improve life expectancy and quality of life for everyone in Darlington, Durham and Tees.

3 The programme aims to continue improving the services available in Darlington, Durham and Tees but in doing so, key challenges have been identified including:

- The changing health needs of local people;
- Meeting recommended clinical standards;
- Availability of highly trained and skilled staff;
- High quality seven-day services;
- Providing care closer to home;
- Making the best use of our money.

4 The Better Health Programme Board will provide the Joint Health Scrutiny Committee with a presentation which sets out the background to the Better Health Programme and also a detailed report setting out the stakeholder engagement undertaken to date.

Better Health Programme Timeline for 2016

5 Commissioners have stated their desire to work with stakeholder organisations and public representatives during the Programme and an indicative timeline for 2016 has been shared with stakeholders indicating that public consultation will commence around November 2016.

Provisions for consultation and engagement with Overview and Scrutiny Committees

6 The Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 require the formation of a joint scrutiny arrangement, where an NHS body or relevant health service provider consults more than one local authority on proposals to make substantial variations or developments to services. They provide that all the local authorities whose residents receive such services must participate in the joint scrutiny arrangement for the purpose of responding to the consultation, using the method most appropriate to the areas and issues being considered.

7 A local authority can opt-out if, having considered the information provided by the NHS body or relevant health service provider proposing the service change, they determine that the proposal is not “substantial” for their residents. Where a local authority opts out in this way, they will relinquish the power to refer the proposed change to the Secretary of State for the purposes of that particular consultation.

8 Only the joint scrutiny committee can require the organisation proposing the change to provide information to them, or attend before them to answer questions. That organisation is under a duty to comply with these requirements. If a local authority has opted out of the joint arrangement, they may not request information or attendance from the NHS body or relevant health service provider proposing the change.

9 In scrutinising the proposals, the joint committee should aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal. Only the joint scrutiny arrangement can then make a report and recommendations back to the organisation proposing the change.

Establishment of a Joint Health Scrutiny Committee

10 The establishment of joint Health Scrutiny Committee has been proposed consisting of representatives from Darlington Borough Council, Durham County Council, Hartlepool Borough Council, Middlesbrough Borough Council, North Yorkshire County Council, Redcar and Cleveland Borough Council and Stockton-upon-Tees Borough Council.

11 In accordance with the regulations detailed above, the Joint Committee will be the vehicle through which the respective Local Authorities will respond to the consultation.

12 A Protocol, Terms of Reference and proposed Project Plan has been developed by health scrutiny officers across the respective local authorities for the proposed Joint Health Scrutiny Committee setting out the role and function of the joint Committee as well as the proposed representation required from each Council. These documents are attached to this report.

Recommendations

13 The Better Health Programme Joint Health Scrutiny Committee is recommended to:-

(a) receive and comment upon the information detailed within the report and;

(b) agree the proposed Protocol, Terms of Reference and Project Plan for the Better Health Programme Joint Health Scrutiny Committee

Background papers

- Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013

Contact:	**Stephen Gwillym, Principal Overview and Scrutiny Officer, Durham County Council**
Tel:	**03000 268 140**

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – This report details the Committee's statutory responsibilities in respect of any proposed consultation and engagement activity in respect of the Better Health Programme.

Procurement - None

Disability Issues - None

Legal Implications – This report has been produced in response to the Committee's statutory responsibilities to engage in health scrutiny consultations as detailed in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 and associated Department of Health Guidance.

Protocol for a Joint Health Scrutiny Committee

Better Health Programme

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering and providing a formal consultation response in relation to proposals for substantial development and variation to health services as contained in the 'Better Health Programme'. The proposals affect the Durham and Tees Valley region and are being proposed by the following:

   - Darlington Clinical Commissioning Group (CCG);
   - Durham Dales, Easington and Sedgefield CCG;
   - Hartlepool and Stockton-on-Tees CCG;
   - North Durham CCG;
   - South Tees CCG.

2. The terms of reference of the Joint Health Scrutiny Committee is set out at **Appendix A**.

3. A Joint Health Scrutiny Committee ("the Joint Committee") comprising Darlington BC; Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC; and Stockton-on-Tees BC ("the constituent authorities") has been established in accordance with the Regulations for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraphs 1. In particular in order to be able to:-

   (a) respond to the consultation

   (b) require the relevant NHS Bodies to provide information about the proposals;

   (c) require members/employees of the relevant NHS Bodies to attend before it to answer questions in connection with the consultation.

4. The Joint Committee formed for the purpose of the consultation outlined at paragraph 1 will, following approval of this protocol and terms of reference at its first meeting, circulate copies of the same to:-

   Local Authorities

   Darlington Borough Council (BC); Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC and Stockton-on-Tees BC;

   Clinical Commissioning Groups
   Darlington; Durham Dales, Easington and Sedgefield; Hartlepool and Stockton-on-Tees; North Durham; South Tees.

   [This may be replaced by 'Better Health Programme Board' or similar]

NHS Foundation Trusts

County Durham and Darlington Trust
North Tees and Hartlepool Trust
South Tees Hospitals Trust

Membership

5. The Joint Committee will consist of equal representation, with three representatives to be appointed by each of the constituent authorities.

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.

8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.

9. The quorum for meetings of the Joint Committee shall be a minimum of one member representative from each of the constituent authorities.

Chair and Vice-Chair

10. The Chair of the Joint Committee will be a Member representative from [XXXX] and the Vice-Chair will be a Member representative from [XXXX]. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraphs 1. Terms of reference are set out at Appendix A.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.

14. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.

16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Report and Consultation Response

17. The relevant NHS body are required to notify the Joint Committee of the date by which its consultation response is required, and the date by which it intends to make a decision. The Guidance highlights that it is sensible for the Joint Committee to be able to consider the outcome of public consultation before its makes its consultation response.

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of its final report and formal consultation response to the relevant NHS Bodies and the constituent authorities.

18. The primary objectives of the Joint Committee will be to reach consensus, but where there are any aspects of the consultation as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Following the Consultation

19. Any next steps following the initial consultation response will be taken with due reference to the 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny' (Department of Health; June 2014).

Principles for joint health scrutiny

20. In scrutinising the proposals, the joint committee will aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal.

21. The constituent authorities and the relevant NHS Bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

22. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

23. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

Appendix A

Better Health Programme Joint Health Scrutiny Committee

Terms of Reference

1. To consider proposals for substantial development and variation to health services as contained in the 'Better Health Programme' and as proposed by the following:

   a) Darlington Clinical Commissioning Group (CCG);
   b) Durham Dales, Easington and Sedgefield CCG;
   c) Hartlepool and Stockton-on-Tees CCG;
   d) North Durham CCG;
   e) South Tees CCG.

2. To consider the following in advance of the formal public consultation:

   - The aims and objectives of the Better Health Programme
   - Information on the Options Appraisal process
   - The plans and proposals for public and stakeholder consultation and engagement

3. To consider the Programme's substantive proposals during the period of formal public consultation, and produce a formal consultation response, in accordance with the protocol for the Joint Health Scrutiny Committee and the consultation timetable established by the relevant NHS Bodies.

4. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined above, the Joint Committee may:-

   a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee; and

   b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.

5. To ensure the formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

6. The Joint Committee does not have the power of referral to the Secretary of State.

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Appendix 3

WHEN Times/Dates/ Locations	DESIGNATED LEAD Member/ Officer	WHO Key Witness	WHAT Evidence/Information	HOW Meeting/Visit/ Correspondence/ Briefing Paper/ Research	OUTCOMES	WHY
Session 1 Thursday 7 July 2016 at 2.00 p.m. Hartlepool Borough Council	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Better Health Programme Board Reps CCG Reps NHS Foundation Trust Reps	• Report detailing proposed Joint OSC Terms of Reference, Protocol and Project Plan • Overview report from Better Health Programme Board detailing the Better Health Programme – History and work to date including previous iterations i.e. Acute Services legacy project/Securing Quality in Health Services (SeQIHS) • Report from Better Health Programme Board detailing Phase 1 pre-engagement activity undertaken and outcomes	Working Group Meeting Briefing Papers/Reports	Agreed Joint OSC Terms of Reference, Protocol and Project Plan Joint OSC members appraised of the background to the Better Health Programme Joint OSC informed of:- • the experience of people using current health services • the ways in which those people, and the wider general public, think health services could be improved across Durham, Darlington and Tees • the view of clinicians and other stakeholders including the voluntary sector, in relation to health services across Darlington, Durham and Tees	To satisfy the statutory Heath Scrutiny requirements set out under Section 244 of the NHS Act 2006 To provide members with the key feedback received during Phase 1 Pre-engagement activity

WHEN Times/Dates/ Locations	DESIGNATED LEAD Member/ Officer	WHO Key Witness	WHAT Evidence/Information	HOW Meeting/Visit/ Correspondence/ Briefing Paper/ Research	OUTCOMES	WHY
Session 1 (cont)	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Better Health Programme Board Reps CCG Reps NHS Foundation Trust Reps	• Report from Better Health Programme Board detailing Phase 2 Engagement undertaken in developing the Better Health Programme Clinical Model including whether consensus on the model has been reached across key stakeholders	Working Group Meeting Briefing Paper	Joint OSC informed of:- • the views of patients and public, stakeholders and staff in respect of the emerging clinical model. • Whether consensus on the preferred clinical model has been reached and the key areas of agreement/disagreement.	To provide members with the key feedback received during Phase 2 engagement activity and the opportunity to comment on the engagement feedback.
Session 2 Venue TBC Thursday 21 July 2016 at 2.00 p.m.	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Better Health Programme Board Reps CCG Reps NHS Foundation Trust Reps	• Report from Better Health Programme Board highlighting the potential long list of scenarios and evaluation criteria to be used and associated proposals for engagement for Phase 3	Working Group Meeting Briefing Paper	Joint OSC informed of :- • The potential long list scenarios developed following Phase 1 and 2 engagement; • The evaluation criteria to be used to develop the short listed scenarios; • The proposals for Phase 3 engagement.	To provide members with the opportunity to comment on the potential long list scenarios for Phase 3 engagement and the associated engagement plans.

Appendix 3

WHEN Times/Dates/ Locations	DESIGNATED LEAD Member/ Officer	WHO Key Witness	WHAT Evidence/Information	HOW Meeting/Visit/ Correspondence/ Briefing Paper/ Research	OUTCOMES	WHY
Session 3 Venue TBC Thursday 8 September 2016 at 2.00 p.m.	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Better Health Programme Board Reps CCG Reps NHS Foundation Trust Reps	• Report from Better Health Programme Board detailing the results of Phase 3 Engagement and the evaluation of the "long list" scenarios and rationale for the development of shortlisted scenarios • Report from Better Health Programme Board highlighting the potential short list of scenarios and evaluation criteria to be used and associated proposals for engagement for Phase 4	Working Group Meeting Briefing Paper	Joint OSC informed of:- • the results of Phase 3 Engagement and the evaluation of the "long list" scenarios; • the rationale for the development of shortlisted scenarios; • The proposals for Phase 4 engagement.	To provide members with the key feedback received during Phase 3 engagement activity and the opportunity to comment on the engagement feedback and development of short list scenarios.
Session 4 Venue TBC Thursday 13 October 2016 at 2.00 p.m.	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Better Health Programme Board Reps CCG Reps NHS Foundation Trust Reps	• Report from Better Health Programme Board detailing the results of Phase 4 Engagement and the evaluation of the "short list" scenarios and rationale for the development of those scenarios proposed for the Statutory Consultation and Engagement process. • Draft report from Better Health Programme Board on Phase 5 Consultation and Engagement	Working Group Meeting Briefing Paper	Joint OSC informed of:- • the results of Phase 4 Engagement and the evaluation of the "short list" scenarios; • the rationale for the development of those scenarios proposed for the statutory consultation and engagement process;	To provide members with the key feedback received during Phase 4 engagement activity and the opportunity to comment on the Phase 5 Consultation and Engagement including details of the consultation, communications and engagement plans

WHEN Times/Dates/ Locations	DESIGNATED LEAD Member/ Officer	WHO Key Witness	WHAT Evidence/Information	HOW Meeting/Visit/ Correspondence/ Briefing Paper/ Research	OUTCOMES	WHY
			including details of the consultation, communications and engagement plan for the consultation		• the proposals for Phase 5 engagement.	
Session 5 Venue TBC Thursday 19 January 2017 at 2.00 p.m.	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Better Health Programme Board Reps CCG Reps NHS Foundation Trust Reps	• Progress report from Better Health Programme Board in respect of Phase 5 the Statutory consultation exercise; • Update reports from Constituent LA Health OSCs highlighting emerging issues/feedback from localities in respect of the Phase 5 consultation	Working Group Meeting Briefing Paper	Joint OSC receives :- • Progress report from the Better Heath Programme Board on Phase 5 engagement; • locality feedback from constituent Health OSCs	To provide members with an update on feedback received during Phase 5 engagement activity and the opportunity to comment on the emerging issues from the statutory consultation and engagement plans
Session 6 Venue TBC Thursday 9 March 2017	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Better Health Programme Board Reps CCG Reps NHS Foundation Trust Reps	• Report from Better Health Programme Board in respect of Phase 5 the Statutory consultation exercise including the feedback provided as part of the Statutory Consultation and Engagement process; • Report from Better Health Programme Board setting out key proposals for future service delivery/changes as a result of the consultation exercise, including the views of NHS	Working Group Meeting Briefing Paper	Joint OSC receives :- • Report from the Better Heath Programme Board on Phase 5 engagement and responses received to the consultation; • Initial draft proposals from the Better Health Programme Board setting out key proposals for future service delivery/changes.	To provide members with the key feedback received following Phase 5 engagement activity and the opportunity to comment on the emerging issues from the statutory consultation and engagement plans including the potential implications on future health

WHEN Times/Dates/ Locations	DESIGNATED LEAD Member/ Officer	WHO Key Witness	WHAT Evidence/Information	HOW Meeting/Visit/ Correspondence/ Briefing Paper/ Research	OUTCOMES	WHY
			providers, commissioners and local authority Adult and Children's services			service delivery/changes
Session 7 Venue, Date and Time TBC	Cllr John Robinson, Chair Stephen Gwillym, Principal Overview and Scrutiny Officer, DCC	Stephen Gwillym	Draft Report of the Better Health Programme Joint OSC detailing, key findings, recommendations and commentary in respect of the statutory Consultation and engagement undertaken in respect of the Programme and any associated proposals for changes to health service delivery across the Better Health Programme locality.	Working Group Meeting Draft Report	Draft Report and Recommendations	To satisfy the statutory Heath Scrutiny requirements set out under Section 244 of the NHS Act 2006

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Better health programme

NHS

The NHS in Darlington, Durham and Tees

7 July 2016

Better Health Programme - Project Executive

Report on Engagement to date (phases 1 and 2) and next steps (phase 3)

Purpose

To outline to the Joint OSC members engagement work undertaken and planned as part of the Better Health programme

Attachments

- Appendix 1 Better Health Programme communications and engagement strategy
- Appendix 2 Market research report (2015)
- Appendix 3 Independent analysis report on Phase 1 engagement (to February 2016)
- Appendix 4 Independent analysis report on Phase 2 engagement (May 2016)
- Appendix 5 Phase 2 narrative – basis of video and other communications for Phase 2 engagement
- Appendix 6 Phase 3 narrative – basis of video and other communications for Phase 3 engagement

Link

- Engagement video, May 2016 https://www.youtube.com/watch?v=W_ZeGWxQFKc

Background

Communications and Engagement work is being delivered by a working group comprising communications and engagement staff from the NHS commissioning organisations and foundation trusts. It reports to the Programme Board.

Our approach to engagement and consultation is informed by national guidance on the public sector duty to involve and the advice of the Consultation Institute. See Appendix 1 Better Health Programme communications and engagement strategy

Our engagement is an iterative process, building on the feedback we receive and using this to develop further iterations. Engagement and consultation is being managed in five phases:

Phase 1 pre-engagement (to February 2016) focus on the experience of people using current health services and the ways in which those people, and the wider general public, think health services could be improved

Phase 2 pre-engagement (May 2016) focus on the case for change and the draft principles and framework of care

Phase 3 pre-engagement (July 2016) focus on development of the decision making criteria and long list of scenarios (possible solutions) for how services could be designed in the future

Phase 4 pre-engagement (September 2016) will focus on the short list of scenarios and the consultation process

Phase 5 formal consultation (beginning November 2016)

Phase 1 – feedback

More details in Appendix 2 and 3

This engagement included:

- Market research (May 2015) including 1,000 telephone interviews and 6 focus groups
- Stakeholder event (27 January) – attended by 116 people including 54 stakeholder representatives
- 12 patient and public engagement events (February/March 2016) attended by 168 people

Market research feedback - Priorities among the local public with regard to hospital services, identified by the market research, are:

- Knowledgeable, professional staff
- Quality of care - Particularly effectiveness of treatment
- Cleanliness and hygiene

In an ideal world residents would like all services available at their local hospital; however there is a general acceptance that sometimes there may be the need to travel for specialist care. If travelling further, residents expect a higher standard of care.

Stakeholder Forum (27 January 2016) - feedback shows attendees:

- Acknowledge pressures on the system
- Believe decisions from BHP will be influenced by local politics
- Many felt that the public need to be educated and to have more realistic expectations about their local health services
- We need to change unnecessary demand and make things less complicated.
- Workforce pressures are understood and in most cases accepted
- Provision of care needs careful consideration and NHS should not compromise on quality when looking at reforms
- Transport - When it comes to the location of services it is not an issue of where it is, but how to get there and back
- The right technology needs to be in place to support BHP's potential changes

- Clarity is needed around public engagement
- Clarify the specialist pathways that need to new model of delivery

Patient and public events (February-March 2016) - feedback from the 12 locality events show that people:

- Value the "A&E brand", and have confidence in it
- Not sure how/where to access other unplanned care and feel communication is poor
- Not confident in 111, ambulance response times
- Want local services in their local hospital
- Want more community based services
- Understand the need to travel for specialist care BUT different views on what this might mean
- Concerned about access to primary care and mental health services
- Concerned about travel and transport
- Interested in technological solutions
- Would like better public health education

Phase 2: Engagement

Phase 2 engagement (May 2016) focused on the case for change and the draft principle and framework of care. Engagement was based around "narrative" on these issues presented as a video. The narrative is attached as Appendix 5.

Key elements of phase 2:

- 130 delegates attended the stakeholder forum on 4 May, including clinicians, patient representatives and stakeholder organisations
- 17 local public engagement events took place to ensure a good geographical spread across the CCG localities. 278 people have attended these meetings in total, including around 115 at one event in Darlington.
- Staff events are being held across our Foundation Trusts and CCGs using existing systems, supplemented where necessary by special briefing events
- Continuing briefings with patient reference groups, MPs, health and wellbeing boards

The purpose of Phase 2 has been to establish whether there is consensus on the model across hospital, community and primary care clinicians, commissioner boards and membership, FT boards and governors and key stakeholders.

The feedback from our Phase 2 events has been analysed independently. The executive summary states:

"The majority of attendees from all events broadly agreed with the direction of travel of the BHP programme but were keen to see a clear definition of specialist services that would be made known to the public.

"There was wide acknowledgement of the benefits of specialisation and the prospect of increased travel but there is some scepticism and untested conditional support of the programme at this early stage as detailed scenarios were not presented."

Key messages:

- Most people were supportive of the draft principles and framework as the future direction of travel
- There was a broad support and understanding of the benefits of specialist care
- Understanding that this may mean further travel for some patients, which was a concern for some people
- There was support for more services closer to home and people are keen to have more detail
- Availability of funding and staff, especially GPs.
- Receptive to the idea of shared hubs and other clinicians, such as pharmacists, providing more care
- Assurance wanted that resources will be available for more services in the community, and the effective integration of these services
- There was a lot of discussion about effective discharge and support when patients leave hospital
- The importance of people feeling "confident" in services outside hospital, and the responsiveness of NHS 111 and the ambulance service.
- They supported sharing more information electronically across health services. Many were surprised that, for example, GPs and hospitals still do not share a single record for patients.

More details are included as Appendix 4.

Phase 3 engagement

Phase 3 of engagement will focus on development of the decision making criteria and long list of scenarios (possible solutions) for how services could be designed in the future

The purpose of Phase 3 is to support the development of the decision making criteria and long list of scenarios for how services could be designed in the future.

Engagement will be based around a Phase 3 "narrative" which focuses on these issues. See Appendix 6.

During Phase 2, we have achieved a wide geographical engagement of the communities we serve, including local stakeholders and representatives of the public and patients.

In the next phase of engagement there are key areas where we want to take forward further work:

- Engaging with voluntary sector and hard to reach community groups, ensuring that we cover protected characteristics identified in the Equalities Act

- Further engagement with staff in FTs and CCG GP membership and CCG staff, facilitated by the communications teams within those organisations

- Further and more detailed conversations with MPs and Health and Wellbeing Boards, and other key stakeholders led by CCGs and FTs

Recommendation

The Joint OSC is asked to consider the engagement work to date in Phases 1 and 2, and planned for Phase 3 and provide feedback as to additional areas where we could engage further.

Edmund Lovell
Communications and Engagement Lead, Better Health Programme

The NHS in Darlington, Durham and Tees

Better health programme

Communications and engagement strategy

NHS Darlington, Durham & Tees: Better Health Programme

Version control

Date	Version	Change	Author
26.11.15	V3	Initial draft	Sarah Murphy
14.04.16	V4	Second draft	Edmund Lovell

Contents

Introduction and purpose of document

This paper sets out a communications, engagement and consultation strategy to underpin the delivery of the Better Health programme which aims to improve standards of clinical care across Darlington, Durham and Tees.

This work is being undertaken on behalf of:

- NHS Darlington Clinical Commissioning Group,
- NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group
- NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group,
- NHS North Durham Clinical Commissioning Group, and
- NHS South Tees Clinical Commissioning Group.

This project is being undertaken by North of England Commissioning Support (NECS) on behalf of the Better Health Programme Board. The Programme Board will work closely with NHS Hambleton Richmondshire and Whitby CCG, and with the hospital foundation trusts in the area:

- County Durham and Darlington NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- South Tees NHS Foundation Trust

This work will be delivered by the Communications and Engagement working group (CEG), comprising key staff, which reports to the Programme Board and will oversee the practical implementation of plans relating to this strategy.

This document provides a framework for the engagement and consultation process and includes but is not limited to:

- The aims and objectives of the strategy; including some high level key messages
- Current legislation on the 'Duty to Involve 'and the 'Equality Act 2010'
- The key principles for communication, engagement and consultation

- Proposals for the engagement process including a clear action plan
- The work required preparing for consultation and any additional resources required to deliver the strategy and plan
- The action plan details the work required for all aspects of communication, engagement and consultation. This is essential to support good practice and to fit in with guidance such as that from the Cabinet Office who recommend at least a 13 week consultation process. Prior to this, there will also be a three phase listening and engagement exercise.

Background

This programme is one element of wider public service system reform being implemented nationally with the aim of improving outcomes for all local residents. There is a shared ambition of delivering better outcomes for residents and patients through clinically sustainable and financially viable services.

The draft clinical and financial cases for change set out in detail the drivers for change and the nature of the challenging choices that are presented to commissioners. These state clearly a need for change.

A preliminary research report was commissioned from MRUK by the clinical commissioning groups into what the public and service users value in the hospital services currently provided, how they can be improved and how the challenges faced by the NHS might be addressed. This was completed in May 2015.

Since then, work was undertaken to develop a Framework of Care by the Clinical Leadership Group (a working group of the Better Health Programme Board) which provides clinical leadership, advice and challenge to the programme. The aim of the Framework of Care is to provide a direction of travel for the unit of planning area across Durham, Darlington and Tees in providing services that meet the best practice clinical standards for health services.

Aims and objectives of this strategy

- To ensure that appropriate mechanisms are in place so that the public, key stakeholders and partners are engaged and informed throughout the process
- To provide a framework by which all NHS bodies involved in the programme are able to deliver consistent messages through a coordinated approach to communications and engagement activity.
- To monitor and gauge public and stakeholder perception throughout the process and respond appropriately
- To be clear about what people can and cannot influence throughout the engagement and consultation phases
- To achieve engagement that is meaningful and proportionate, building on existing intelligence and feedback such as previous engagement/consultation activities, complaints, compliments etc.
- To provide information and context about the proposals in clear and appropriate formats that is accessible and relevant to target audiences
- To give opportunities to respond through a formal consultation process
- To maintain trust between the NHS and the public that action is being taken to ensure high quality NHS services in their local area
- To demonstrate the NHS is planning for the future

Key messages

- The Better Health programme is about how the NHS in Darlington, Durham and Tees can improve outcomes and experience for patients when they need care, especially in an emergency.
- Whereas in the past, much of the care offered by the NHS was in hospital, caring for long term conditions needs a different approach, with more community based support and services.
- In the past, most hospitals could offer people the best treatment available at the time for most conditions. Clinical practice has taken great strides forward in the last four decades, and this is no longer the case.

- As healthcare is becoming more specialised it is becoming increasingly difficult to have that level of expertise available in every hospital for every service.
- The national vision, which we want to implement locally, is:
- To provide highly responsive, effective and personalised services outside of hospital for people with urgent but non-life threatening needs These should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families

- To make sure people with more serious or life threatening emergency needs are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.

- To provide planned care in an environment, separate from emergency care, which avoids unnecessary delays and cancellations.

- As part of the Better Health programme, around 100 experienced clinical staff from the local NHS – including hospital consultants and GPs - have been looking at how we implement this vision.
- They have identified 700 standards developed by the Medical Royal Colleges and other organisations which could improve care.
- These 100 clinicians have therefore devised an ambitious draft framework for how care should be provided in the future.
- This is likely to result in significant changes to the way services are provided to patients, and the way our staff work, and we want to engage with people to seek their views to influence how this is done

Legislation – our statutory requirements

Any reconfiguration of services requires a robust and comprehensive engagement and consultation process.

NHS organisations are required to ensure that local people, stakeholder and partners are informed, involved and have an opportunity to influence any changes.

Section 242 of the NHS Act 2006 sets out the statutory requirement for NHS organisations to involve and consult patients and the public in:

- The planning and provision of services.
- The development and consideration of proposals for changes in the way services are provided.
- Decisions to be made by NHS organisations that affect the operation of services.

Section 244 of the NHS Act 2006 requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

Section 2a of the NHS Constitution gives the following right to patients:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services."

In addition the Secretary of State for Health has outlined four tests for service change:

Support from GP Commissioners	Engagement with GPs, particularly with practices whose patients might be significantly affected by proposed service changes
Clear clinical evidence base	The strength of the clinical evidence to

	be reviewed, along with support from senior clinicians from services where changes are proposed, against clinical best practice and current and future needs of patients
Strengthened patient and public engagement	Ensure that the public, patients, staff, Healthwatch and Health Overview and Scrutiny Committees are engaged and consulted on the proposed changes
Supporting patient choice	Central principle underpinning service reconfigurations is that patients should have access to the right treatment, at the right place and the right time. There should be a strong case for the quality of proposed service and improvements in the patient experience

Further information is included in appendix 1.

Stakeholders

For the purpose of this strategy, the definition of stakeholders is anyone who will be affected (either positively or negatively) by a proposed change to health services locally, those who have an opinion on the proposed changes and those who could influence other stakeholders.

There are a wide range of stakeholders who will have varying degrees of interest in and influence on the acute care services agenda.

Broadly, those stakeholders fall into the following categories:

- Internal
- Partners
- Patients and the public
- Political audiences
- Governance and regulators.

See Appendix 2 for a stakeholder map

Engagement and consultation process

The engagement stage forms part of the early discussions and is about gathering detailed information to support the health economy to develop proposals for the formal public consultation proposal for service change.

This engagement will involve the collection of:

- Existing staff, patient and public views based on previous feedback (including customer feedback, complaints, suggestions and previous surveys)
- Three phases of consultation to seek the views of stakeholders to inform the programme as it develops
- Sharing information from the programme at key points to inform the development of proposals for consultation

This engagement will lay the groundwork for discussions during the formal consultation.

Pre-engagement and Options Development

Three phases of pre-engagement are planned which will inform and underpin:

- the development of a proposed new framework for health services across Durham, Darlington and Tees
- the decision making process by which scenarios and eventual options will be assessed
- the development of a full public consultation on the proposals.

These phases of pre-engagement aim to achieve the following objectives:

Phase 1 pre-engagement (to March 2016) focusing on:

- the experience of people using current health services
- the ways in which those people, and the wider general public, think health services could be improved across Durham, Darlington and Tees
- perceptions around “the right services in the right place” – where services are provided

This engagement included:

- Market research (May 2015) including 1,000 telephone interviews and 6 focus groups
- Stakeholder event (27 January) – attended by 116 people including 54 stakeholder representatives
- 12 patient and public engagement events (February/March 2016) attended by 168 people

A full report has been published analysing feedback from Phase 1.

Phase 2 pre-engagement (May 2016) will focus on the case for change and the draft framework of care:

Key elements of phase 2:

- "Launch" stakeholder event on 4 May, similar to that held in January
- A series of patient public events, with a strong focus on involvement of Patient reference groups, and practice participation groups
- Voluntary sector facilitated discussion groups, including a focus on special interest groups and protected characteristics
- Engagement events within FTs and CCG membership

During phase 2, we will be listening to the views of our patients and public, stakeholders and staff and will be demonstrating an openness and flexibility to taking views into account as we develop our clinical model.

At the end of Phase 2 we expect to be in a position to form an opinion on whether there is consensus on a framework of care across hospital, community and primary care clinicians, commissioner boards and membership, FT boards and governors and key stakeholder bodies such as health and wellbeing boards.

We will then be in a position to generate a long list of scenarios.

Phase 3 pre-engagement (July 2016) we plan to focus on the long list of scenarios and evaluation criteria

Phase 4 pre-engagement (September 2016) will focus on the options for consultation and the consultation process

Consultation- to provide:

- the public with the opportunity to comment on the scenarios that are taken forward from the appraisal and scoring process
- a balance between clinical and public perspectives within the models going forward as potential options for consultation
- engagement around the equality analysis conducted by the Better Health Programme Board
- validation of the equality analysis

Key activities across all phases

- Production of clear public information on the case for change
- Liaison with Health and Wellbeing Boards and Health Overview and Scrutiny Committees
- Briefing key partners and stakeholders including MPs and local Healthwatch
- Establishing a stakeholder forum
- Local engagement events with invited audiences
- In-depth survey of patients currently using services (or their carers)
- Focus group activity with protected groups (with voluntary sector organisations)
- Online activity including dedicated programme website
- Discussion though Patient Reference Group/patient participation groups
- Cascade of information via stakeholders, partners and community and voluntary organisations
- Social media presence
- GP engagement – clinical support for the changes
- Staff and staff side engagement
- Media relations

As part of this work we will consider the best ways to engage with those who are easy to overlook and protected groups and ensure that information is delivered in the most appropriate format.

Events

- Events to be held across Darlington, Durham and Tees with dedicated stakeholder events in each of the CCG clinical localities.
- Events will follow a presentation and discussion
- Local stakeholders will be invited to take part
- Key stakeholders (e.g. user/patient groups) will be offered a pack of material to support local discussions and feedback

Questionnaire

- A briefing and questionnaire will be sent to all local stakeholders
- Questionnaires will be available in paper and on-line format. As required, different formats / methods will be developed to engage protected groups/those easy to overlook

Patient survey

- We will seek input from patients / carers who have or might use services in the scope of the programme

Public affairs

- This will involve ongoing liaison with Health and Wellbeing Boards and Overview and Scrutiny Committees, with regular briefings for key partners and stakeholders including MPs and all local Healthwatch organisations.

Focus groups

- Packs will be provided to community and voluntary sector organisations with a particular focus on protected characteristics

Online

- The programme website will include details of this engagement work and provide an opportunity for people to respond online or by email
- A dedicated Facebook page will be established and information on events and other opportunities to engage will be communicated via Twitter

Patient reference groups

- Information will be provided to the patient reference group for cascade to patient groups
- PRG will be encouraged to provide feedback and a pack will be developed to facilitate this
- In the event that there is no operational PRG, a pack will be prepared for use by patient groups

GP member engagement

- Information on the ongoing engagement activity will be provided through regular practice bulletins
- GPs will be engaged in discussion through their locality meetings and CCG members' assemblies & councils.

Provider staff and staff side engagement

This will be undertaken by the Foundation Trusts. Staff will be engaged in the following ways:

- Specific briefings for staff who are working in services that may be directly affected by any potential change.
- Existing internal communications mechanisms.

Supporting collateral materials

A range of material will be produced to support this work including:

- Written and video content
- Briefings for key stakeholders
- Key messages
- Flyers to promote public events
- Focus group packs
- Social media presence
- Advertisements for public events
- Display material for events
- Press releases

Also available are / will be:

- Pre-consultation business case
- Financial Case for Change
- Clinical Case for Change
- Model of care
- Programme timelines

All materials will be available in alternative formats as appropriate.

Partnership working

As well as securing feedback from partner and stakeholder organisations, we will ask them to promote this work to their membership and where possible, to include information in their own newsletters, websites etc.

Media and promotion

A media handling plan will be developed to include the dissemination of information about the process and reactive media handling.

Storytelling

Development of patient / clinical stories to explain the rationale for change and the share the journey and vision of the programme.

The consultation process

Following the engagement process, there will be a formal consultation period of 13 weeks.

The consultation will employ the following tactics.

- Consultation document which outlines the case for change and questions. This will be distributed widely across the district, available online and on request.
- A range of mechanisms and activities to gather feedback and views including:
    - Organised formal, public meetings in appropriate and accessible locations
    - Presentations to a wide range of groups and audiences (pro-active and on request)
    - Staff briefings and meetings
    - Information in prime community and health settings
    - Information on relevant websites
    - Media relations
    - Posters in a range of community venues throughout the health economy including health settings, libraries etc
    - Information distributed and shared through public partners publications and information points
    - Feedback forms and questionnaires
    - Social media
    - Paid-for advertising

Post consultation

Once the consultation process is complete, the communications and engagement team will provide feedback to key stakeholders using agreed channels which will include email / letter, website and local media.

Communications/engagement management and responsibilities

A communications team has been established to lead this work, working with communications teams in FTs and CCGs.

A communications and engagement working group comprising representatives from CCGs and foundation trusts led by Amanda Hume (Chief Officer South Tees CCG) and reporting to the programme board will oversee the practical implementation of plans relating to this plan.

The communications and engagement workstream will meet on a bi-monthly basis to review:

- the effectiveness of the communications and engagement strategy
- effectiveness in line with the wider programme strategy
- progress against programme timeline
- the action register
- the risk log

Quality Assurance

External quality assurance will be provided by the Consultation Institute.

Evaluation

This communications and engagement strategy will be evaluated at each stage of the process:

- At the end of each phase of engagement
- In the middle of consultation stage
- At the end of consultation stage

Appendices

Appendix 1: Legislation

The process for involving people requires a clear action plan and audit trail, including evidence of how the public have influenced decisions at every stage of the process and the mechanisms used.

The Gunning Principles

Before 1985 there was little consideration given to consultations until a landmark case of Regina v London Borough of Brent ex parte Gunning. This case sparked the need for change in the process of consultations when Stephen Sedley QC proposed a set of principles that were then adopted by the presiding judge. These principles, known as Gunning or Sedley, were later confirmed by the Court of Appeal in 2001 (Coughlan case) and are now applicable to all public consultations that take place in the UK.

The principles are:

- **Consultation must take place when proposals are still at a formative stage**
  Consultation should be at a stage when the results of the consultation can influence the decision-making (and Gunning 4).
- **Sufficient reasons must be put forward for the proposals to allow for intelligent**

A preferred option may be included and this must be made obvious to those being consulted. Information and reasons for the proposals must be made available to allow for consultees to understand why they are being consulted as well as all the options available and what these mean.

- **Adequate time must be given for consideration and response**
  There is no set timeframe recommended but reasonable steps must be taken to ensure that those consulted are aware of the exercise and are given sufficient time to respond.
- **The outcome of the consultation must be conscientiously taken into account**
  Decision-makers must be able to show they have taken the outcome of the consultation into account – they should be able to demonstrate good reasons and evidence for their decision. This does not mean that the decision-makers have to agree with the majority response, but they should be able to set out why the majority view was not followed.

Best practice and managing risk

This strategy takes account of NHS England good practice guidance - Transforming Participation in Health and Care - 'The NHS Belongs to us all' by:

- Engaging communities with influence and control e.g. working with CVS and HealthWatch
- Engaging the public in the planning and delivery of service change e.g. engage early and build on insights
- Providing good quality information
- Providing a range of opportunities for participation

- Working with patients and the public from the initial planning stages

In summary, any reconfiguration of services requires a robust and comprehensive engagement and consultation process. The risk of not following these procedures could result in a Judicial Review. A number of public bodies across the UK have been taken to Judicial Review and deemed to have acted unlawfully in the Public Sector Equality Duty – usually linked to the four Gunning Principles.

As well as documented evidence of GP support, the case for change will need to:

- State clearly the benefits for patients, quality and finance.
- Demonstrate that the clinical case conforms to national best practice.
- Be aligned to commissioners' strategic plans.
- Be aligned with the recommendations of *Healthy Ambitions.*
- Have clear details of option appraisals.
- Provide an analysis of macro impact.
- Be aligned with QIPP work streams.

The Independent Reconfiguration Panel (IRP), whose role is to advise ministers on controversial reconfigurations, recommends that those considering proposals for significant health service changes should:

- Make sure the needs of patients and the quality of patient care are central to the proposal.

- Consider the role of flexible working in the proposals – this may involve developing new approaches to working and redesigning roles.
- Assess the effect of the proposal on other services in the area.
- Give early consideration to transport and site access issues.
- Allow time for public engagement and a discussion phase before the formal consultation – people want to understand the issues, so involving them early on will help when it comes to the formal stage.
- Obtain independent validation of the responses to the consultation.

They IRP has also identified a range of common themes:

- Inadequate community and stakeholder engagement in the early stages of planning change
- The clinical case has not been convincingly described or promoted
- Clinical integration across sites and a broader vision of integration into the whole community has been weak
- Proposals that emphasis what cannot be done and underplay the benefits of change and plans for additional services
- Important content missing from the reconfiguration plans and limited methods of conveying them
- Health agencies caught on the back foot about the three issues most likely to excite local opinion - money, transport and emergency care.
- Inadequate attention given to responses during and after the consultation.

Consultations should influence final proposals and it is important to be able to show that they have. Clearly, not all these recommendations will be applicable to all engagement and consultation exercises, but the basic principles of early involvement, and being able to demonstrate that responses have influenced the final outcome, are.

Commissioners and providers should also consider how their engagement and consultation activity impacts upon a wide range of service users including those protected groups identified within the Equality Act.

Key principles

This strategy is underpinned by the following guiding principles for communication, engagement and consultation to ensure consistent messages are adopted by all partners, adhering to the following principles of good practice*:*

- **Open** – decision makers are accessible and ready to engage in dialogue. When information cannot be given, the reasons are explained.
- **Corporate** – the messages communicated are consistent with the aims, values and objectives of the Better Health Programme.
- **Two way** – there are opportunities for open and honest feedback, and people have the right to contribute their ideas and opinions about issues and decisions.
- **Timely** – information arrives at a time when it is needed, relevant to the people receiving it, and able to be interpreted in the correct context.
- **Clear** – communication should be in plain English, jargon free, easy to understand and not open to interpretation.

- **Targeted** – the right messages reach the right audiences using the most appropriate methods available and at the right time.
- **Credible** – messages have real meaning, recipients can trust their content and expect to be advised of any change in circumstances which impact on those messages.
- **Planned** – communications are planned rather than ad-hoc, and are regularly reviewed and contributed to by senior managers and staff, as appropriate.
- **Consistent** – there are no contradictions in messages given to different groups or individuals. The priority to those messages may differ, but they should never conflict.
- **Efficient** – communications and the way they are delivered are fit for purpose, cost effective, within budget and delivered on time.
- **Integrated** – internal and external communications are consistent and mutually supportive.

Appendix 2: Stakeholder plan

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)
Internal	CCG Governing bodies	**Key Player**	Face to face meetings
Internal	Heads of clinical service	**Key Player**	Face to face meetings and briefings
Internal	Senior clinical staff – GPs, FTs	**Key Player**	Face to face meetings and briefings
Internal	Staff-side representatives	**Active Engagement and Consultation**	Face to face meetings/briefings
Internal	Medical staffing committee	**Active Engagement and Consultation**	Meetings/briefings
Internal	Staff affected by changes	**Active Engagement and Consultation**	Team and individual briefings/meetings with line managers/ Q&As/ existing internal comms channels
Internal	FT Governors	**Active Engagement and Consultation**	Meetings / briefings
Patients & Public (charities)	Charitable organisations and highly interested groups	**Active Engagement and Consultation**	Face to face meetings and briefings/engagement events and activities

Patients & Public	General public	**Keep Informed Engage and Consult**	Public meetings/ media releases/ website/information stands/ posters/info distributed at prime settings/consultation and engagement documents
Patients & Public	Affected service user groups	**Active Engagement and Consultation**	Meetings with identified service user groups/ engagement events/ consultation events
Patients & Public	GP Patient Participation Groups	**Keep Informed and engaged via practices**	Meetings/briefings
Patients & Public	HealthWatch organisations	**Active Engagement and Consultation**	Meetings and presentations/ongoing briefings and updates/ consultation and engagement documents
Patients & Public	Protected groups, voluntary and community groups, third sector	**Active Engagement and Consultation**	Meetings with identified groups/ engagement events/ consultation events
Patients & Public	Foundation Trust members	**Keep Informed and Consult**	Briefings
Political Audiences	Local MPs	**Key Player**	Regular briefings/letters/ meetings
Political Audiences	Local Councillors	**Active Engagement and Consultation**	Regular correspondence updating on progress /OSC/engagement and consultation documents

Political Audiences	Overview and Scrutiny Committees	**Key Player**	Meetings & presentations/ regular briefings
Media	Local and regional media	**Keep Informed**	Pro-active and re-active press releases and statements/ interviews / briefings/ paid-for advertorials and supplements
Partners	Councils CXs / DASS / portfolio holders /leaders in relevant councils	**Key player**	Briefings as required/ engagement and consultation documents
Partners	Local Medical Committee	**Active Engagement and Consultation**	Meetings & presentations/ regular briefings
GPs	GPs	**Active Engagement and Consultation**	Meetings & presentations at clinical council/ regular briefings
Partners	Surrounding trusts	**Key player**	Briefings as required/ engagement and consultation documents
Governance & regulators	NHS England	**Keep Informed**	Briefings via regional office
Governance & regulators	Care Quality Commission	**Keep Informed**	Regular Briefings/ Consultation Documents
Governance & regulators	National Reconfiguration Team	**Keep Informed**	Briefings
Governance & regulators	Health Gateway Team	**Key Player**	Meetings/briefings
Governance & regulators	Local health and Wellbeing Board	**Key Player**	Meetings/briefings

Appendix B: communications and engagement action plan

Better health services action tracke

Securing Quality in Health Services

Findings from the public research

May 2015

Commissioned on behalf of The Clinical Commissioning Groups (CCGs) across Durham, Darlington, Tees and North Yorkshire

This work has been conducted in accordance with ISO 20252, the international standard for market and social research

About the research

The Clinical Commissioning Groups (CCGs) across Durham, Darlington, Tees and North Yorkshire are working with hospital trusts in their areas to improve standards of clinical care and increase seven day working. They are doing this at a time of increasing financial pressure in the NHS and shortages of some staff groups. This programme of work is called "Securing Quality in Health Services."

The service areas covered in this work are acute services i.e. not planned care, and they include: A&E, acute medicine, acute surgery, critical care, maternity, children's services, the care of very small or very sick babies and end of life care.

The CCGs commissioned this research because they are keen to understand what the public and service users value in the hospital services currently provided, how they can be improved and how the challenges faced by the NHS might be addressed. They also wanted to find out what people think about the balance that the commissioners and providers of services have to achieve between quality, access and affordability.

Contents

Executive summary: hospital service priorities

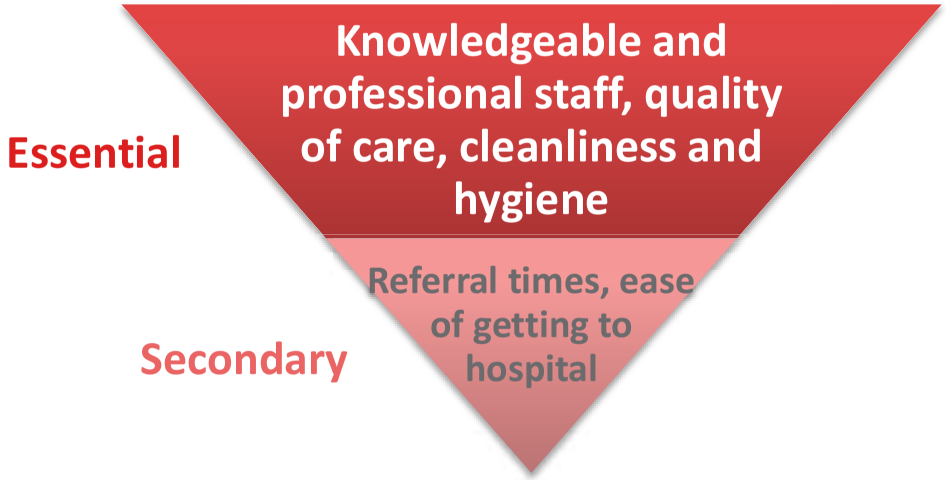
What are the priorities among the local public with regard to hospital services both generally and with regard to the six specific clinical areas?

- Priorities among the local public with regard to hospital services are:
  - 1st Knowledgeable, professional staff
  - 2nd Quality of care → Particularly effectiveness of treatment
  - 3rd Cleanliness and hygiene
- With regards to the six specific clinical areas, residents find it very difficult to prioritise. In an ideal world residents would like all services available at their local hospital, however there is a general acceptance that sometimes there may be the need to travel for specialist care. If travelling further, residents expect a higher standard of care.
- Deciding between which of the six clinical services should be provided locally proved inconclusive.
- Most are willing to travel for planned care but would like unplanned/emergency care close by.
- Having end of life care close by is one of the services mentioned by most which should be available locally. However different services are seen to be important to be available locally to different people at different stages of their lives. For example, those starting a family would want a maternity unit close by.
- Having an A&E department available at all local hospitals is seen to be essential.

Executive summary: hospital services priorities among service users and non-users

What are the priorities among service users (i.e. patients)? How do the views of service users and non-users compare with regards to what they value from services?

- The top three priorities are broadly consistent across users of all services and non-users. They rate knowledgeable and professional staff, overall quality of care and cleanliness and hygiene in their top three. For some service users the order of the top three priorities vary slightly.
- End of life care users differ with regards to their third priority – which is ease of getting to hospital.
- The findings of the research suggest that people at different stages of their lives have different priorities from NHS services. For example, those of working age and with children tend to place more emphasis on time-related issues such as speed of referral.
- There are three essential aspects which users expect, while two are secondary.



Executive summary: understanding quality, access & affordability

Does the public understand the need to consider quality, access and affordability?

- Residents understand quality of care to be having knowledgeable and professional staff, effective treatment and a clean and hygienic environment in which they are treated
- Approaching three quarters of residents who rate quality of care in their top three priorities are satisfied with the quality of care provided at their local hospital. Nevertheless, there is still some room for improvement to increase satisfaction scores.
- Ease of access had varied meaning. Most understood it to be mostly focused on parking issues such as cost and availability. However others suggest ease of access could mean access to hospital services whether it be the availability of services or waiting times.
- The satisfaction score with ease of access is average with just over half of residents who rate it as a top three priority expressing satisfaction.
- Three quarters of residents recognise that the NHS and their local hospital services are under financial pressure. Residents have heard about this via local and national media.
- Spontaneous suggestions to reduce spending include:
  - Cutting back on non-essential treatments
  - Charging patients who miss appointments
  - Charging overseas patients for treatment
  - Greater use of technology which in turn would allow more time to be spent with patients rather than completing admin tasks and paperwork
- When prompted with a list of options, those taking part in the telephone survey were most likely to suggest that patients should be required to change their lifestyle before administering some treatments

Executive summary: understanding the need for change

Does the public understand the need for change within the NHS?

- Residents are aware of the need for change within the NHS. They understand that this is driven by a number of factors including financial pressures along with an ageing population and increasingly complex health requirements.
- Around half of residents suggest some fundamental changes are needed to make the NHS work better. Only a small minority feel there is so much wrong with the NHS that it needs to be completely rebuilt.
- Suggestions for change include:
  - Reducing wastage such as the admin and paperwork
  - Increasing the number of patient facing staff (and reducing the number of administrative staff)
  - Improving cleanliness
  - Improving communication between hospitals, GPs and patients
  - Improving after care services to reduce readmissions
  - Introducing charges for missed appointments
  - Charging patients from overseas for treatment
  - Addressing car parking issues such as availability and cost

Contents

Research objectives

The CCGs required research to inform the planning of future services with regard to quality of health services provided by acute hospitals in County Durham, Darlington and Teesside.

- Research was required to inform priority setting and decision making in order to improve the quality of health services provided by acute hospitals in County Durham, Darlington and Teesside.
- **mruk** recommended a staged approach of telephone interviews with residents followed by focus groups and depth interviews to ensure learnings from stage one fed into the subsequent phase.

The research needed to address the following key questions:

- *What are the priorities among the local public with regard to hospital services both generally and with regard to the six specific clinical areas?*
- *What are the priorities among service users (i.e. patients)?*
- *How do the views of service users and non-users compare?*
- *Does the public understand the need to consider the balance between quality, access and affordability?*
- *Does the public understand the need for change within the NHS?*

Key to reading the report

Telephone survey findings

Focus group findings

Depth interview findings

Respondents who answered ‘don’t know’ or declined to give an answer have been excluded from the charts. Percentages are rounded to the nearest whole number and, for this reason, may not total 100% in all cases. Comparisons between sub groups are commented on only where differences are statistically significant.

Methodology

Stage 1 – quantitative research

1,000 telephone interviews with local residents

Interviews conducted during November and December 2014

Robust representative survey to understand views and priorities of local residents

Stage 2 – qualitative research

6 x focus groups with local residents

5 x face to face focus groups and 1 x online focus group conducted during March 2015

4 x in-home interviews with those with a disability or long term illness

4 x face to face in-home interviews conducted during March 2015

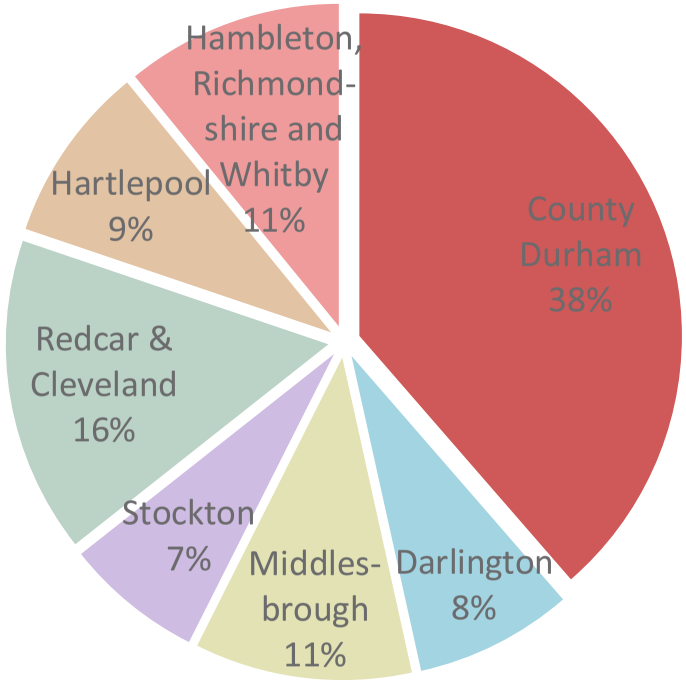
To gather more detailed feedback and understand reasons behind initial quantitative findings

Contents

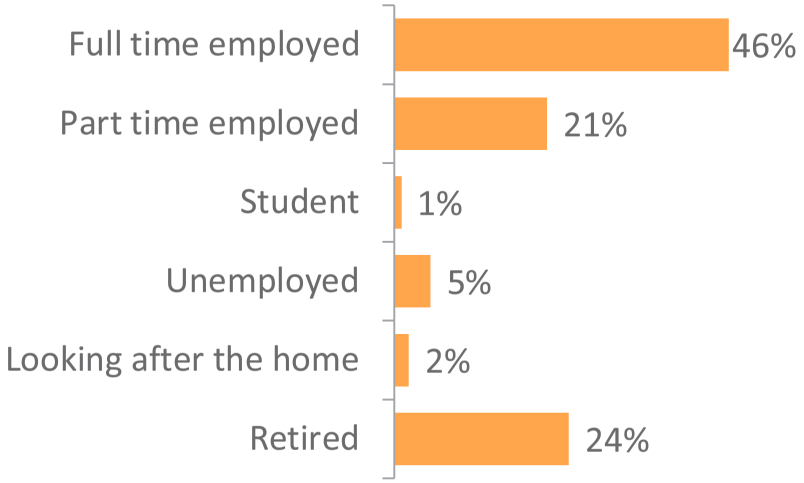
Demographic profile of residents taking part in the telephone survey

Quotas were set by location, age and gender to ensure a representative profile of the local population was interviewed.

Location



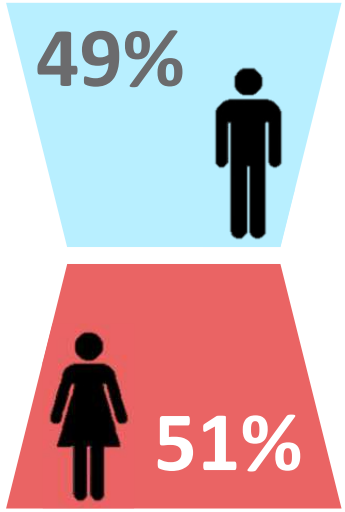
Employment status



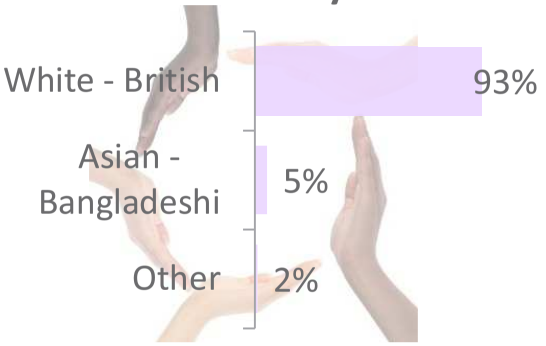
Children aged 16 or under

20%

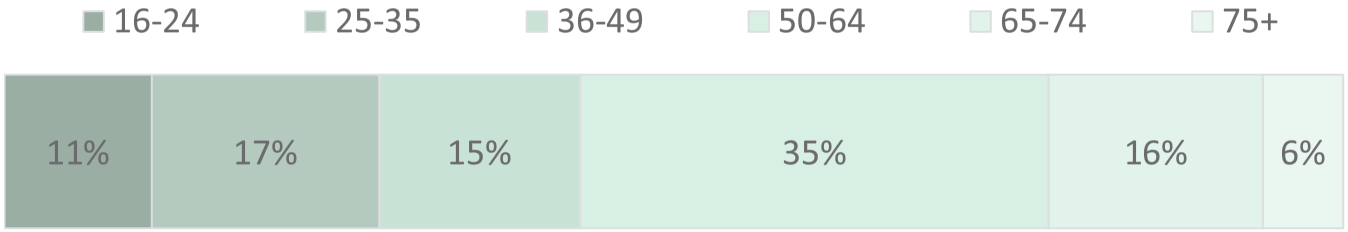
Gender



Ethnicity



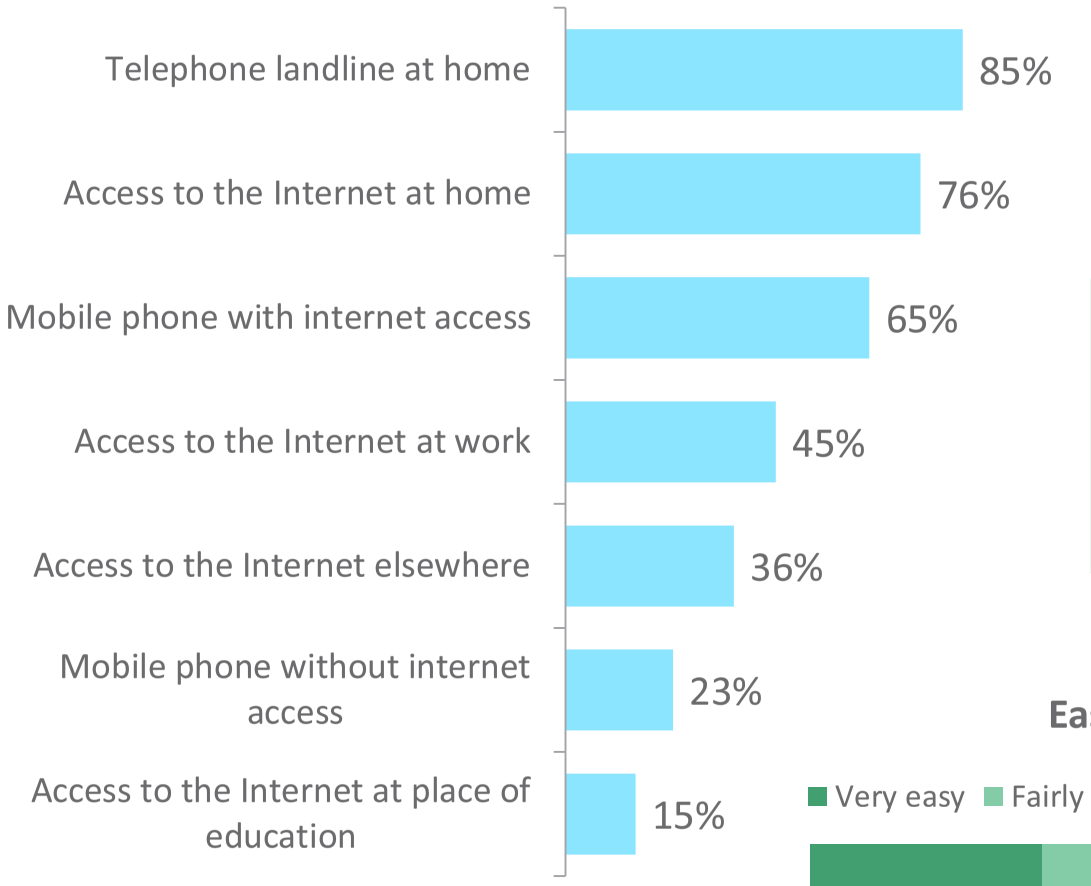
Age



Base: All Respondents (1,000)

Demographic profile continued…

Access to technology



* 2011 Census figures for Co Durham, Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton

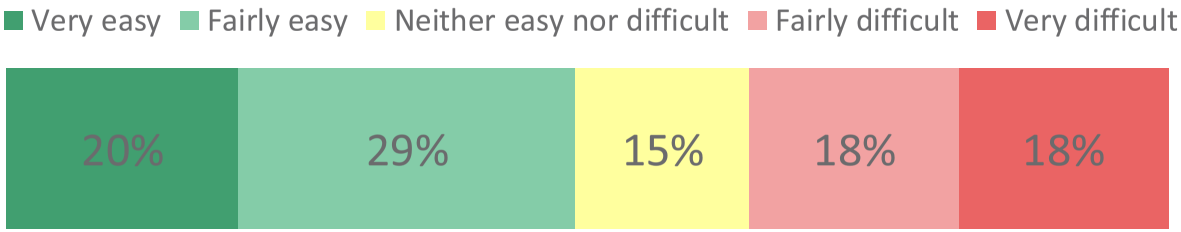
Day-to-day activities limited

Yes, limited a lot	**9%**	*11%
Yes, limited a little	**11%**	*11%
No	**80%**	*78%

Personal access to a house vehicle

Access as a driver	**74%**	
Access as a passenger	**13%**	
No access	**13%**	*29%

Ease of access to public transport for hospital



Demographic profile of focus group and depth interview participants

Group	Location	Recruitment Criteria
Face to face	North Durham	• At least 3 service users • At least 3 residents who are satisfied with services • At least 3 residents who are dissatisfied with services • Good spread in terms of demographics (e.g. age, gender, employment status, children in household, car access)
Face to face	South Durham	
Face to face	Darlington	
Face to face	North Tees	
Face to face	South Tees	
Online	Spread across all areas	• All dissatisfied with ease of access to hospital services • At least 4 females
4 x in-home interviews	Spread across all areas	• Service users • All with a disability or long term illness

Contents

Importance of hospital services

Residents tend to rate all aspects of hospital services as important. Having knowledgeable and professional staff, helpful and friendly staff, cleanliness and hygiene and overall quality of care are the most important priorities.

Base		% important
965	Knowledgeable, professional staff	*90%*
968	Helpfulness and friendliness of staff	*89%*
969	Cleanliness and hygiene	*88%*
969	Overall quality of care	*88%*
953	Range of facilities available that meets your needs	*81%*
971	Ease of getting to hospital	*70%*
923	Referral time (from GP etc)	*70%*
936	Waiting times to be seen	*65%*

Regional differences

Residents in Hambleton, Richmondshire and Whitby are more likely to give the highest importance ratings for knowledgeable staff (98%), friendliness and helpfulness of staff (96%), quality of care (95%), referral times (79%) and waiting times (78%).

User and non-user differences

There are no significant differences between service users and non-users.

Other differences

Younger residents aged under 35 years are less likely to rate referral times as important (64%) when compared to older residents (73%). However younger residents are more likely than older residents to rate cleanliness and hygiene as important (92%).

Base: All respondents excl don't know as shown

Priorities from hospital services

When asked to prioritise the three most important factors, knowledgeable and professional staff, overall quality of care and cleanliness and hygiene are the most important priorities.

Residents were asked to pick which of the aspects of hospital services they would rank 1st, 2nd and 3rd

	Most important	Combined top 3 % important
Knowledgeable, professional staff	1st	*53%*
Overall quality of care	2nd	*52%*
Cleanliness and hygiene	3rd	*48%*

Regional differences

South Tees residents rate cleanliness and hygiene second (52%).

User and non-user differences

The top three priorities amongst service users are broadly consistent, however there is some variation in the order of the top three priorities. End of life care users differ as they rate ease of getting to the hospital as the third priority. Acute paediatrics, maternity or neonatology users rate referral time as third most important.

Other differences

Younger residents aged under 35 years rate cleanliness and hygiene as joint first with knowledgeable and professional staff when asked to prioritise services.

Priorities for improvement

- Knowledgeable & Professional Staff
- Effectiveness of Treatment
- Cleanliness & Hygiene
- Patient Safety
- Reducing Waiting Times
- Reducing Referral Times
- Patient Experience
- Ease of Access
- Helpful & Friendly Staff
- Range of Facilities

"If you don't have knowledgeable staff you're not going to get anything done"

"Cleanliness and hygiene is very important…you don't want to come out of hospital with something else"

"If everything else was brilliant I wouldn't mind waiting"

"Ease of access is a struggle but you have to accept that to prioritise the quality of care"

"You can have the smiliest, most helpful staff but if they don't have the knowledge you're getting nowhere!"

The general consensus is that as long as the top three priorities are in place these would filter down and improve aspects further down the hierarchy. For example having knowledgeable & professional staff will help to improve the overall patient experience

Are there any other important factors? (unprompted)

Over three quarters of residents didn't mention any other important factors. Of those who did, other important factors include having a hospital close by, staff competence, range of departments available at local hospitals, treating patients with dignity and car parking costs.

"It's important that the staff empathise and realise that they're dealing with ill patients."

"I am a bit concerned that local hospitals are closing down and therefore travel increases making emergencies harder to deal with."

Staff competence

Quality of emergency care

Car parking costs

Staffing levels

Hospital location

Quality of facilities

Overcrowding

Aftercare

Quality of food

Quality of NHS generally

Treating patients with dignity

"Sometimes in our area we are referred to other hospitals, in other areas and it's hard to get to them as we don't have transport. The hospital doesn't provide us with transport and can't use the ambulance as we are mobile. Make referrals to local hospitals."

Range of departments available

Consistency between hospital departments

"Services in your local hospital, not having to go from one place to the other."

Quality of care of hospital services – what does it mean?

Quality of care is closely linked to having knowledgeable and professional staff, effective treatment and a clean and hygienic environment.

"A clean environment, good treatment and getting better…getting better is the most important thing"

"How they make you feel when you are there, how they deal with the problems you've got, how much they understand you as a person"

What does 'quality of care' mean?

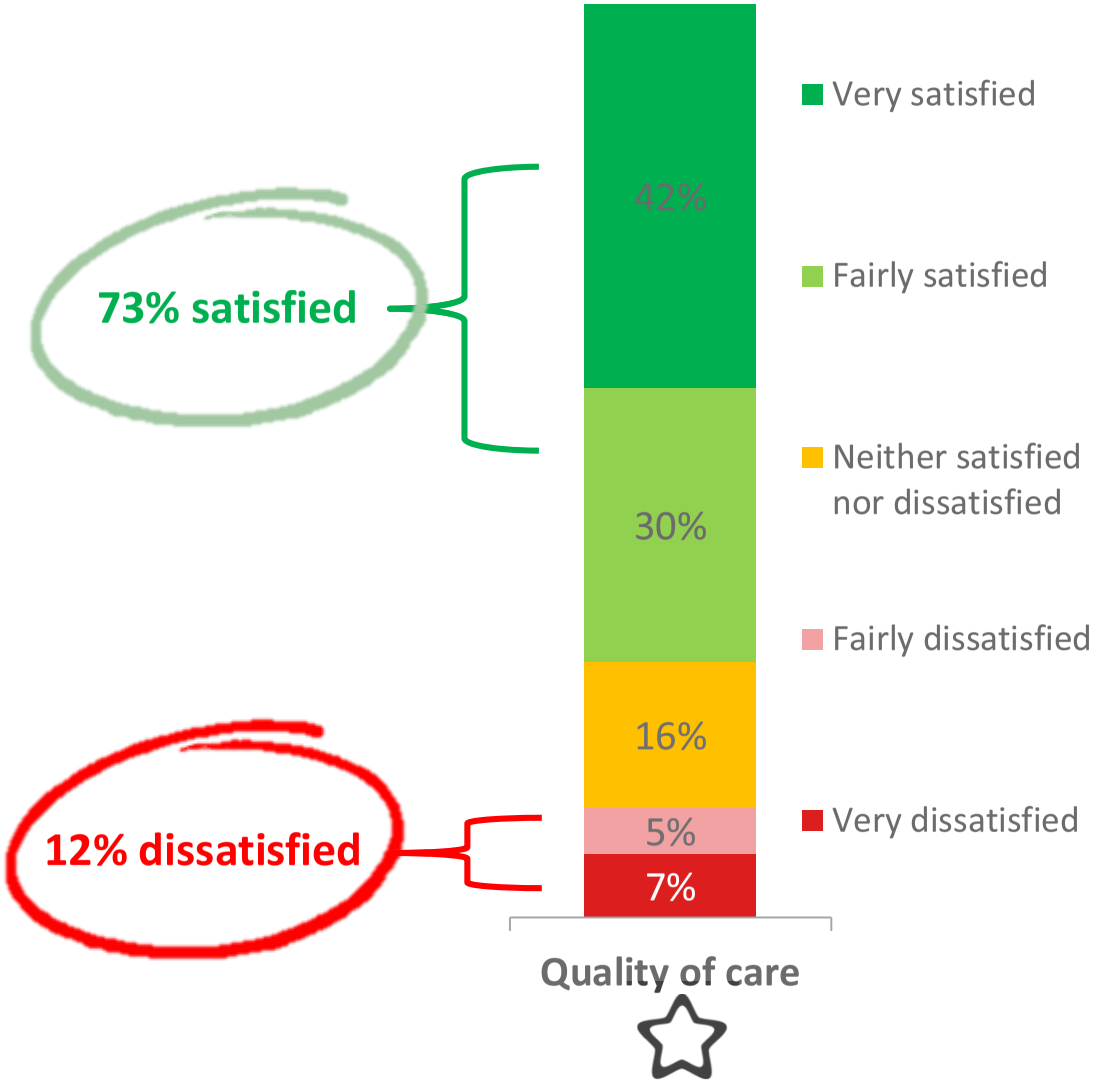
"Reassurance"

"It is the treatment and the care afterwards in getting you back on your feet so you can go home quicker"

"Being in good hands"

Satisfaction with quality of care of hospital services

Amongst those who rate quality of care as one of the three most important factors, nearly three quarters are satisfied.



Regional differences

Residents in South Tees (83%) and Hambleton, Richmondshire and Whitby (81%) are more satisfied with quality of care than those in the North of Tees area (59%).

Other differences

Males are significantly more satisfied than females with regards to overall quality of care (77% and 69% respectively).

Base: All who rated quality of care in top 3 excl don't know (493)

Dissatisfaction with quality of care

Reasons for dissatisfaction with quality of care are related to a lack of patient care and interest from staff.

"I was sitting touching distance from a dead man"

"With her ulcers, the consultant didn't look at her leg and he discharged her when she shouldn't have been"

"One person does all of the work while the others stand around and watch"

"I've seen them dump the food in front of old people when they can't even reach it"

"If her daughters hadn't gone in to feed her at every meal she would have passed away"

"There's people just walking past you and no-one is bothered. Even at A&E you say to people what should I do about this and they say 'oh we are so busy, we've got so many people in the room"

"If you didn't have someone there to look after you, you'd have been left to rot"

Ease of access to hospital services – what does it mean?

The majority associate 'ease of access' with physical access to hospital services.

- Ease of access was mostly associated with parking issues – primarily cost, but also availability.
- Alternatively ease of access can also mean access to services more generally: both in terms of availability and also associated waiting times.

"Ease of access has got to mean car parking"

"Ease of getting to the hospital… both time to get there and how easy it is to find"

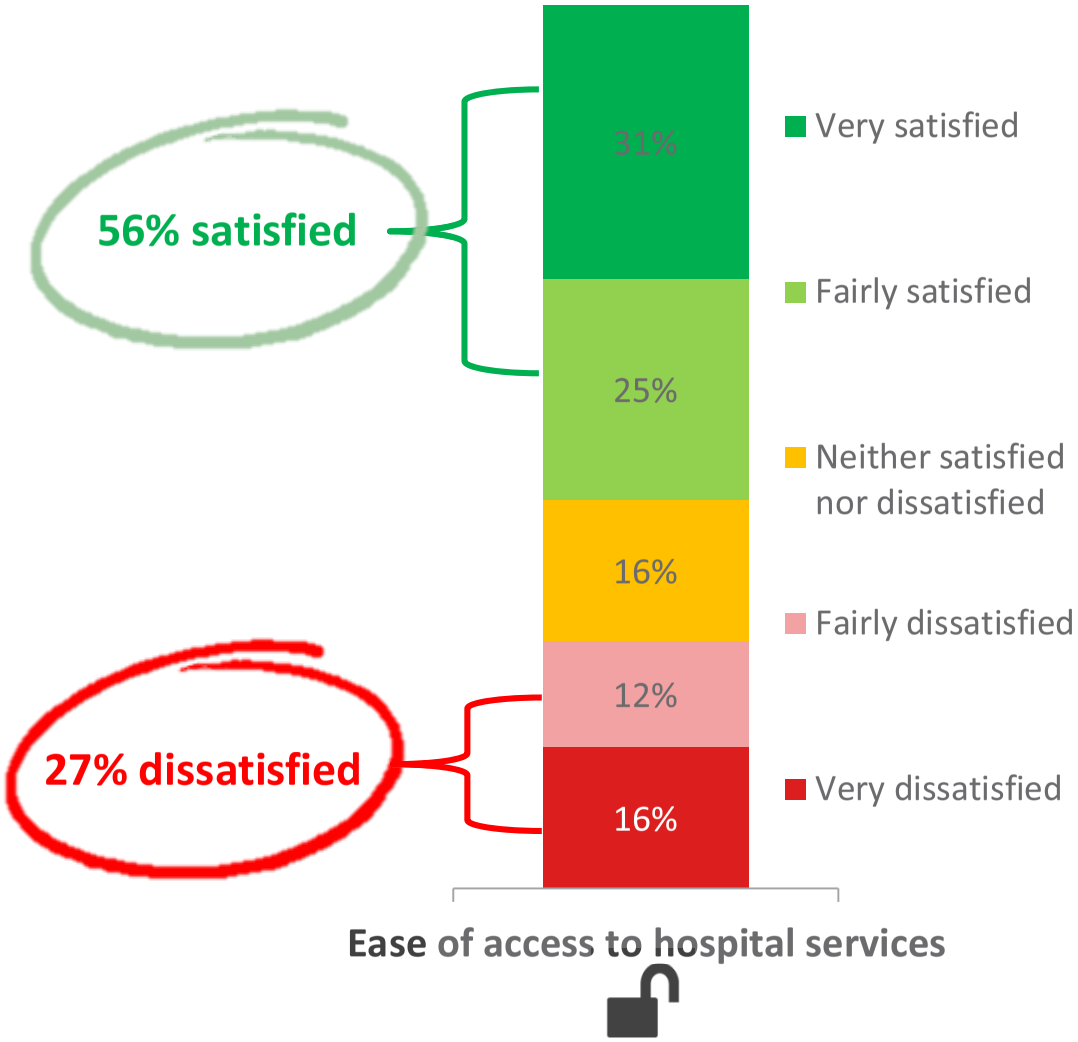
What does 'ease of access' mean?

"It could also mean accessibility of services e.g. access to a physiotherapist"

"Could be related to waiting time to get referred which can sometimes be a long time"

Satisfaction with ease of access to hospital services

Satisfaction with ease of access to hospital services is average at 56%. This appears to be an area for improvement (although it is not one of the most important priorities). Low satisfaction with ease of access could be related to lack of consistency with regard to what it actually means.



Regional differences

Levels of dissatisfaction vary across the region, with the highest levels of dissatisfaction seen in the North of Tees area (46%), followed by County Durham (31%).

Other differences

There is a significant difference by gender, with males expressing higher levels of satisfaction (63%) than females (48%).

Base: All who rated ease of access in top 3 excl don't know (272)

Dissatisfaction with ease of access

Dissatisfaction with ease of access is linked to parking, particularly parking charges.

"It has either got to be free as you are not there by choice you are because you have to be, or an all day nominal fee as you don't know sometimes how long you will be (£2)"

"Driving and getting to Durham is fine but parking can be stressful"

"Especially as you never know how long you are going to be in there for, so it's difficult to know how much to put in"

"I'm still gobsmacked at how much they charge for parking (especially as only there 15-20mins), *its £2.50 for up to 2 hours" "It is a bit of a bug bear of mine"*

"You see people driving round and round the car park because there are no spaces"

"I think the charges for parking are extortionate"

Contents

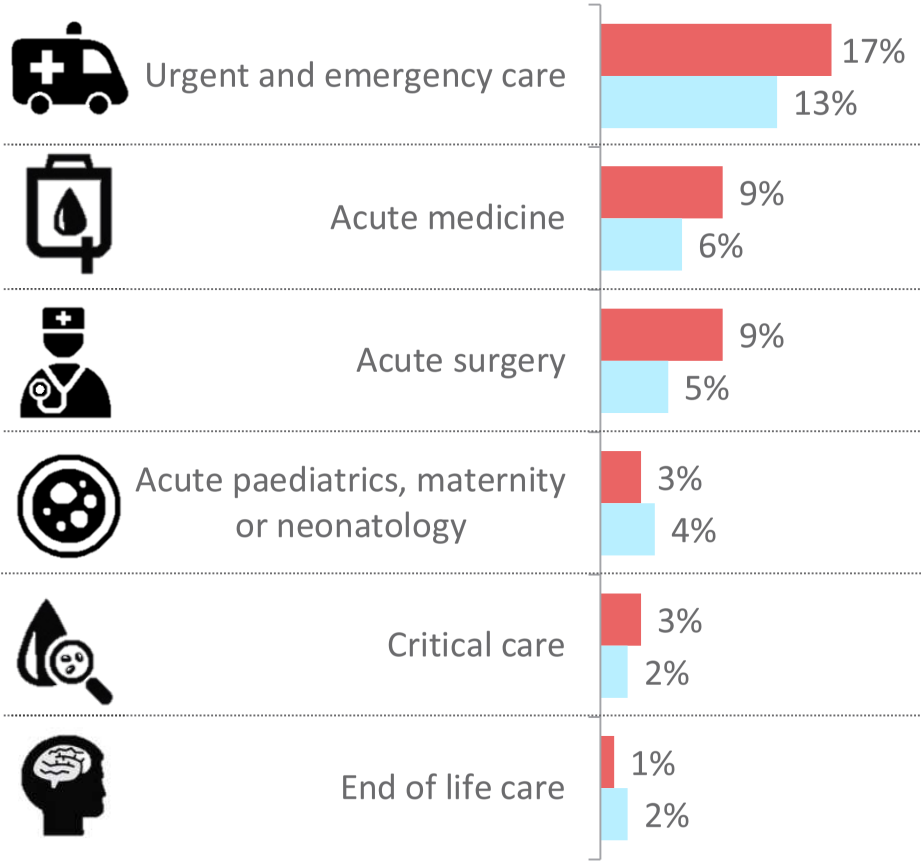
Services used and satisfaction with services

Over a quarter of residents within the survey are service users (29%); primarily of urgent and emergency care services. Residents with a disability are more likely to be service users. Residents are most satisfied with quality of care and patient outcome.

Services used

Used within the last 12 months

Household used within last 12 months



Overall satisfaction (% satisfied)

	As a patient	*Quality of care*	*Ease of access to services*	*Patient outcome*	*Base*
Urgent and emergency care	72%	77%	74%	81%	*166*
Acute medicine	85%	88%	74%	84%	*87*
Acute surgery	78%	84%	69%	88%	*85*
Acute paediatrics, maternity or neonatology	77%	84%	78%	84%	*33*
Critical care	78%	88%	75%	82%	*31*
End of life care	90%	100%	88%	89%	*9*

Base: All respondents excl don't know (998)

Dissatisfaction with services

Residents are most dissatisfied with experience as a patient and ease of access with urgent and emergency care, critical care and acute paediatrics, maternity or neonatology.

	Overall dissatisfaction (% dissatisfied)				
	As a patient	*Quality of care*	*Ease of access to services*	*Patient outcome*	*Base*
Urgent and emergency care	**15%**	8%	**13%**	8%	*166*
Acute medicine	4%	1%	9%	4%	*87*
Acute surgery	5%	4%	9%	4%	*85*
Acute paediatrics, maternity or neonatology	**12%**	7%	**18%**	9%	*33*
Critical care	**13%**	6%	**13%**	6%	*31*
End of life care	0%	0%	0%	**11%**	*9*

Base: All respondents excl don't know (998)

Satisfaction with quality of care and patient outcome

Quality of care

- There are very few significant differences.
- North Tees residents have the lowest levels of satisfaction with urgent and emergency care (67%)
and acute paediatrics, maternity and neonatology (41%).

Patient outcome

- Darlington and North Tees residents are less likely to be very satisfied with acute paediatrics, maternity and neonatology when compared to other areas.
- Similarly North Tees residents are less likely to be very satisfied with urgent and emergency care services outcomes.

Proximity of services

The majority of residents would be willing to travel further for specialist treatments, however they would also expect improved quality of care.

- Residents find it very difficult to prioritise the specific services they would like to be available locally – although emergency care should be closest.
- While (ideally) residents would like all services available at their local hospital there is a general acceptance that sometimes there may be the need to travel for specialist care (in return for greater quality of care).
- Most are willing to travel for planned care with some suggestions of travelling up to 20 miles for specialist treatment.
- A number of residents mentioned they would like end of life care close by as a comfort to friends and family.
- Different services are important to people at different stages of their lives (e.g. older residents would prioritise end of life care while young families might prioritise paediatrics).
- The importance of having services locally also depends on whether the resident is a car user or would be travelling by public transport.

"It's impossible to give these a priority, they're all equally important"

"If I got better treatment I would travel 20 miles if they haven't got the expertise. There's no point going to a local hospital with a heart attack if they've not got the specialists. I'd rather travel 20 miles to The Freeman Hospital"

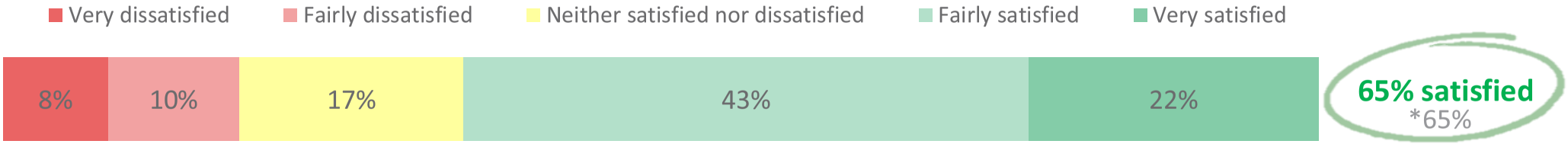
"Planned care can be further afield but anything that is an emergency needs to be close by"

"I think it depend on your circumstances - for example I would want Paeds close to home as I have children"

Contents

Overall satisfaction with the NHS

Overall satisfaction with the way the NHS runs received a moderate score of 65% inline with findings from other research conducted. Residents appreciate and value the NHS although some fundamental changes are required.



Regional differences

Dissatisfaction with the NHS is highest in the North of Tees area (27%) followed by County Durham (20%).

User and non-user differences

There are no significant differences between service users and non-users.

Other differences

Females express higher levels of dissatisfaction than males (20% and 15% respectively).

"I wouldn't like to be without the NHS and I hope and pray it's still here for my grandchildren in the future"

"I have been to countries that don't have a universal health care system so I compare it with them. I value the NHS for both myself and my loved ones. So I'm reasonably happy to recommend it and appreciate it"

"I think it needs improvement but not at the massive expense of a major overhaul and re-organisation. Long live the NHS!!"

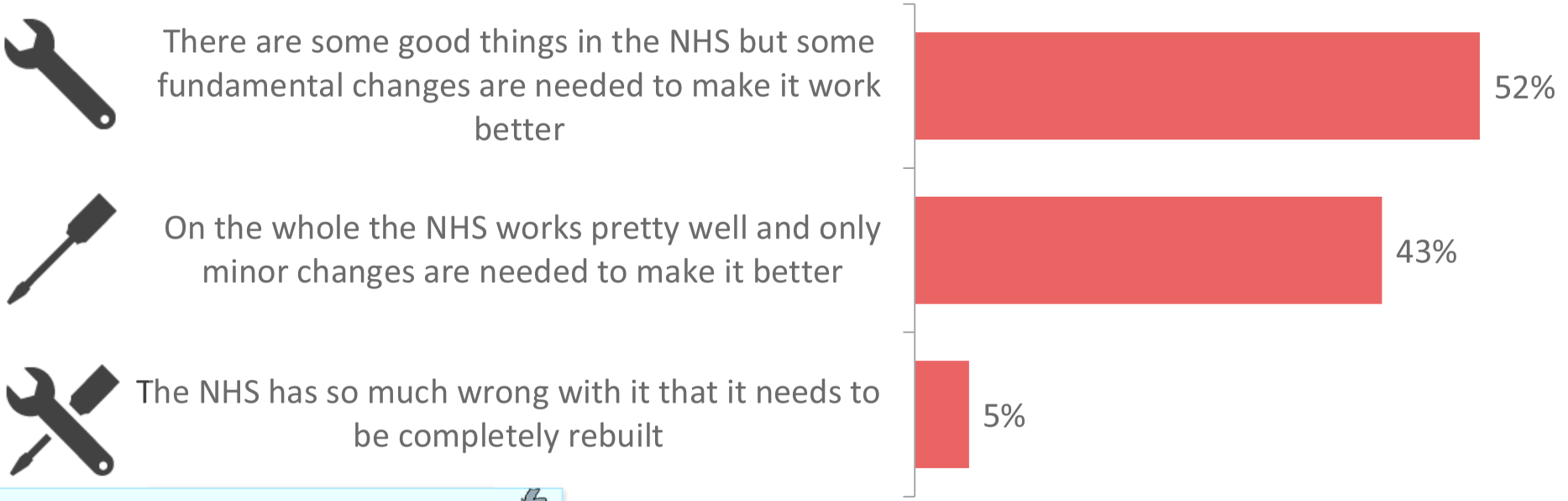
* Comparisons with the British Social Attitudes Survey 2014

Base All respondents excl don't know (983)

Overall view of the changes required in the NHS

Half of residents recognise that there are some good things in the NHS but some fundamental changes are needed to make it work better.

Which one of the following statements comes closest to reflecting your overall view of the NHS?



Regional differences

Residents in the North of Tees area are more likely to suggest the NHS has so much wrong it needs to be rebuilt (8%), compared to 2% of South Tees residents. Hambleton, Richmondshire and Whitby residents are more likely to suggest the NHS only needs minor changes.

User and non-user differences

More service users (7%) than non users (4%) would like to see the NHS completely rebuilt.

Other differences

Males are more likely than females to suggest the NHS only needs minor changes (49% and 38%). Residents aged 36-64 years are more likely to say the NHS needs to be rebuilt, whereas over 65's are most likely to say the NHS only needs minor changes.

Fundamental changes needed to the NHS

Reduce admin/paperwork for patient facing staff

Improve cleanliness

Employ more patient facing staff

Improve communication between hospitals, GPs and patients

Improve aftercare services to reduce readmissions

Reduce wastage

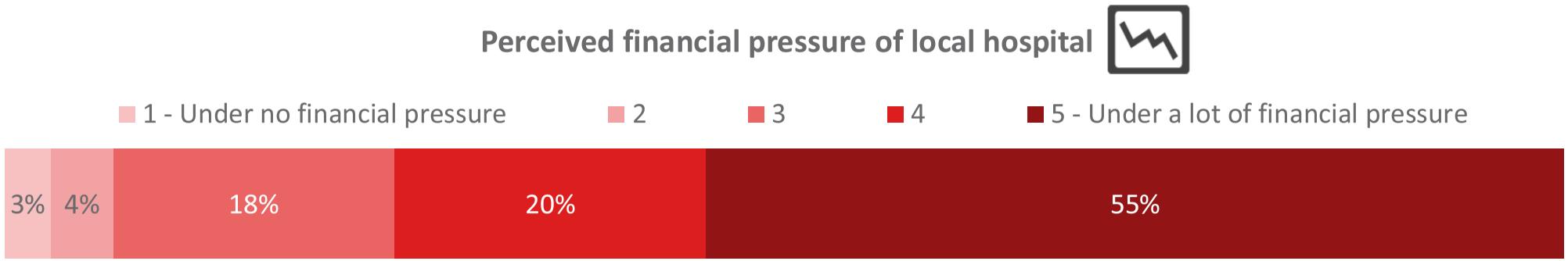
Address car parking issues

Charge patients from overseas for treatment

Introduce charges for missed appointments

Local hospital services being under financial pressure

Three quarters of residents recognise their local hospital services are under financial pressure.



"There was a programme on BBC2 'spending 2 million and rising' about the cost of the NHS and the debate surrounding where the money should be spent"

"It is constantly being mentioned by the politicians… it's a political thing"

- Most are aware of the issue through newspapers, TV, radio and word of mouth
- Many feel that hospital services and the NHS are receiving a lot of media coverage at the moment due to the forth coming elections

Suggestions on how the NHS could save money

Residents have many suggestions for saving the NHS money however they also realise that some would be very difficult to implement.

Ideas include:

- Saving money on what some deem non-essential treatments (e.g. fertility, plastic surgery, gastric bands etc.).
- Some suggest charging in some instances – e.g. those missed appointments or those attending A&E with an alcohol related injury - although there is a realisation that this would be difficult to administer.
- Many believe there should be a commitment from a patient to change their lifestyle before receiving treatment (e.g. organ transplants following alcohol misuse).
- Many feel that the NHS should charge overseas patients for any treatment.
- Many suggest the NHS should focus on improving technology to improve efficiency, therefore enabling more time to be spent with patients.

"At some point they may have to decide on whether they offer treatments such as fertility, maybe they should charge for that"

"This country is too soft, people from overseas should have to pay for their treatment"

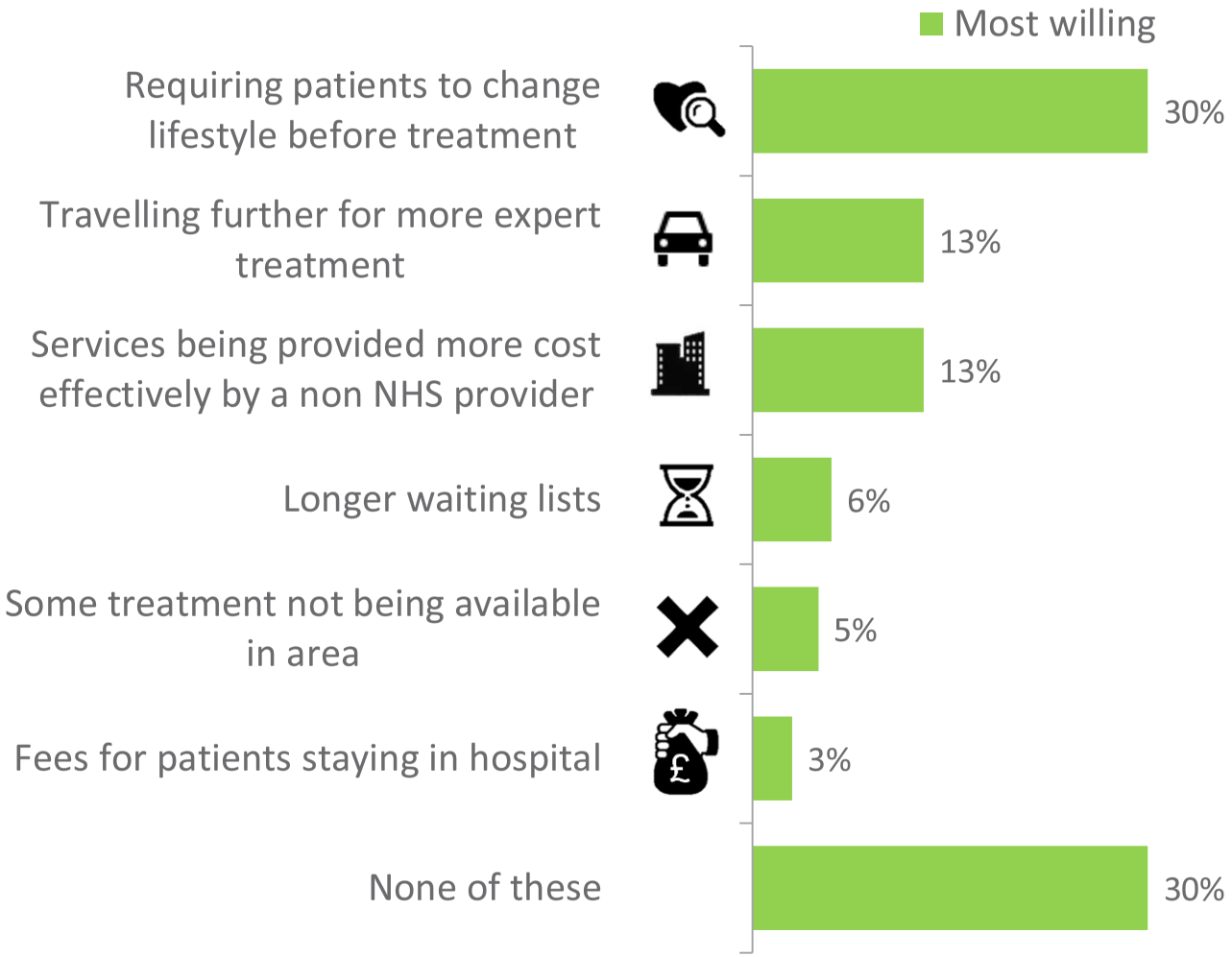
"They should stop smoking or drinking if they want a lung or a liver. You're giving them something to make them better so why should they do something to make it worse again?"

"Change the ways of working such as electronic records. They'd have to spend some capital upfront but long term it would be better"

Reducing future spend – most willing

If local hospital services were to face spending cuts, 30% would be most willing to accept a change to patient's lifestyles before they were given treatment as a solution.

Attitudes to reductions in future spend and changes



Base All respondents (1,000)

Regional differences

South Tees residents are significantly more likely to accept lifestyle changes to try to reduce spend (38%) wihile Durham and Hambleton, Richmondshire and Whitby residents are least likely (25% and 26%). County Durham residents are more willing to travel further for treatment (17%) while Hambleton, Richmondshire and Whitby residents are more willing to accept longer waiting lists (11%).

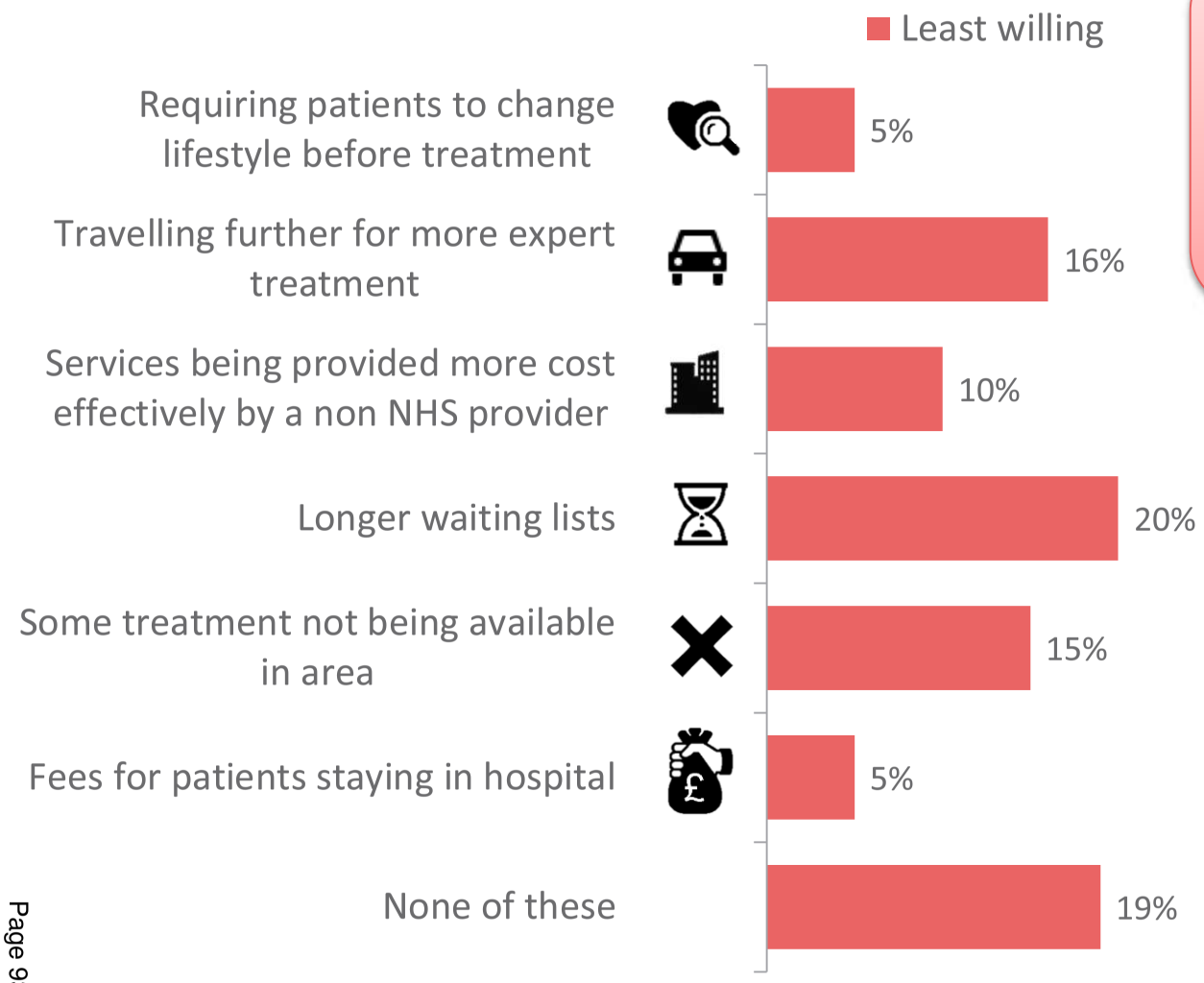
Other differences

Females are more willing to travel further for expert treatment (16%) than males (11%). The proportion willing to accept lifestyle changes decreases with age from 37% of under 35's to 22% of over 65's. Younger residents are most willing to accept any form of change.

Reducing future spend – least willing

If local hospital services were to face spending cuts residents are least willing to accept longer waiting lists.

Attitudes to reductions in future spend and changes



Base All respondents (1,000)

"It is sometimes not realistic for people to travel distances for care - there is a big difference for a one-off operation for someone who has a car compared to someone who needs regular treatment but relies on public transport. We shouldn't have a system that provides access to care dependent upon ability to travel (time, cost, ability)"

Other differences

Younger residents say they are less willing to accept longer waiting lists (24%) when compared to older residents (15%).

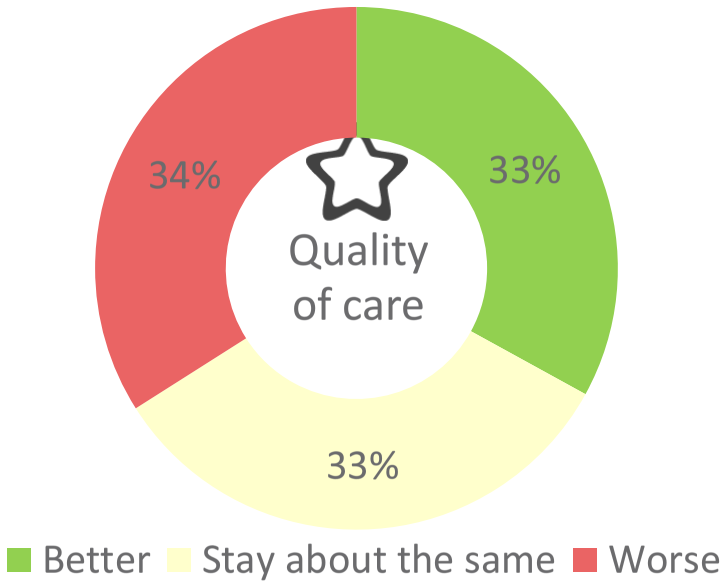
Those with children in the household say they are less willing to accept longer waiting lists than those without children (25% and 19% respectively).

Older residents say they are less willing to travel further for treatment (20%) when compared to younger residents (14%).

Changes to quality of care over the next 3 years

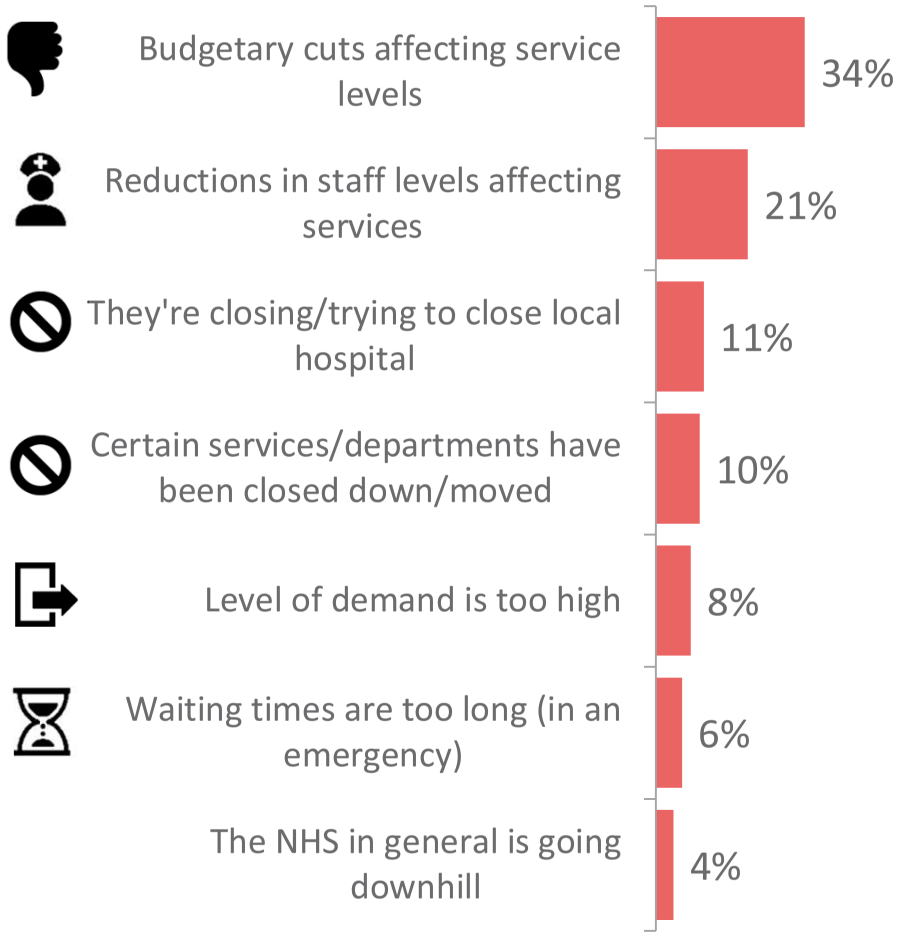
A third of residents expect quality of care to get better over the next 3 years, predominantly younger females. Around the same proportion expect quality of care to deteriorate, primarily due to budgetary cuts.

Expectations for the next 3 years



Base All respondents excl don't know (962)

Reasons for worsened quality of care (unprompted)



Base All respondents who expect quality of care to get worse (330)

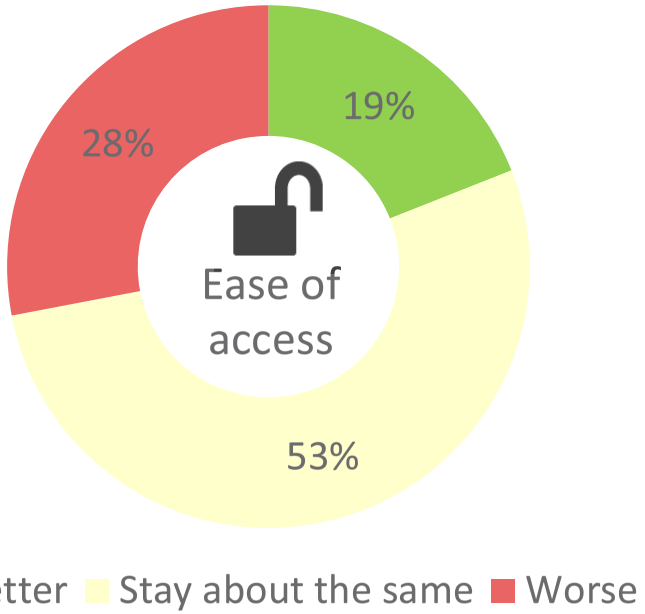
Other differences

Females are significantly more likely to expect quality of care to improve over the next 3 years (36%, compared to 29% of males). Younger residents aged under 35 years (45%) are also more likely to expect improvement.

Changes to ease of access over the next 3 years

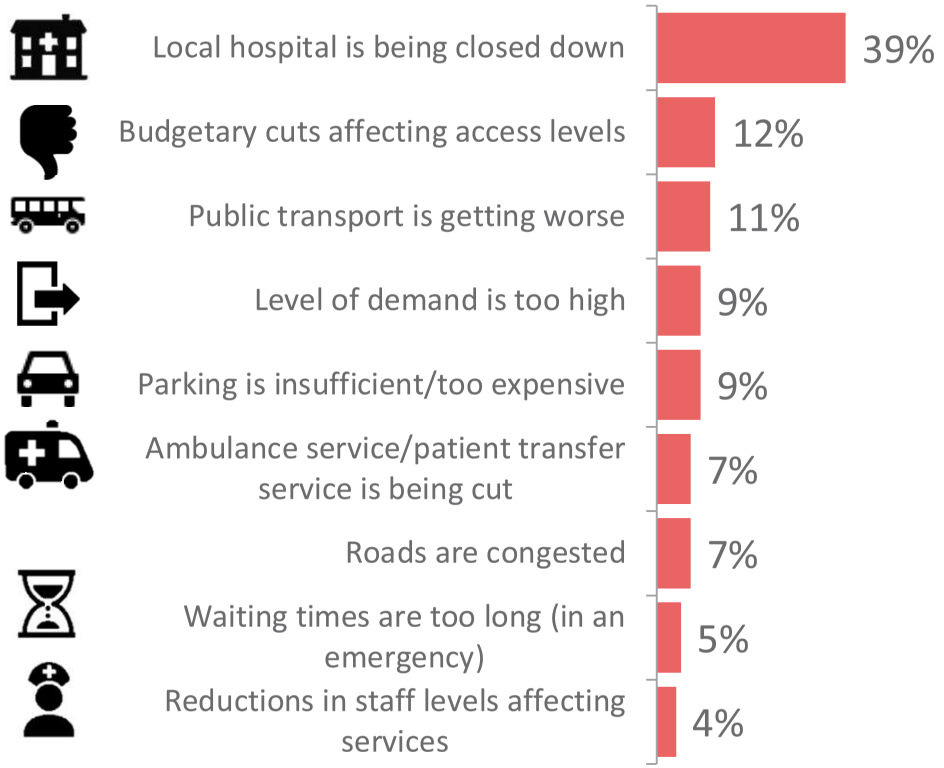
One in five expect ease of access to services to get better, whilst more than one in four expect ease of access to get worse. Services being centralised is a major reason given for ease of access deteriorating.

Expectations for the next 3 years



Base All respondents excl don't know (961)

Reasons for worsened ease of access (unprompted)



Base All respondents who expect ease of access to get worse (266)

Other differences

Younger residents aged under 35 years are significantly more likely to expect ease of access to improve over the next 3 years (28%). Those with children in the household (25%) also expect improvement.

Regional differences

South Tees residents are most likely to expect ease of access to improve (26%), whilst those in the North of Tees are most likely to expect it to get worse (44%).

Views on problems recruiting staff in the NHS

Awareness of the shortage of staff within the NHS is high

- Many feel that hospitals can be understaffed - especially on weekends.
- It is suggested that there is a need for more patient-facing staff and fewer recruited at a managerial level.
- The majority feel that the substitution of English staff with those from overseas is not beneficial and can affect the quality of care, mostly due to language barriers.
- It is recommended that the NHS should invest in a recruitment drive in schools and elsewhere to provide more positive views of the public health service as a career.
- Some recommend that more training could be done in-house - in a similar way to an apprenticeship rather - than through colleges and universities.
- Staff pay (nurses in particular) is thought to be low and this should be raised in order to attract more people to the profession.

"It should be more vocational for nurses…people are put off when they see you need a degree"

"There's a poor image of overworked and they don't get paid enough. When they leave school people don't say 'I want to be a physiotherapist or a nurse?"

"They need to increase nurses pay to make it a more attractive profession"

Contents

Case Study 1

About Colin:

- Colin has a compound fracture in his vertebrae therefore cannot lift heavy objects, he struggles lifting or twisting.
- He attends a pain clinic to help manage the pain at Bishop Auckland.
- Colin also has a heart condition where his heart beats fast and attends Darlington A&E if this happens. It is an intermittent condition which sometimes requires an ambulance and he can end in resuscitation.

Views on Darlington hospital:

- Colin usually gets a taxi to hospital as he cannot drive, therefore ease of access isn't seen as an issue.
- Overall he is very satisfied with the care he has received. He has never had to wait for a long period of time and finds the staff very helpful, professional and friendly.

Quality of care:

- Colin relates quality of care to receiving appropriate treatment, given by professional and friendly staff. Being seen quickly and efficiently is also part of this.

"The staff were great.. they reassure you, they're very professional, very friendly and nothing is too much trouble"

Ease of access:

- He associates ease of access with both the time it takes to get to the hospital and how easy it is to find.
- He is aware parking can be a problem but it does not affect him as he would arrive by taxi, get dropped off by a friend or arrive by ambulance in an emergency.

"I know for example that the Freeman specialises in hearts, so that would be fine"

Locality of services:

- Colin is happy to travel further afield for specialist services but would expect to receive better quality of care if he did this.

Impact of his disability:

- Colin's disability and illness has not impacted his views on the quality of care he has received and it has never posed problems for him when accessing services.

Case Study 2

About Robert:

- Robert had his right foot amputated last year.
- His deterioration of his feet is caused by his diabetes. He is therefore classed as a high risk patient.

Views on Durham hospital:

- Overall Robert is very satisfied with Durham hospital. He finds the nursing staff to be 'fantastic', and he has never had to wait a great length of time to be seen and is particularly impressed with the standards of cleanliness and hygiene.
- He does however find it very difficult to find a parking space even with his blue disability badge.

Quality of care:

- Robert believes quality of care covers the whole spectrum of care services and is mainly driven by nurses and other staff's desire to provide it.
- He is very happy with the quality of care he receives at Durham hospital.

"A girl came to clean the bed. She washed both sides of the mattress and the whole of the bed, including the underneath, it was just amazing"

Ease of access:

- Ease of access to him means how easy it is to get to hospital and the speed of receiving treatment.
- The only improvement he would make to Durham hospital would be to add a raised floor of additional car parking spaces.

Locality of services:

- Robert feels it is common sense to travel for services if needed, especially for specialist care but would not expect to travel further to attend A&E.

"I don't object to the principal of centres of excellence but A&E is a different matter"

Impact of his disability:

- Robert feels his disability has not posed any problems for him in accessing services.
- In fact he believes being classed as high risk means he receives a better quality of care.

Case Study 3

About Julie:

- Julie is retired and suffers with exertional asthma and has severe arthritis in her knees.
- This affects her everyday life as she can't walk very far and can't do any housework.

Views on James Cook hospital:

- Julie has mixed views on the hospital. She finds the staff very helpful and friendly and the hospital to be clean and tidy however she has experienced long waiting times for appointments (sometimes up to an hour) and feels that waiting times should be communicated better at A&E departments.

Quality of care:

- Julie associates quality of care with the overall care received and how patients are treated.
- She worries quality of care could deteriorate in the future due to staff pressures.

"The staff are always polite and friendly…the nurses help to put me at ease"

Ease of access:

- Julie associates ease of access with waiting time to be seen and treated, but also with the availability of car parking.
- She feels the disabled parking spaces at James Cook are not monitored enough and are being abused by those without a blue badge. There are also a number of steps going into the hospital that are difficult for her to negotiate.

"You walk along and look in the cars and don't see any blue badges"

Locality of services:

- Julie does not have an issue travelling for services providing there is sufficient disabled parking and disabled access to the building.

Impact of her disability:

- Sometimes Julie has had to attend several appointments in one day. She feels it would be easier if departments could communicate with each other and co-ordinate these into one morning or afternoon to avoid multiple trips.

"I ended up with letters from different departments for appointments on the same day, but with one in the morning and one later in the afternoon, so it was a pain having to go twice"

Case Study 4

About Warren:

- Warren suffers from a bad back caused by an accident at work over 3 years ago.
- Doctors have also told him that if he lost weight this would help with his back pain.

Views on James Cook hospital:

- Warren feels some improvements could be made to the hospital. His father recently underwent a prostate operation at James Cook. He suffered subsequent problems and had to be readmitted to hospital.
- He believes this could have been avoided with more checks and diagnosis before he was released.
- Warren also felt the hospital was a little untidy in places.

Quality of care:

- Quality of care to Warren means getting the correct treatment, quickly and efficiently.
- Overall he is fairly satisfied with the quality of care however feels it may get worse in the future due to financial pressures.

"If there's a constant drive for efficiency so you're looking to cut corners wherever you can. Preferably without anyone really noticing"

Ease of access:

- Warren relates ease of access to the ease of getting to hospital and the distance travelled, but also to the time it takes to be seen and successfully treated.
- He feels car parking is expensive but understands the revenue is needed to maintain it.

"It's always infuriating that you're being charged for car parking, as essentially you are being charged for being ill. But there's no way around that, you can't turn down the revenue."

Locality of services:

- Warren would not mind travelling for planned care however would expect to be taken to a local hospital in an emergency situation.

Impact of his disability:

- His disability and condition has not had a great impact on the quality of care he has received or posed any problems in terms of ease of access.

Contents

Telephone questionnaire

NECS QUALITY IN HEALTH SERVICES – RESIDENT TELEPHONE SURVEY - 13174M

Good morning/afternoon/evening. My name is _____ from mruk research limited. We have been commissioned by the NHS in the region to carry out some research to find out what members of the public think about hospital services in County Durham, Darlington and Teesside. You have been selected at random for this survey, and I wonder if I could ask you some questions? It should take approximately 10 minutes, and all the answers you give will be kept completely confidential.

We operate under the Market Research Society's Code of Conduct, and adhere fully to the Data Protection Act. This guarantees your anonymity. You will not be approached to buy anything as a result of taking part in this research. It is only your opinion we want to understand.

All the answers you give will be added with hundreds of others and only presented in statistical format.

SECTION A: SCREENING & CLASSIFICATION QUESTIONS

ASK ALL

S1 Sub-region. CODE FROM SAMPLE.

Single code

Code	Text	Instructions
1	County Durham	
2	Darlington	
3	Teesside – Middlesbrough	
4	Teesside – Redcar & Cleveland	
5	Teesside – Stockton	
6	Teesside – Hartlepool	
7	Hambleton, Richmondshire and Whitby	
99	Refused	Thank and close

S2 Which age group do you fall into?

Single code

Code	Text	Instructions
1	16-24	
2	25-35	
3	36-49	
4	50-64	
5	65-74	
6	75+	
99	Refused	Thank and close

Do not read out

S3 Gender

Single code

Code	Text	Instructions
1	Male	
2	Female	

S4 What is your employment status?

Single code

Code	Text	Instructions
1	Full time employed	
2	Part time employed	
3	Student	
4	Unemployed	
5	Looking after the home	
6	Retired	
7	Other	

Telephone questionnaire continued…

SECTION B: PRIORITIES FROM HOSPITAL SERVICES IN GENERAL

ASK ALL

Q1 Thinking about hospital services in general in your area, how would you rate each of the following on a one to five scale, where five is essential to you and one is of no importance at all?

Single code. Rotate statements.

Code	Text	1	2	3	4	5	Don't know
1	Overall quality of care						
2	Ease of getting to hospital						
3	Waiting times for treatment (on arrival at the hospital)						
4	Referral time – ie the time between your GP referring you to the hospital and being seen there						
5	Knowledgeable, professional staff						
6	Helpfulness and friendliness of staff						
7	Cleanliness and hygiene						
8	Range of facilities available that meets your needs						

ASK ALL

Q2 And which of these factors is most important to you, which is second most important and which is third most important?

Single code. Re-read factors and ideally, ask resident to write these down

Code	Text	1st	2nd	3rd	Don't know
1	Overall quality of care				
2	Ease of getting to hospital				
3	Waiting times for treatment (on arrival at the hospital)				
4	Referral time – ie the time between your GP referring you to the hospital and being seen there				
5	Knowledgeable, professional staff				
6	Helpfulness and friendliness of staff				
7	Cleanliness and hygiene				
8	Range of facilities available that meets your needs				

ASK IF QUALITY OF CARE IN TOP 3 AT Q2

Q3 You mentioned that **overall quality of care** was one of the three most important factors. How satisfied are you with your local hospital services with regard to this, on a one to five scale where five means you are very satisfied and one means you are very dissatisfied?

Single code

Code	Text	Instructions
1	Very dissatisfied	
2	Fairly dissatisfied	
3	Neither satisfied nor dissatisfied	
4	Fairly satisfied	
5	Very satisfied	
99	Don't know **(explain that perceptions are ok if they have not used services)**	

Telephone questionnaire continued…

ASK IF EASE OF ACCESS IN TOP 3 AT Q2

Q4 You mentioned that **ease of access to hospital services** was one of the three most important factors. How satisfied are you with your local hospital services with regard to this, on a one to five scale where five means you are very satisfied and one means you are very dissatisfied?

Single code

Code	Text	Instructions
1	Very dissatisfied	
2	Fairly dissatisfied	
3	Neither satisfied nor dissatisfied	
4	Fairly satisfied	
5	Very satisfied	
99	Don't know **(explain that perceptions are ok if they have not used services)**	

ASK ALL

Q5 Is there anything else that is important to you, which hasn't been mentioned?

_____

_____

_____

SECTION C: USE OF SERVICES

ASK ALL

Q6 Can you tell me which of the following services you have used within the last 12 months? **Multi code**

Q7 And has anyone else in your household used these services in the last 12 months as far as you are aware? **Multi code**

Code	Text	Instructions
1	Acute surgery *(This means injury or illness leading to a hospital admission for an operation or surgical procedure that was not planned)*	
2	Acute medicine *(This could be a hospital assessment or admission for an illness where treatment does not involve surgery. This does not include A&E or an urgent care centre and would happen in a ward area)*	
3	Critical care *(This is a high dependency unit or an intensive care unit)*	
4	Acute paediatrics, maternity or neonatology *(This means hospital care for a child or an expectant or new mother and their preborn or newborn baby)*	
5	End of life care *(This means hospital care for those with advanced, progressive and/or incurable illness. This is excluding hospice based care)*	
6	Urgent and emergency care *(This is attendance at an A&E department or an urgent care centre for an urgent or emergency condition.)*	
7	Not accessed any of the above services	SKIP TO Q14
8	Don't know (try to avoid)	SKIP TO Q14

Telephone questionnaire continued…

ASK IF NOT CODE 7 OR 8 AT Q6 (IE SERVICE USERS)

Q8 Was your treatment planned in advance or an emergency?

Multi code

Code	Text	Planned	Emergency	N/A
1	Acute surgery			
2	Acute medicine			
3	Critical care			
4	Acute paediatrics, maternity or neonatology			
5	End of life care			
6	Urgent and emergency care			

ASK IF NOT CODE 7 OR 8 AT Q6 (IE SERVICE USERS). ASK FOR ALL USED AT Q6

Q9 Thinking about (_____) (**services used from Q6**), how would you rate your **overall experience as a patient** on a one to five scale, where five means you are very satisfied and one means you are very dissatisfied?

Single code. Rotate statements.

Code	Text	1	2	3	4	5	Don't know
1	Acute surgery						
2	Acute medicine						
3	Critical care						
4	Acute paediatrics, maternity or neonatology						
5	End of life care						
6	Urgent and emergency care						

ASK IF NOT CODE 7 OR 8 AT Q6 (IE SERVICE USERS). ASK FOR ALL USED AT Q6

Q10 And again, thinking about (_____) (**services used from Q6**), how would you rate the **overall quality of care** you experienced on a one to five scale, where five means you are very satisfied and one means you are very dissatisfied?

Single code. Rotate statements. **NB – if respondent had several mixed experiences, ask them to think about their most recent one**

Code	Text	1	2	3	4	5	Don't know
1	Acute surgery						
2	Acute medicine						
3	Critical care						
4	Acute paediatrics, maternity or neonatology						
5	End of life care						
6	Urgent and emergency care						

ASK IF NOT CODE 7 OR 8 AT Q6 (IE SERVICE USERS). ASK FOR ALL USED AT Q6

Q11 And again, thinking about (_____) (**service used from Q6**), how would you rate the **ease of access to the service** you experienced on a one to five scale, where five means you are very satisfied and one means you are very dissatisfied?

Single code. Rotate statements.

Code	Text	1	2	3	4	5	Don't know
1	Acute surgery						
2	Acute medicine						
3	Critical care						
4	Acute paediatrics, maternity or neonatology						
5	End of life care						
6	Urgent and emergency care						

Telephone questionnaire continued…

ASK IF NOT CODE 7 OR 8 AT Q6 (IE SERVICE USERS). ASK FOR ALL USED AT Q6

Q12 And again, thinking about (_____) (**service used from Q6**), how would you rate **the patient outcome** you experienced on a one to five scale, where five means you are very satisfied and one means you are very dissatisfied?

Single code. Rotate statements.

Code	Text	1	2	3	4	5	Don't know
1	Acute surgery						
2	Acute medicine						
3	Critical care						
4	Acute paediatrics, maternity or neonatology						
5	End of life care						
6	Urgent and emergency care						

ASK ALL

Q13 Are there any other comments you would like to make about your experiences of using these services?

_____

_____

_____

SECTION D: CHANGES IN THE NHS

ASK ALL

READ OUT: Now I would like to ask you a few questions about changes in the NHS.

Q14 Thinking about the **overall quality of care** provided by your local hospital services over the next three years, do you expect them to …?

Single code

Code	Text	Instructions
1	Get much better	
2	Get a little better	
3	Stay about the same	
4	Get a little worse	
5	Get much worse	
99	Don't know **(try to avoid)**	

ASK IF CODE 4 OR 5 AT Q14

Q15 In what ways do you feel that the quality of care is likely to get worse?

_____

_____

ASK ALL

Q16 Thinking about the **ease of access to** your local hospital services over the next three years, do you expect them to …?

Single code

Code	Text	Instructions
1	Get much better	
2	Get a little better	
3	Stay about the same	
4	Get a little worse	
5	Get much worse	
99	Don't know **(try to avoid)**	

ASK IF CODE 4 OR 5 AT Q16

Q17 In what ways do you feel that ease of access is likely to get worse?

_____

_____

ASK ALL

Q18 To what extent do you feel that your local hospital services are under financial pressure on a scale of one to five where 1 represents no financial pressure and 5 represents a lot of financial pressure? **Single code**

Code	Text	Instructions
1	Under no financial pressure	
2		
3		
4		
5	Under a lot of financial pressure	
99	Don't know **(try to avoid and encourage response)**	

Telephone questionnaire continued…

ASK ALL

Q19a You may have heard in the national media about the need to reduce future spending in the NHS. If your local NHS hospital services were to face lower levels of spending, which of these would you be most willing to accept?

Q19b And which would you be least willing to accept?

Single code. Read out. Rotate statements.

Code	Text	Most	Least
1	Longer waiting lists		
2	Requiring patients to change lifestyle before they were given treatment		
3	Fees for patients staying in hospital		
4	Some types of treatment not being available in your area		
5	Services being provided more cost effectively by a non NHS provider		
6	Travelling further for more expert treatment		
7	None of these		

Q20 All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays? **Single code**

Code	Text	Instructions
1	Very dissatisfied	
2	Fairly dissatisfied	
3	Neither satisfied nor dissatisfied	
4	Fairly satisfied	
5	Very satisfied	
99	Don't know **(try to avoid)**	

Q21 Which one of the following statements comes closest to reflecting your overall view of the NHS? **Single code. Rotate statements**

Code	Text	Instructions
1	The NHS has so much wrong with it that it needs to be completely rebuilt	
2	There are some good things in the NHS but some fundamental changes are needed to make it work better	
3	On the whole the NHS works pretty well and only minor changes are needed to make it better	
99	Don't know **(try to avoid)**	

SECTION E: OTHER CLASSIFICATION QUESTIONS

Q22 Are there any children aged 16 or under in the household for whom you are responsible or partly responsible? **Single code.**

Code	Text	Instructions
1	Yes	
2	No	
3	Refused	

Q23 So that we ensure we have spoken to a representative spread of the community, can you tell me how would you describe your ethnic group? **Single code**

WHITE	British	0	1
	Irish	0	2
	Eastern European	0	3
	Any other White background	0	4
MIXED	White & Black Caribbean	0	5
	White & Black African	0	6
	White & Asian	0	7
	Any other mixed background	0	8
ASIAN OR ASIAN BRITISH	Indian	0	9
	Pakistani	1	0
	Bangladeshi	1	1
	Any other Asian background	1	2
BLACK OR BLACK BRITISH	Caribbean	1	3
	African	1	4
	Any other Black background	1	5
CHINESE OR OTHER ETHNIC GROUP	Chinese	1	6
	Other	1	7
Refused		1	8

Q24 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

Single code. If yes, establish whether limited a lot or a little.

Code	Text	Instructions
1	Yes, limited a lot	
2	Yes, limited a little	
3	No	
4	Refused	

Telephone questionnaire continued…

Q25 Which of the following best describes your access to technology?

Multi code

Code	Text	Instructions
1	Mobile phone with internet access	
2	Mobile phone without internet access	
3	Telephone landline at home	
4	Access to the Internet at home	
5	Access to the Internet at work	
6	Access to the Internet at place of education	
7	Access to the Internet elsewhere	

Q26 Which of the following best describes your personal access to a house vehicle?

Single code

Code	Text	Instructions
1	Have access to a household vehicle as a driver - always	
2	Have access to a household vehicle as a driver - sometimes	
3	Have access to a household vehicle as a passenger - always	
4	Have access to a household vehicle as a passenger - sometimes	
5	No access to a household vehicle, but can get lifts from other friends/ family	
6	No access to any private vehicle	

Q27 How easy is it for you to get to hospital on public transport (i.e. bus or train)?

Single code

Code	Text	Instructions
1	Very easy	
2	Fairly easy	
3	Neither easy nor difficult	
4	Fairly difficult	
5	Very difficult	

Q28 We will be conducting some further in-depth discussions as part of this research in early 2015. This will involve attending a group discussion and you will be given an incentive for participating. Would you be interested in being invited?

Single code

Code	Text	Instructions
1	Yes	ASK FOR CONTACT DETAILS
2	No	THANK & CLOSE

Contents

Focus group discussion guide

Introduction and Warm-up (10 minutes max)

Hello, my name is …. I work for **mruk** research, an independent market research agency. Thank you very much for agreeing to join us here today.

As you know we are conducting this research to find out what members of the public think about hospital services in the area. Some of you may remember taking part in a telephone interview on this topic a few months back!

- The discussion will last no longer than an hour and a half.
- There's no right or wrong answers, it is purely your opinions we are after. We value your honest feedback – please don't tell us anything because you think it's what we want to hear. Equally don't feel that you can't tell us things that we don't want to hear.
- The discussion will be audio-recorded – just to save me taking notes. Only the team at **mruk** has access to the recording, and they will be destroyed at the end of the project.
- Everything you say will be completely confidential, all comments will be anonymised; you will not be personally identified in our report.

Please help yourself to more tea, coffee and biscuits as we go along.

Now that I have introduced myself, I would like each of you to introduce yourself to the rest of the group. We'll go round the table and if each of you could tell me…

- Your first name
- Where you're from

Section 2 – Your local hospital (15 minutes max)

Let's begin by talking about your local hospital …

- Which hospital would you class as your local hospital? If there's more than one which one do you use the most?
- For those who have used the hospital recently (in the past year), tell me a little bit about your experiences…

  How did you get to the hospital?

  How easy is it for you to get to the hospital?

  What services did you use?

  Did you have to wait very long to be seen?

  What were the staff like?

  How would you rate the cleanliness and hygiene of the hospital?

  Overall how satisfied would you say you were with your visit?
- Could your experience have been improved in any way? If so how?

Focus group discussion guide continued…

Section 3 – Priorities (40 minutes max)

ACTIVITY

Imagine you as a group are in charge of your local hospital budget, I'm going to give you a total of 50 points and you have to allocate these points to the following features of services. You will need to prioritise what service features you want to give points to and decide how many points to give them.

SHOWCARDS:

Effectiveness of treatment, Patient safety, Patient experience, Ease of access, Reducing waiting times, Reducing referral times, Knowledgeable and professional staff, Helpful and friendly staff, Cleanliness and hygiene of the hospital, Range of facilities available to meet your needs.

Probe on why they have allocated points in such a way.

- From the telephone survey we conducted (mentioned previously) just over half (53%) rated the quality of care hospital as important – what do you think of that figure?
- What does quality of care mean to you?
- How would you rate the overall quality of care at your local hospital?
- Do you think quality of care will get better or worse in the future?
- Why do you think that? *(Probe on financial pressures, probe on manpower pressures)*
- How could quality of care be improved?

- Again from our survey we found that just under a third(30%)of people said they were dissatisfied with ease of access to hospitals –what do you think of that figure?
- What does ease of access mean to you?
- Now that you have thought about what ease of access means to you, do you want to reconsider your points allocation?
- How would you rate the ease of access at your local hospital?
- Do you think ease of access will get better or worse in the future?
- Why do you think that? *(Probe on financial pressures, probe on manpower pressures)*
- How could ease of access be improved?

Focus group discussion guide continued…

Section 4 – Local services provided (10 minutes max)

Ok just moving on slightly to talk about specific services provided at your local hospital…

- Imagine you had an appointment to go to hospital but your local hospital didn't provide that service so you had to travel a little bit further to another hospital? How would you feel about that?

- Which of these services would you say are the most important for your local hospital to provide? Why?
- Which ones are least important for local hospital to provide? Why?
- Which of these would you be willing to travel a little bit further for if you had to? Why do you say that?

SHOW SERVICE CARDS:

- Acute surgery (This means injury or illness leading to a hospital admission for an operation or surgical procedure that was not planned)
- Acute medicine (This could be a hospital assessment or admission for an illness where treatment does not involve surgery. This does not include A&E or an urgent care centre and would happen in a ward area)
- Critical care (This is a high dependency unit or an intensive care unit)
- Acute paediatrics, maternity or neonatology (This means hospital care for a child or an expectant or new mother and their preborn or newborn baby)
- End of life care (This means hospital care for those with advanced, progressive and/or incurable illness. This is excluding hospice and home based care)
- Emergency life threatening condition care (This is attendance at an A&E department)
- Urgent care (this is attending an urgent care centre or minor injuries unit for an urgent condition.)

Section 5 – Overall satisfaction (10 minutes max)

It's been really interesting to hear about your local experiences. Now thinking about the NHS in general…

- Overall how satisfied would you say you are with the way the NHS is run nowadays?
- Why do you say that?
- 50% of people in our survey said 'there are some good things about the NHS but some fundamental changes are needed to make it work better' – what are your thoughts on this?

Focus group discussion guide continued…

Conclusion (5 minutes max)

- That's all of my question - is there anything else that you would like to say in relation to your local hospital and services it provides that we should pass on?

Thank you very much for your time it is very much appreciated.

FURTHER INFO: We are carrying out a number of these discussion groups across County Durham, Darlington and Teeside. Once we've completed all of our research we will put all of our findings together into a report to give to the NHS – please be assured everything will be completely confidential your names will not be mentioned in the report.

There may be an opportunity to take part in some further research looking at NHS service provision in the future – if you would be willing to take part please tick the box on the incentive sheet as you sign it and we will pass on your contact details to the NHS.

Moderator provide incentive.

Contents

Depth interview discussion guide

Introduction and Warm-up (5 minutes max)

Hello, my name is …. I work for **mruk** research, an independent market research agency. Thank you very much for agreeing to take part in our research.

As you know we are conducting this research to find out what members of the public think about hospital services in the area. You may remember taking part in a telephone interview on this topic a few months back!

- The discussion will last no longer than 45 minutes.
- There's no right or wrong answers, it is purely your opinions we are after. We value your honest feedback – please don't tell us anything because you think it's what we want to hear. Equally don't feel that you can't tell us things that we don't want to hear.
- The discussion will be audio-recorded – just to save me taking notes. Only the team at **mruk** has access to the recording, and they will be destroyed at the end of the project.
- Everything you say will be completely confidential, all comments will be anonymised; you will not be personally identified in our report.

Section 2 – Your local hospital (10 minutes max)

Just to start off with would you be able to tell me a little bit about yourself?

(probe for disability and impact it has on their day to day life)

Let's begin by talking about your local hospital …

- Which hospital would you class as your local hospital? If there's more than one which one do you use the most?
- Thinking about the last time you used the hospital either as a patient or a visitor, tell me a little bit about your experience…

  How did you get to the hospital?

  How easy is it for you to get to the hospital?

  Probe on whether or not their disability affects how they get to hospital. If so how? Is sufficient disabled access provided?

  What services did you use?

  Did you have to wait very long to be seen?

  What were the staff like?

  How would you rate the cleanliness and hygiene of the hospital?

  Overall how satisfied would you say you were with your visit?
- Could your experience have been improved in any way? If so how?

Depth interview discussion guide continued…

Section 3 – Quality of Care and Ease of Access (10 minutes max)

- From the telephone survey we conducted just over half (53%) rated the quality of care at hospital in there top 3 most important factors – what do you think of that figure?
- What does quality of care mean to you?
- How would you rate the overall quality of care at your local hospital?
- Do you think quality of care will get better or worse in the future?
- Why do you think that?

  Probe on financial pressures, probe on manpower pressures
- How could quality of care be improved?

- Again from our survey we found that just under a third (30%) of people said they were dissatisfied with ease of access to hospitals –what do you think of that figure?
- What does ease of access mean to you?
- How would you rate the ease of access at your local hospital?

  Probe on impact of disability on ease of access if appropriate
- Do you think ease of access will get better or worse in the future?
- Why do you think that?

  Probe on financial pressures, probe on manpower pressures
- How could ease of access be improved?

- Thinking about your local hospital what would you say it's most important priority for improvement would be? Why do you say this?

Depth interview discussion guide continued…

Section 4 – Local services provided (10 minutes max)

Ok just moving on slightly to talk about specific services provided at your local hospital…

- Imagine you had an appointment to go to hospital but your local hospital didn't provide that service so you had to travel a little bit further to another hospital? How would you feel about that?

  Probe on impact of disability if appropriate
- Which of these services would you say are the most important for your local hospital to provide? Why?
- Which ones are least important for local hospital to provide? Why?
- Which of these would you be willing to travel a little bit further for if you had to? Why do you say that?

SHOWCARD:

- Acute surgery (This means injury or illness leading to a hospital admission for an operation or surgical procedure that was not planned)
- Acute medicine (This could be a hospital assessment or admission for an illness where treatment does not involve surgery. This does not include A&E or an urgent care centre and would happen in a ward area)
- Critical care (This is a high dependency unit or an intensive care unit)
- Acute paediatrics, maternity or neonatology (This means hospital care for a child or an expectant or new mother and their preborn or newborn baby)
- End of life care (This means hospital care for those with advanced, progressive and/or incurable illness. This is excluding hospice and home based care)
- Emergency life threatening condition care (This is attendance at an A&E department)
- Urgent care (this is attending an urgent care centre or minor injuries unit for an urgent condition.)

Section 5 – Overall satisfaction (5 minutes max)

It's been really interesting to hear about your local experiences. Now thinking about the NHS in general…

- Overall how satisfied would you say you are with the way the NHS is run nowadays?
- Why do you say that?
- 50% of people in our survey said 'there are some good things about the NHS but some fundamental changes are needed to make it work better' – what are your thoughts on this?

Depth interview discussion guide continued…

Conclusion (5 minutes max)

- That's all of my question - is there anything else that you would like to say in relation to your local hospital and services it provides that we should pass on?

Thank you very much for your time it is very much appreciated.

FURTHER INFO: We are carrying out a number of these interviews across County Durham, Darlington and Teeside. Once we've completed all of our research we will put all of our findings together into a report to give to the NHS – please be assured everything will be completely confidential your name will not be mentioned in the report.

There may be an opportunity to take part in some further research looking at NHS service provision in the future – if you would be willing to take part please tick the box on the incentive sheet as you sign it and we will pass on your contact details to the NHS.

Moderator provide incentive.

Organisations involved in the Securing Quality in Health Services Programme

- **Clinical Commissioning Groups**:

- NHS North Durham Clinical Commissioning Group
- NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group
- NHS Darlington Clinical Commissioning Group
- NHS Hartlepool and Stockton on Tees Clinical Commissioning Group
- NHS South Tees Clinical Commissioning Group
- NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

- **Hospital Trusts**:

- County Durham and Darlington NHS Foundation Trust
- Hartlepool and North Tees NHS Foundation Trust
- South Tees NHS Foundation Trust

- **Two local authorities represent the LAs on the area**:

- County Durham
- Middlesbrough

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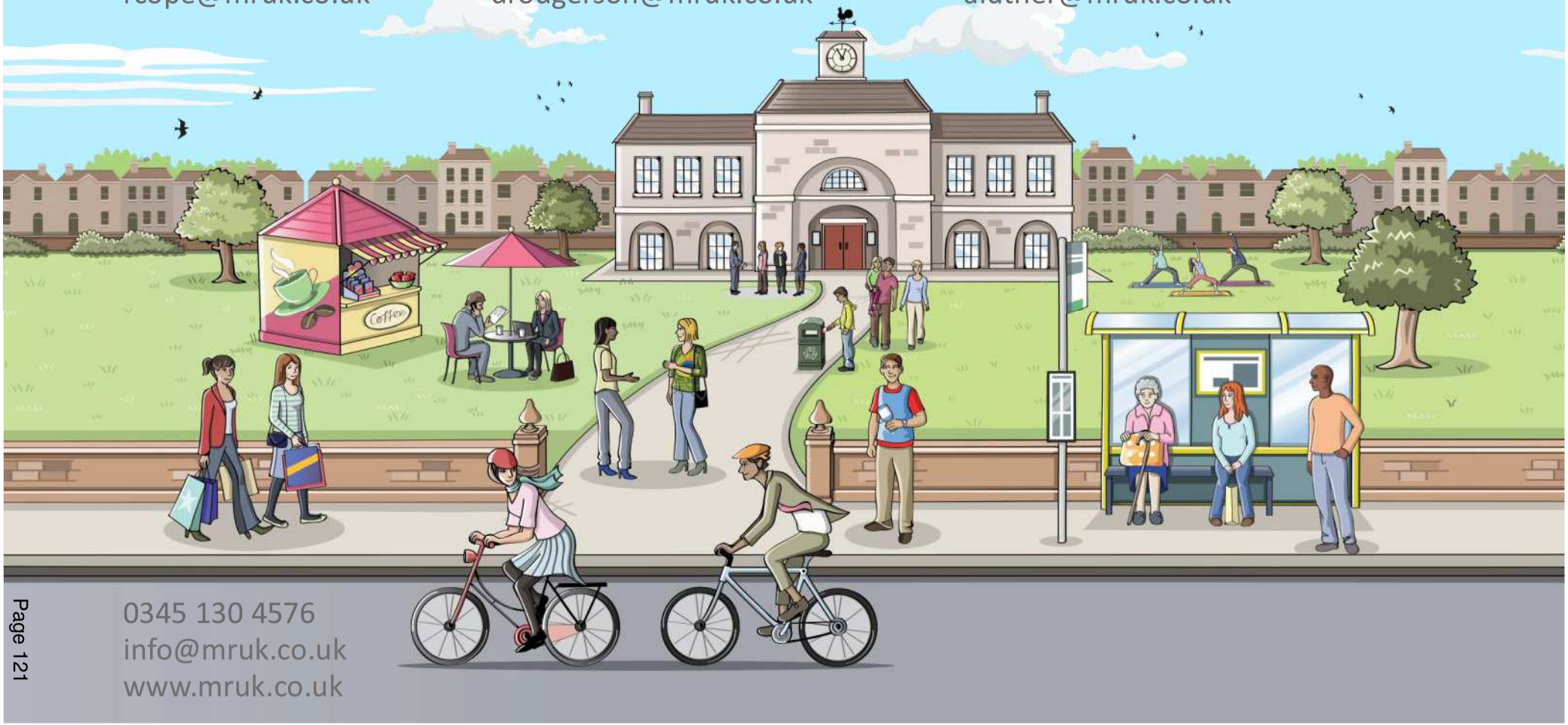

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Independent Analysis of the 12 Public Engagement Events (February/March 2016) for the Better Health Programme

Proportion Marketing April 2016

Contents

1.0 Introduction

A series of 12 Better Health Programme public engagement events ran by the NHS in Darlington, Durham and Tees were held between February and March 2016. There were 168 member of the public attendees recruited from a number of sources including online, local press, Healthwatch, social media, word of mouth or CCG activity.

Feedback was recorded by scribes at each table and, for one exercise, by comments placed on concentric circles on wall charts.

The feedback in this report has been independently analysed by Proportion Marketing Limited.

During a presentation introducing the Better Health Programme, attendees were asked the following to prompt a dialogue:

Let's discuss…
What does your local health service do well?
What can we do better?

Let's discuss...
• How can we the right services in the right place, so people understand what services they need and how to access them?
• Where should these services be? (A wall chart exercise)
• How can we better match clinical resource to the needs of our population?
• How can we improve quality of care?

Let's discuss...
• How can we best engage with people about changes?
• Which groups should we be talking to?
• What information do you need to help inform you about the issues?
• Has this event been helpful? Would you come and talk to us again?

Most of the feedback analysed in this report was successfully generated in these discussions – although dialogue was allowed to flow outside of the questions set.

Many comments were made on recent and historic personal experience as patient or carer.

The wall chart exercise was used in 7 out of 12 meetings. In all the meetings, the above questions prompted discussions in which attendees raised concerns about current health care provision.

2.0 Executive summary

These first engagement events proved successful in highlighting a number of issues the Better Health Programme should feed into its processes.

The key themes over the 12 events that attracted the most comments were as follows:

TRAVEL & TRANSPORT - Current travel and transport issues were a common concern - particularly for rural, elderly and vulnerable patients. Potential travel and transport issues after service reconfiguration were highlighted.

ACCESS TO GPs - Although not a direct question from the BHP programme, the difficulty in accessing Primary Care, and in particular known, local GP surgeries, was a common and passionate issue. Some attendees did have positive experiences of this.

NHS RESOURCES - The pressure on NHS resources was a concern for many these events. Pressure to provide 24/7 care with reduced budgets was seen as reaching a crisis point for some providers. Waste is a common issue in this theme.

POPULATION CHANGES - An ageing population with complex healthcare needs and the addition of a population with language and cultural challenges were seen as the two areas with the biggest impact on local NHS service.

THE NHS 111 SERVICE - Some attendees were critical of this service, particularly when considered as an alternative to attending A&E. Some attendees had positive comments and experiences of the NHS 111 service. There remains some confusion around the circumstances defining the best use of this service.

MENTAL HEALTH ACCESS - Mental Health access and provision was mentioned by a number of attendees and dominated comments from one event were there were a few attendees.

STAFF SHORTAGES - There were comments about previous NHS experiences regarding staff shortages which resulted in a poor patient experience. Many comments were as much about perception as to first hand experience.

EMERGENCY SERVICES AND AMBULANCE RESPONSES - An ever-present concern, particularly in rural areas, ambulance response times were mentioned at several events.

COMMUNICATION AND ENGAGEMENT - Prompted by the presentation questions, there were comments around the need to engage with a wider audience (particularly from attendees who thought the events were valuable).

The key messages that the organisers took from the BHP public engagement events are listed as follows:

- People value the “A&E brand”, and have confidence in it
- Not sure how/where to access other unplanned care
- Not confident in 111, ambulance response times
- Want local services in their local hospital
- Believe there could be more community based services
- Understand the need to travel for specialist care BUT different views on what this might mean
- Concerned about travel and transport
- Want better access to primary care and mental health
- Interested in technological solutions

This report supports their findings but would stress that the number of comments about mental health services and travel and transport would suggest these deserve a higher placing in the above list.
On the whole, many attendees are satisfied with the care they eventually receive but often are concerned about the journey before and after receiving that care (access, diagnostics, travel, confusion of where to go, integration with social care, the impact of staff shortages and continuity of care). These concerns are multiplied for the vulnerable, the elderly, the young and those with mental health issues.

The attendees had good ideas on the use of technology, services that could be provided in the community and better use of pharmacies and joined up voluntary services.

In terms of communicating the Better Health Programme, attendees urge the NHS to use simple language, be as honest as possible about the realities of resource and finance and to place the patient at the centre of all processes.

Attendees were asked to suggest where they felt health services should go. This exercise created detailed discussion and was a useful engagement and participation tool supplying useful feedback from the attendees.

368 comments were recorded in this exercise. Most comments placed services in the community, reflected in the following breakdown:

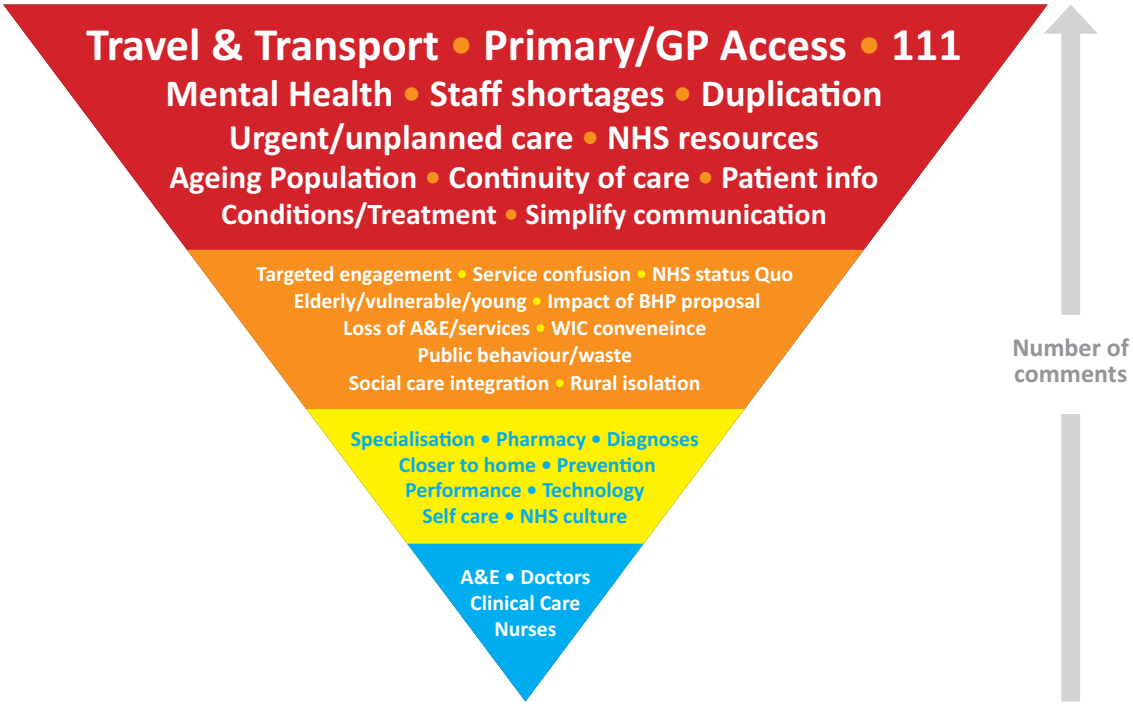
49% of comments referred to the inner 3 ‘not in hospital’ settings
20% of comments referred to the 2 outer ‘in hospital’ settings
31% of comments were placed outside of the rings altogether

Comments placed outside of the rings were non-setting specific about the wider issues surrounding travel and transport, communications, finance, integration and joined up care.

The 12 public engagement events were a worthwhile public engagement exercise with 168 attendees contributing to the exercise. Most attendee event feedback was positive and suggested the events were well ran, easy to get to (99% strongly agree/agree), provided enough background information (80%), allowed individuals to express their point of view (87%) and make sound judgments (78%) and were both informative and useful (86%). Additional comments ranged from more people need to know about these events to keeping discussions on track.

3.0 What Patients Care About - Key Themes from feedback

Comments captured from the scribe notes from each of the 12 events were allocated to subject matters or 'themes'. The key themes were those matters that raised the most comments consistently throughout the events.



The above diagram summarises the key themes raised in the engagement feedback. The feedback was prompted by specific 'Let's discuss' questions in the presentation.

The main themes over the 12 events that attracted the most concern and comments (represented below by the red band) were as follows:

- TRAVEL & TRANSPORT
- ACCESS TO GP
- NHS RESOURCES
- POPULATION CHANGES
- NHS 111
- MENTAL HEALTH CARE
- STAFF SHORTAGES
- EMERGENCY SERVICES/AMBULANCE RESPONSE
- COMMUNICATION AND ENGAGEMENT

Other themes that attracted some concern and comments (represented below by the orange band) were as follows:

- Loss of hospital services (particularly A+E in Hartlepool)
- Integration between health and social care and the voluntary networks
- Confusion over service provision and location
- The cost of some public behavior (inappropriate use of A+E, missing GP appointments)

Themes that attracted little concern and few comments (represented below by the yellow band) were as follows:

- Specialisation of services
- Care closer to home
- Greater use of pharmacies
- The use of technology e.g. Skype, Tele-health
- Prevention strategies

There was least concern (represented below by the blue band) over the actual job doctors and nurses do, when patients actually get in front of them. A+E comes in for particular praise, although most face-to-face clinical care is recorded in positive terms.

Key themes with illustrative comments

3.1 TRAVEL & TRANSPORT

Current travel and transport issues were a common concern - particularly for rural, elderly and vulnerable patients. Potential travel and transport issues after service reconfiguration were highlighted. Attendees understood the need to travel for certain treatment but insisted this a priority when planning future services. Comments include:

Delays due to additional travel would raise people's anxiety (especially maternity).

Transport needs to be thought about. Are we linking in with transport services to make sure there's adequate provision?

Would rather travel to a specialist service. There's got to be a change.

I wouldn't mind travelling far – would rather do that and go to a surgeon who has done lots more operations.

Bring a doctor to Hartlepool for a clinic rather than lots of people travelling to Sunderland for appointments at clinics.

Travelling - you could be help with that. Not everyone has a car. It's an expedition.

Maternity services in Hartlepool – not good to travel. But depends on numbers of clinicians available.

Issues in travel to hospital services for A&E or other services are an issue, particularly with public transport if you live in more rural areas of the Dales.

Even if we revise the whole health service in this area, its still going to be fragmented as people will still need to travel to get everywhere and not know where to go.

There is a lack of transport after 8pm.

The need for transport on a night for patients.

There is a need for stronger community services – then there would be less need for transport. More would be available in the community for high numbers of patients.

Transport and parking charges - 2 key issues

Do we use health money for transport? Where would we take this money from?

NHS shouldn't spent budget on transport.

Transport better in those places e.g. health village

3.2 ACCESS TO GPs

Although not a direct question from the BHP programme, the difficulty in accessing Primary Care, and in particular known, local GP surgeries, was a common and passionate issue. Some attendees did have positive experiences of this. Comments include:

The availability of GP appointments is a common complaint and needs looking at as part of the BHP

People say they can't get a GP appointment. WICS don't have your notes. Offer GP appointments in your locality via 111.

GPs are great!

GP access – hear a lot of negativity but GP access in area scores highly on national surveys.

There were 2 GP practices in Ingleby Barwick 30 years ago when one member of the group moved there. There are still only 2 practices now despite constant growth in the number of families living there.

Instead of waiting to see a GP, you can see a pharmacist quickly.

Patchy experience with GPs. Some GPs are good and some are complacent. GP technology e.g. appointment reminders via texts is good.

Weekend GP opening has been trialed but demand was low.

Problem is not with the actual GPs and their services, it's the frustration with appointments.

More now seeing their GP than in hospital, people living with long term illness.

If you have a condition, people prefer same GP for consistency.

People of Hartlepool would rather wait longer to see their own GP than use the One Life Centre or go to North Tees.

Feel rushed because GPs are so busy.

Could we have a code of conduct for all GP practices i.e. same response everywhere – provides confidence in the system.

3.3 NHS RESOURCES

The pressure on NHS resources was a concern for many these events. Pressure to provide 24/7 care with reduced budgets was seen as reaching a crisis point for some providers. Waste is a common issue in this theme. Comments include:

Discharge from the hospital can sometimes be made longer due to lack of resources.

Too ready to use ambulances – too much care can be sent to patients who do not need it – waste of resources.

More money is spent on hospitals here in the North East than anywhere else in England. This money then can't be spent on GP services or community services. Other areas spend a lot more on assessment etc.

Money is being wasted on transport.

We need to shift the people and the money out of hospital and into the community.

Need a feasibility study of cost savings on bringing day-to-day services back to Hartlepool.

The One life is a total waste of money, nothing more than a referral centre.

Lots of money is wasted in the voluntary sector.

The voluntary sector doesn't share information. People are let down by the voluntary sector. They waste time and money.

With there being a shortage of consultants we have to bring in locum consultants so it still costs money.

Opinion from the group – North Tees and Hartlepool NHS Foundation Trust wasted millions of pounds on the Wynyard project.

A lot of waste in prescription drugs.

Prescriptions - Issues were discussed around waste, difficulty in understanding the way certain meds are prescribed and reviewed.

Too much medication is wasted – could be much more efficient.

Look at the culture – NHS spending a lot on training and there are already counsellors who are trained that can't get jobs.

Variation in care form GPs – need to spend the money better.

3.4 POPULATION CHANGES

Adding to the pressure on NHS services were the population changes which were having an affect on certain services or areas. An ageing population with complex healthcare needs and the addition of a population with language and cultural challenges were seen as the two areas with the biggest impact on the local NHS service. Comments include:

Emerging communities in Middlesbrough have difficulty accessing services. Not asylum seekers who can access at Haven. Need to be aware of cultural sensitivities and how they understand the complex health system so they don't just go to A&E.

A number of immigration groups from Europe to Africa around Middlesbrough don't understand the system and haven't registered with the GP.

There is an aging population in Hartlepool and we need to make sure we are able to deliver the right services in the right place for the right people.

Many patients are older and have more complex needs – aging population

There is never a solution for the whole population.

Dementia needs to be a priority as we have an ageing population – Could the community and voluntary sector take this up?

Vulnerable groups such as those who are hearing impaired need to be considered, especially as numbers will grow in an aging population.

Foreign speaking patients can't use 111 – what happens to them?

Care for frail and elderly people not working well – resource is available but it's not accessed well.

Self-medication with technology works for some people, not the elderly.

Geriatrics – elderly care needs inputs from other specialists, but is a specialty in itself.

Personal choice – local knowledge important, depends on circumstances, would be a very different situation for an elderly person with mobility issues.

Broken wrist – local hospital/MIU – need facilities to diagnose and fix. If more complex e.g. for a frail elderly person then more support, including from social services would also be needed.

There are more elderly people – not enough geriatric specialist consultants and doctors.

A lot more families are not taking responsibility for their elderly relatives.

3.5 THE NHS 111 SERVICE

Attendees were critical of this service, particularly when considered as an alternative to attending A&E. There remains confusion around the circumstances defining the best use of the NHS 111 service. Comments include:

I wouldn't think of ringing 111. They find it difficult to deviate from the script. I don't trust the service.

One Life is a waste of space. People are told to stand outside and ring 111.

111 is a disaster.

111 need improvement to deal with mental health issues – the out of hours don't know how to deal with it and just send an ambulance when it doesn't need to be.

Stakeholder expectations – People expect '111' handlers to be medically trained.

111 work off a script. We need people on those phones that have knowledge.

111 is a good system which worked perfectly for one member of the group. Clinician rang quickly and the GP arrived quickly also.

111 isn't needed - money should be put into front line services instead.

111 has tried to stop the relentless tide to A&E.

111 has created unnecessary demand.

STAR service is available so people can see a GP out of normal working hours. 8am-8pm on weekends. Access via calling 111.

There is a lot of hearsay around NHS 111, not had experience themselves. Wouldn't call 111 in regards to mental health problems, they can't help.

Extra funding will allow system to be more joined up. All needs to be improved. More confidence needed in 111. We have to make it work.

111 is a stressful situation – trying to self-diagnose – not urgent enough.

3.6 MENTAL HEALTH ACCESS

Mental Health access and provision was mentioned by a number of attendees and dominated comments from one event were there were a few attendees. Comments include:

Delays in accessing support for mental health issues (counselling / talking therapies). Left to deal with condition at home with no support.

Social prescribing – access to database – mental health service would benefit.

People go to A&E as they feel they get referred to the necessary service faster than a GP could arrange (e.g. mental health providers).

JCUH parking – shocking also the travel is such a long way if you have mental health issues it's a lot to ask you to get 2 /3 busses when you are already anxious.

Mental Health isn't illustrated within the urgent care proposals very well. There aren't any urgent services for non-physical needs.

People in crisis that aren't classed as life threatening are slipping through the net.

Mental health isn't represented enough - as can be seen by the wider discussions form today's session.

As a counsellor, concerned at the gaps in service particularly around mental health.

Never seem to see own GP, difficulties with knowing history, frustrating having to go over the same things time and time again with different clinicians, particularly concerning mental health problems.

Current urgent care consultation - option to put GP at A&E will help enormously. Fully in support of proposals. Access to mental health crisis team is the weak link.

Massive gaps in mental health services. Voluntary sector are picking up the gaps, but services are not joined up. Are too many short term pots of funding and competition between providers leads to reluctance to work collaboratively.

Need to look at low level mental health intervention close to home, with more specialist services further afield, people would be happy to do this.

Services aren't joined up, particularly around long term conditions and mental health.

More focus on mental health and wellbeing, this in turn helps people to manage their physical health.

We need more work de-stigmatising mental health problems, and where to go to provide preventative help. Is there a way when advertising 'what service to access when' that mental health providers are incorporated in this.

3.7 STAFF SHORTAGES

There were comments about previous NHS experiences regarding staff shortages which resulted in a poor patient experience. Many comments were as much about perception as to first hand experience. Comments include:

Lead in time for doctors is 15 years, lead in time for therapists, nurses and paramedics 3-4 years

Not enough GPs at the moment and not enough consultants. 900 a year fewer nationally than is needed. It is difficult to attract doctors to the North East.

Government – more degrees now students loans 15 years till we get consultants trained.

Consultant being trained as specialists e.g. breast surgeons, whereas we used to have general surgeons.

How are we dealing with patients if there's a GP shortage?

With there being a shortage of consultants we have to bring in locum consultants so it still costs money.

Shortage of ambulances.

Staffing shortage hasn't just happened overnight.

There is a shortage of staff at NTH.

There seems to be a shortage of specialist nursing staff.

Shortage in nearly every speciality.

Massive shortage of doctors.

Not enough nurses being trained.

Not enough doctors and not enough nurses.

Not enough paramedics.

There are 4 hospitals in the area. Not enough doctors to man more than 2 across the whole patch.

There are more elderly people – not enough geriatric specialist consultants and doctors.

3.8 EMERGENCY SERVICES AND AMBULANCE RESPONSES

An ever-present concern, particularly in rural areas, ambulance response times were mentioned at several events. Comments include:

Knock on effect of BHP proposals on ambulance services.

Urgent care means we get a St Johns not proper ambulance.

You don't get the same outcomes if you attend hospital in an emergency at 4am on a Sunday as if you attend at 4pm on a week day.

Why can't A&E come to Hartlepool? 7 ambulances have been stood outside North Tees Hospital and staff are not available to book patients in to hospital.

Concern was raised around ambulance response times. Not possible to find out the figures just for Hartlepool.

Too easy to access emergency care when it isn't needed.

Ambulance service response times. We were waiting an hour recently for an emergency ambulance. (non-emergencies take 3 hours we we're told).

In West Yorkshire, you call out-of-hours and get an appointment to see a GP in a hospital – if its emergency, as least you're already in the hospital.

We're waiting for hours when it's urgent, not emergency, for St Johns.

My surgery doesn't treat emergencies.

What is an emergency? I had to lie to say my friend was unconscious, just so they'd send an ambulance when she feel down and broke her arm.

Ambulance crews should not take risks and take everyone to A&E

Transport and ambulance needs to be included in the model

Ambulances don't know the local area well enough. The service is not local enough. It has become too distant from Teesside and not enough local knowledge.

Daughter had brain haemorrhage. Ambulance arrived and it was rickety and old. 2 men were operating it and the daughter had to be walked to the ambulance in the rain when in extreme pain. Once at hospital the care was excellent as was the ongoing care.

Issues with the ambulance – delays with the ambulance arrival time, concern for other ambulance drivers coming from other areas not knowing the Dales area.

Would be happier to see services delivered from their GP surgeries, issues rose with DBC not sorting 'rural roads' for ambulances.

3.9 COMMUNICATION AND ENGAGEMENT

Prompted by the presentation questions, there were comments around the need to engage with a wider audience (particularly from attendees who thought the events were valuable). There were clear pleas to ensure the messages were clear, simple and honest and that changes were happening. Comments include:

A lot of care can take place out of the hospital and closer to home. Communicate better that you don't have to go to A&E for everything.

Say fairly bluntly, it's (BHP) going to happen.

Tell people straight – too much flim flam.

Continually let people know as by the time things like this have got to the media it seems like you have already decided what you want to do.

Use community champions for innovative solutions and to get message out.

Use local networks to raise awareness – VDAs, PCP.

Need to educate patients about self care/communication/use of IT.

There needs to be more communications on BHP and more conversations. Trusts need to improve on this too, though they are getting better.

Communication needed where should people go for services.

We need to make sure posters that are up are in date and relevant. Better communication for messages, keeping them simple.

These events aren't being advertised well enough. Incorrect details in the Evening Gazette. Need to find the balance of e-communications and other methods.

It needs to be communicated that people can't have everything on their doorstep – realistic expectations. People don't want to wait, even if they can.

It's hard for patients to consider what is a reliable source of information – credibility is so important, as is how it's disseminated.

What you could do better? Communication of different services – where people should go.

Communication everything together, rather the separate services.

We need one big campaign to advertise NHS correctly.

Sell in to NHS colleagues before public – patient groups etc.

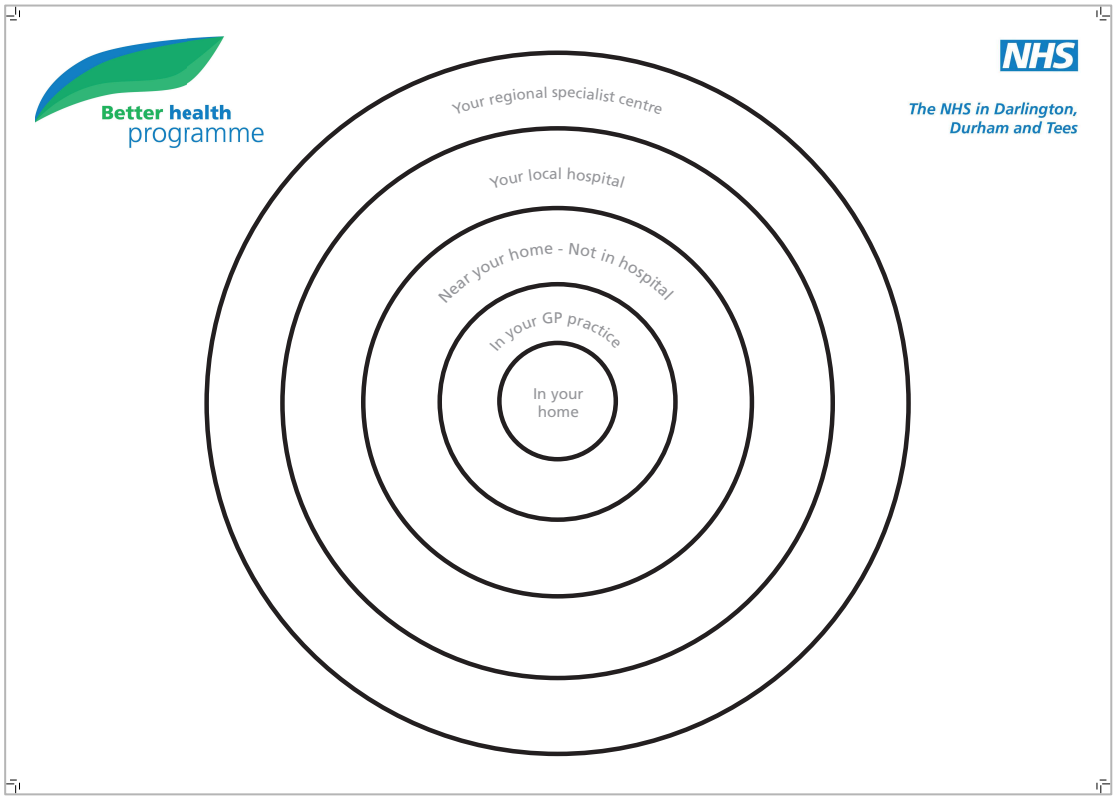
*We must just be open and honest. Tell the public now we need their help **not** when we are very far down the line and decisions have mostly been made.*

Not getting too hung up in the multimedia websites. Get out to GP hubs, community hospitals screens in surgery etc. Reference other local authorities.

4.0 Where should services be (concentric circles exercise)

To answer this question attendees were asked to write services on post-it notes and place them on the wall chart below. It created detailed discussion and was a useful engagement and participation tool supplying useful feedback from the attendees.

7 of the 12 events conducted this circles exercise.



4.1 Overview of the concentric circles exercise

Mental health care is mentioned in 4 out of 7 events and features in every concentric ring from in your home to your regional specialist centre and even comments that were placed outside of the rings. This prominence reflects the concern the attendees had for mental health care.

Travel and transport yields the most comments outside of the concentric rings, matching its high prominence as a theme throughout the 12 events.

368 comments were recorded in this exercise. Most comments placed services in the community, reflected in the following breakdown:

49% of comments referred to the inner 3 ‘not in hospital’ settings
20% of comments referred to the 2 outer ‘in hospital’ settings
31% of comments were placed outside of the rings altogether

Comments placed outside of the rings were non-setting specific about the wider issues surrounding travel and transport, communications, finance, integration and joined up care.

4.2 The results of the concentric circles exercise

Services in your home (15% of comments) - Common services mentioned included:

Tele-health
Telephone support
Skype
Community
District nurses
Community services
Mental health support
Dementia care
Rehabilitation
Physiotherapy
Social support
GP home visits

Attendees from all events were consistent in placing more community-based services in this section, provided good feedback on the value of technology in relieving pressure at GP practices and reducing or avoiding the need to travel for results etc.

Services in your GP practice (16% of comments) - Common services mentioned included:

Specialist nurses / Senior doctors / Consultants
Non-urgent test results relayed over phone or by GP
Injections/vaccinations
Weight/Smoking cessation
Screening/diagnostics
Blood tests
X-ray
Minor surgery
Patient education
Access for deaf patients
Physiotherapy
Mental Health support
Dementia

Attendees placed a lot of diagnostic, testing and assessment in this section. There was a theme of bringing some minor and routine hospital services (or the skilled staff) into the GP practice on a full or part-time basis to reduce the need to travel to hospital.

Services near your home - not in hospital (18% of comments) - Common services mentioned included:

Mental Health support
Triarge
Scans, screening and diagnostics
Elderly care
Dementia
Better use of pharmacies
Rehabilitation
Physiotherapy
Community hospital services

Again, attendees placed diagnostic, testing and assessment in this section as well as counseling, outpatient clinics and social care including voluntary sector support.

Your local hospital (8% of comments) - Common services mentioned included:

A&E
Urgent care
Maternity
Minor operations
Serious operations

Attendees placed mostly existing services in this section. This section yielded the lowest number of comments in the exercise.

Your regional specialist centre (12% of comments) - Common services mentioned included:

Cancer treatment
Heart treatment
Neurology
Specialisms
Children's care
Trauma
Surgery

Attendees placed the most urgent or specialist services in this section. Some attendees added that they expected to travel further for these services.

5.0 Event Evaluation

The 12 public engagement events were a worthwhile public engagement exercise with 168 attendees contributing to the exercise. Most attendee event feedback was positive and suggested the events were well ran, easy to get to (99% strongly agree/agree), provided enough background information (80%), allowed individuals to express their point of view (87%) and make sound judgments (78%) and were both informative and useful (86%). Additional comments ranged from more people need to know about these events to keeping discussions on track.

The Hartlepool event feedback was less positive as many attendees took the opportunity to express their views about the loss of A&E, their fears that University Hospital of Hartlepool would be the most likely to close in any consolidation programme and that residents are without the hospital services they deserve. There was less engagement with the wider BHP issues and some attendees claimed that their points of view had not been listened to fully.

Event details

Event 1 - 9th Feb 2016	**Chester-le-Street**	8 Attendees	Circles used: No
Event 2 - 11th Feb 2016	**Stanley**	4 Attendees	Circles used: No
Event 3 - 15th Feb 2016	**Durham**	2 Attendees	Circles used: Yes
Event 4 - 16th Feb 2016	**Hartlepool**	38 Attendees	Circles used: Yes
Event 5 - 18th Feb 2016	**Darlington**	30 Attendees	Circles used: No
Event 6 - 22nd Feb 2016	**Redcar**	21 Attendees	Circles used: Yes
Event 7 - 24th Feb 2016	**Billingham**	14 Attendees	Circles used: Yes
Event 8 - 25th Feb 2016	**Eston**	4 Attendees	Circles used: Yes
Event 9 - 26th Feb 2016	**North Ormesby**	14 Attendees	Circles used: Yes
Event 10 - 1st March 2016	**Barnard Castle**	14 Attendees	Circles used: No
Event 11 - 2nd March 2016	**Spennymoor**	9 Attendees	Circles used: No
Event 12 - 3rd March 2016	**Murton**	10 Attendees	Circles used: Yes

Feedback Sheets (All events)

The Venue	Number of responses	Strongly Agree	Agree	Disagree	Strongly Disagree
It was easy to get to the venue	124	93 (74%)	31 (25%)		
The venue was accessible	125	93 (74%)	32 (26%)		
The room was appropriate for this type of event	118	69 (55%)	39 (31%)	10 (8%)	

The presentations *Please tick how you felt about each*	Number of responses	Strongly Agree	Agree	Disagree	Strongly Disagree
The presentation contained enough background information	110	42 (34%)	57 (46%)	9 (7%)	2 (2%)
In the facilitated discussion I was able to express my point of view	115	70 (56%)	39 (31%)	2 (2%)	4 (3%)
I had enough information to make informed judgments during this engagement event	111	40 (32%)	58 (46%)	7 (6%)	6 (5%)

Overall	Number of responses	Strongly Agree	Agree	Disagree	Strongly Disagree
I found the event informative and useful	117	60 (48%)	47 (38%)	6 (5%)	4 (3%)
The event ran to time	109	58 (46%)	41 (33%)	7 (6%)	3 (2%)

6.0 Appendices

6.1 Concentric Circles Exercise comments

Where should these services be? Billingham (14 attendees)

In your home	In your GP practice	Near your home - Not in hospital	Your local hospital	Your regional specialist centre	Outside circles
Better use of telehealth	Specialist Practice nurses to see more people	Aging population – dementia needs	Hospitals to run care homes	People willing to travel for major illness or injury, specialist care (children etc)	Info on what transport services are available
Telephone emotional support	Charges for people who don't turn up for appointments	Mental health support	Lab tech working 24/7	Brain – ongoing specialist	Social services to play a part and provide 24/7 services
Babies born	Non-urgent results to be relayed to patients over phone or in GP practices	Triage	Longer term specialist care	Psychiatric hospital	More info about what is available where and when
Carers	More services provided in house	Speech and language therapy	More serious operations	Ultrasound	Voluntary sector and NHS
Telephone consultation	X-ray facilities	Physiotherapy	Carer's base	Neurology	Prevention so there's no need for hospital
Voluntary Mind and Sane	Early test for people who suspect dementia	Diabetes	Premature babies	Allergies	Vulnerable need more support
Crisis team	Home visits	Community hospital		Heart	Parking charges
Dementia age concern	Injections	Clinics on certain days		A&E	Transport and travel
Community nurse	Weight	Drug/alcohol support in the community		Major injuring	Cost of transport and travel
Psychiatric nurse	Smoking				Volunteers – support and transport
Rapid response team (just outside of hospital)	Specialist nursing e.g. Diabetic				
Patient self confidence and resilience	Screening				
Use and promote 111	Minor surgery (warts)				
Self care crucial – why go to A&E	Psychiatric nurses				
	Prevention				
	Elderly services				

Where should these services be? Eston (4 attendees)

No comments for your local hospital or your regional specialist centre

In your home	In your GP practice	Near your home - Not in hospital	Outside circles
Community services	Smears and breast checks should be local	Pediatrics – would travel if appropriate	Public need to buy into changes to make it a success
District nurses	More people rely on pharmacists	Maternity services	Agree the plans with the public
	Patient education – local GPs need to be accessible	Distance to travel clinically safe levels	Smoking, COPD etc. Care - prevention
	Hearing aid batteries from GPs or local village	Northallerton – would travel to meet patient choice	Use of VCS
			Use of social prescribing
			Cost of prescriptions
			Visual case studies for education
			Way to inform people
			Use health watch more
			Walk-in centres/ local hospitals can be intimidating
			Use of community hubs less clinical
			Redcar community network
			Access is from A-B, not about distance
			Walk-in centre patients know they will be seen
			Use social media more
			Technology could be abused
			Technology – children and young people, care home example
			Maternity – can't be one size fits all
			What does CCTH mean to public
			Transport costs
			Emotional and physical strain
			Access to the internet
			Use of 111
			Attitude of staff should be more caring
			Patient experience poor at JCUH – politeness costs nothing
			Access to GP for working people
			VCS resourcing them value for money
			Services working together e.g. Doctors/dentists offer transport together
			East Cleveland transport concerns
			Payment for transport
			Do more in primary care to prevent or reduce long term costs
			Target young people and school children to get info to their families
			Continuity in quality of services
			Need to raise levels of confidence outside of A&E
			Informing the public
			Never underestimate the general public
			Health champions of local groups
			Technology –assurance that it's safe and private
			Inform/educate to address skepticism
			Cost of over the counter medicines versus free prescriptions
			Social media targeted work on local services

Where should these services be? Hartlepool (38 attendees)

In your home	In your GP practice	Near your home - Not in hospital	Your local hospital	Your regional specialist centre	Outside circles
District community nursing	Better access for deaf patients i.e. 1) sms text appointment booking service 2) visual system for calling patients when it's their turn 3) flagging up when patient is deaf to ensure BSL interpreter is booked	Revolving door	Squeeze on social care (whole package)	Specific conditions which are uncommon or require specialist treatment	Travel and transport
GP practice	A&E	Social care provision and funding integration	Stroke unit	Public to be told what services are available where and when	Better home care will keep people out of hospital
Some minor ops	Senior Doctors	Join up GP and Out of Hours access to records	Maternity services	Don't make appointments for Hartlepool residents at North Tees before 9.30am to allow patients to get there via public transport	Cost effectiveness of transport
Home care		Modern 'step down' beds	A&E	Improve emergency access to services – 111, ambulance	Nurse training 'hands on'
Prevention		Community Nurses	Joined up IT		
Qualified nurses					

Where should these services be? North Ormesby (14 attendees)

In your home	In your GP practice	Near your home - Not in hospital	Your local hospital	Your regional specialist centre	Outside circles
Rehabilitation	Vaccination programmes	Elderly care support services	Outpatients	Gynae services	Needs to have infrastructure behind this –
Physiotherapy	Adult autism	Eye care	Maternity	Nuero services	Transport
After care	Cast removals	Third sector/ voluntary sector support	Occupational therapy	Cardiothorasic services	Accessibility
Social Support	Minor surgery	Minor skin surgery	Minor injuries	Surgical treatments	Staffing issues
Community district nursing	Counselling services	Screening services	Acute and complex	Specialist diagnostic testing	Nurse practitioners both in primary care and acute settings
Tele-medicine	Blood tests	X-rays	Children	Cardiology	Transport
Skype	Welfare rights	Speech and language therapies		Cancer-radiotherapy	Technology
Physiotherapy	Physiotherapy	Blood tests in leisure centres/ community halls/ church halls		Cancer-tumour specific surgical treatments	Communication and education needs to improve
District nursing working with carers	Care (HTSC?) package	Better use of pharmacies		Cancer-diagnostic and treatment planning in one centre to reduce variation	Improved integration especially with hospital discharge
Support home carers/ rehabilitation		IV antibiotics		Rare problems – How does that feed back into the rest of the service	Confidence needed across services
Chemotherapy		Social ongoing support/ peers		A&E – managing admissions/	Complexity of case helps decide where
Elderly		Scans in One Life		readmissions	Education public and in schools (self care)
IV antibiotics		Occupational therapy		Better use of specialist staff	Easy access to local services
Children		Mental health		Specialist care	Mental health support through the system
Voluntary sector		End of life			Holistic care – family focus
Crisis mental health		Mental health crisis/ rehabilitation			
Self care					

Where should these services be? Redcar (21 attendees)

In your home	In your GP practice	Near your home - Not in hospital	Your local hospital	Your regional specialist centre	Outside circles
Social care	Blood tests	Community acupuncture – Brotton	Friarage/ RPCH review	Heart transplant	Technology video call option
Physiotherapy	Relationship	Mental health ongoing support	Maternity	Would travel to London if necessary	Confidentiality
Primary care (Nurse sleep)	Diagnostic tests	Social care	Mental health	Rehabilitation	Community agents
Receiving results by phone or Skype	Shared skills and expertise	Chemotherapy in Redcar hospital	Dementia	Trauma	GPs don't refer often
GP practice	Urgent care	Waiting lists	A&E	RVI/ JCUH/ Freeman	Doctors first
Huge gaps in mental health	Weight management	Specialist centre and physical help	Broken bones	Dialysis	Communication – what is available for me
Services for long term mental health illness	Ambulatory blood pressure monitoring	Urgent care	Minor ops	Chemotherapy	Grass roots!
Self care	Ear irrigation	Rehabilitation	Rheumatology	Stroke	People need a credible source of information
Domiciliary care	Pre-op baseline assessment (excluding assessment of anesthetic or surgical risk)	Step down beds/step up beds	Endoscopy locally	Cardiotherapy	Mental health – the funding runs out
District nursing services	Consultants come to practices – great for patients, upskills GPs and improves comms between primary and secondary care	Maternity		Cancer	Poor information for mental health in GP practices
Physiotherapy	Dementia	Dementia		Intervention	Knowing where to go
Mental health	Mental health	Mental health		Mental health	Short term contracts – no sooner here then gone
Maternity	Maternity	Outpatient clinics		Maternity	Resilience
Dementia	Physio	Consultant clinics		Dementia	Advocacy
	Minor surgery follow ups	Scans, diagnostics and x-rays		Cardiac	Joined up care
		Blood tests		Spinal unit	Patient choice – e.g. Maternity
				Intensive care	Depends on needs where services are provided
					Funding and joint working
					Mental health
					Maternity
					Dementia

Where should these services be? Murton (10 attendees)

In your home	In your GP practice	Near your home - Not in hospital	Your local hospital	Your regional specialist centre	Outside circles
GP consultation – Skype etc	Advertising services/sign posting/publicity	Physiotherapy			Capacity
All primary care services – practice nurses	Reception – better assessments	Counselling			Waiting
Text, phone, IT, carer app, TV, radio	Diabetes	Mental health support			Travel costs
	Citizens advice/debt	Scans and x-ray			Transport
	Mental health services	Vascular services			Voluntary sector
	Mental health and learning difficulty patients able to access mainstream services	Sustainable care closer to home			Develop transport scheme
	Minority groups – services more accessible	Lymphoedema services			Support carers
	Community services/PC services more integrated	Community hubs			Holistic approach including housing
	More screening available	Housing – voluntary sector			Integration
	Mental health specialists within GP practices	Bereavement services			Embed in patient pathways
	More diagnostic tests available	Peer support groups from the voluntary sector			Better use of sign posting
	Consultant test results – saves on travel to and from consultants				Communication and education about what services are available
					Information is hard to navigate
					Keeping resources up to date
					Knowledge sharing
					Directory of services
					Multi-agency

Where should these services be? Durham (2 attendees)

In your home	In your GP practice	Near your home - Not in hospital	Your local hospital	Your regional specialist centre	Outside circles
GP home visits	NHS choices	Community pharmacy	Urgent care centre	Three operations for Chrohns at Dryburn. First UHND	Reputation
Local surgery and local pharmacy		Dentists	A&E		Phone 111 or 999 – don't just go
		Primary care centres	Chrohns emergency – phoned 111 they booked appointment at Peterlee walk in centre – excellent		Availability of transport
		Community pharmacy to take pressure off A&E	Peterlee first Chrohns operation Hartlepool 1990		In old days you rang your Dr
		Health promotion			If you are short of money what do you do?
		111			Travel vs time
		Local walk in centre			Limitations around services available on a Saturday
					20 a year not 2 a year
					Minor ailment scheme
					How do you know it's an emergency?

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Independent Analysis of the PHASE 2 Public Engagement Events (May 2016) for the Better Health Programme

Proportion Marketing June 2016

Contents

1.0 Introduction

A series of 12 Phase 1 Better Health Programme (BHP) public engagement events ran by the NHS in Darlington, Durham and Tees were held between February and March 2016. This was followed in April and May 2016 by the Phase 2 Better Health Programme public engagement events.

This BHP Phase 2 public engagement feedback analysis has drawn on the scribe notes, comment cards, evaluation forms, verbal comments and email comments from a stakeholder forum event (held in Newton Aycliffe on the 4th May 2016 - attendance 119) and 17 public engagement events (held between the 7th and 31st May 2016 - total attendance 278).

The events included a presentation describing the framework of the Better Health Programme, attendees were asked the following questions to prompt a dialogue:

*1. Do you support the **principles of care** as a reasonable direction of travel?*

*2. Do you support the **draft framework of care** as a reasonable direction of travel?*

*3. Any ideas or questions you have to enhance the **draft framework of care** or issues raised?*

4. What are your priorities for improving care for patients and for decision-making criteria?

*5. (Darlington Public Events only) What are your thoughts about the **blueprint** for **primary care** and **healthy town proposal**?*

6. Any other comments/suggestions?

Feedback was recorded by scribes at each table and has been independently analysed by Proportion Marketing Limited for this report. As they are scribe notes and not comments/positions assigned to individual attendees it is not possible to quantify support or opposition to ideas, but counting comments and grouping them into themes does provide a sense of the main issues raised by the attendees that should inform BHP decision-making.

2.0 Executive summary

The Phase 2 public engagement events proved successful in highlighting a number of issues that the Better Health Programme should feed into its processes.

2.1 Feedback prompted by the following questions

1. Do you support the **principles of care** as a reasonable direction of travel?
2. Do you support the **draft framework of care** as a reasonable direction of travel?
3. Any ideas or questions you have to enhance the **draft framework of care** or issues raised?

The attendees at the Stakeholder Forum event expressed broad support for both the principles of care and the framework of care. Attendees largely understood the value of specialisation and the benefits of care closer to home and largely agreed with the framework of care in theory.

Many attendees at the Stakeholder Forum work in the healthcare industry and commented on and raised questions around specific services and revealed an insider perspective to the strategic issues around the Better Health Programme.

Some expressed support conditional on vital elements being successfully put in place first such as (listed by most comments):

- social care integration
- more detail on the model of care
- a patient information sharing system
- the role of and access to GPs in the process, and
- comprehensive and clear communication to patients about what services are where.

The attendees at the Public Engagement events, to a lesser extent, also agreed with the attendees Stakeholder Forum event in their support for both the principles of care and the framework of care.

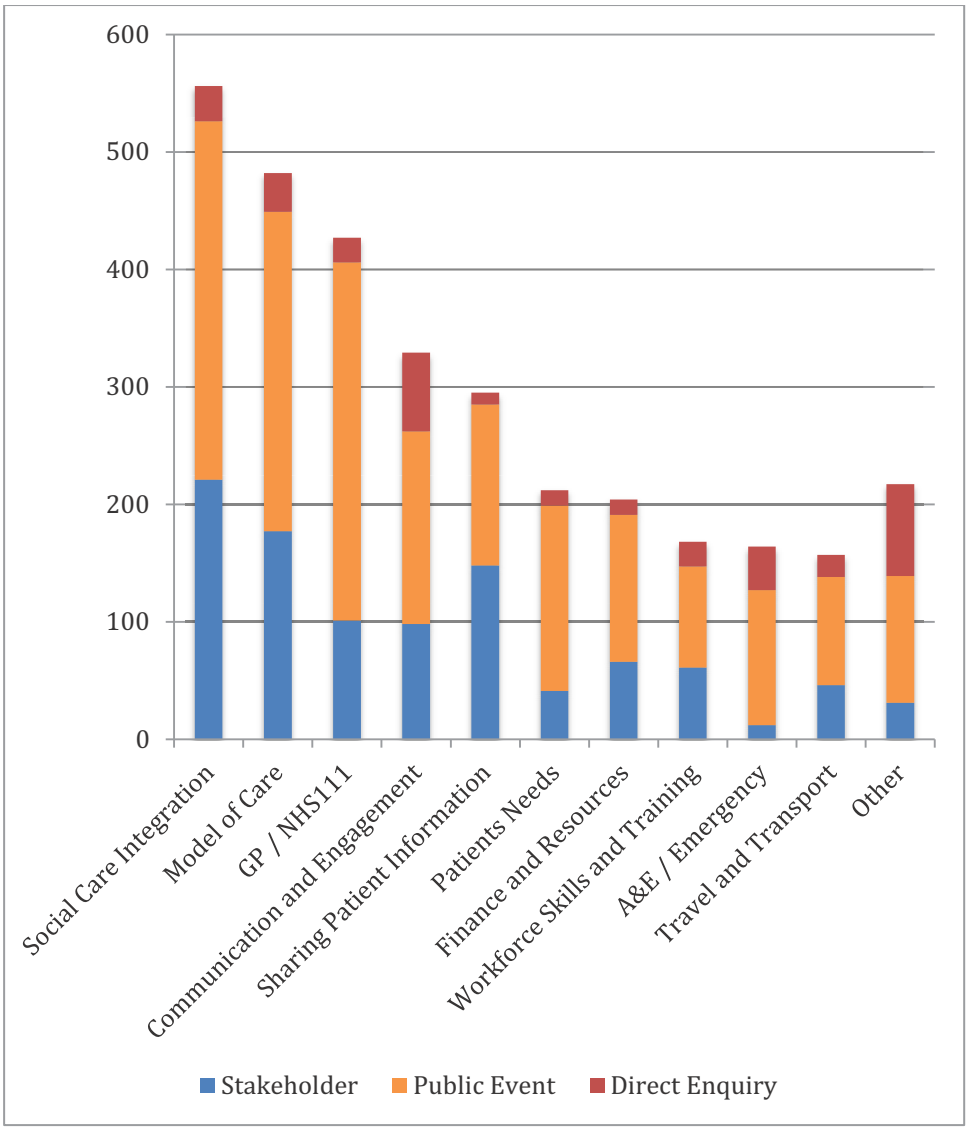
Their views were from a public perspective rather than a healthcare industry perspective. The main issues (listed by most comments) from these events were around:

- the role of and access to GPs

- social care integration
- more detail on the model of care
- communication and engagement, and
- individual patient needs.

The Darlington Public Engagement events expressed less support for both the BHP principles of care and the framework of care as the dialogue was dominated by a concern that Darlington Memorial Hospital (DMH) could lose its A&E department. Opposition in the Darlington events to the BHP direction of travel was clearly stated if it meant losing A&E at DMH.

The table below summarises the 10 key themes raised in Phase 2 (measured by comments) from all attendees and respondents from the Stakeholder Forum, the 17 public events and from individual direct enquiries.



The **Social Care Integration** theme generates the most comments (17% of all comments) around the need to successfully integrate community services, care at home, the role of the voluntary sector and admission and discharge for the BHP programme to work.

The **Model of Care** theme (15%) covered comments about the benefits of using hospitals for specialised services and queries about scenarios around the Model of Care.

The **GP / NHS111** theme (13%) theme covered comments about the importance of the role of GPs and GP access to the BHP programme and the relative merits, weaknesses and opportunities of the NHS111 system.

The fourth **Communication and Engagement** theme (10%) covered comments about the importance communicating to the public about specific changes to specific services, the need to improve signposting amongst healthcare professionals, the need to fully consult with the NHS workforce, the need to educate the public (self care) and the need for service deliverers to promote confidence in the BHP programme to staff and public.

The **Sharing Patient Information** theme (9%) covered comments about whole system unified IT and documentation systems, the uses of IT and technology and the healthcare professionals networking opportunities and their importance in delivering the BHP programme.

The remaining themes included **Patient Needs** (7%), **Finance and Resource** (6%), **Workforce, Skills and Training** (5%), **A&E and Emergency** theme (5%) and **Travel & Transport** (5%).

2.2 Feedback prompted by the following questions

4. What are your priorities for improving care for patients and for decision-making criteria?
6. Any other comments/suggestions?

The comments raised by Q4 were largely related to addressing the concerns raised in the principles of care and framework of care questions listed in 2.1 i.e.

- social care integration
- a patient information sharing system
- the role of and access to GPs in the process,
- clear communication to patients about what services are where, and
- individual patient needs.

The comments raised by Q6 gave respondents a chance to reinforce their concerns on the issues raised previously, which they did in the majority, and also to comment on issues not included in the presentation thus far. Many took the opportunity to raise concerns over A&E at DMH, the sustainability of the BHP programme, to suggest it was a fait accompli or to comment on the presentation content. Positive comments reinforced the direction of travel, the quality of local urgent care consultations and suggestions of how patient groups could support each other.

2.3 Feedback prompted by the following question

5. (Darlington Public Events only) What are your thoughts about the **blueprint** for **primary care** and **healthy town proposal**?

This was asked at the two Darlington events only. There was a mixed response to this question – at lot of positivity about the theory making sense and how exciting it is as a concept but some questions around the reality – its sustainability, the lack of detail, whether it meets Darlington's needs, the political context, the complexity of the presentation, what GPs think of the idea and GPs potential new roles.

2.4 Summary

The majority of attendees from all events broadly agreed in the direction of travel of the BHP programme but were keen to see a clear definition of specialist services that would be made known to the public. There was wide acknowledgement of the benefits of specialisation and the prospect of increased travel but there is some scepticism and untested conditional support of the programme at this early stage as detailed scenarios were not presented.

3.0 Main Findings

Attendees from all events did raise suggestions, concerns and questions about the detail and the practicalities of the Better Health Programme as a whole.

3.1 Suggestions deemed critical to success

Attendees raised a number of issues during the events that they deemed for critical to the success of the Better Health Programme. Some of these issues are listed below:

- Strong leadership and collaboration
- Clear and honest communication & engagement
- Social care integration
- Partnerships pulling together, not competing
- Clear signposting of new system
- Shared patient records / technology / unified IT & documentation
- Stakeholder confidence in new system
- Quality assurance of new system
- Whole-system overview
- Patient-centric thinking
- Win hearts and minds of public
- Use Hartlepool A&E closure and Stroke at Durham as examples of service change
- Account for new houses being built in Darlington, growing population
- Public acceptance that not all hospitals are the same
- Truly reflect local need.

3.2 Areas of concern

Attendees raised a number of concerns about the Better Health Programme. Some of these concerns are listed below:

- Losing A&E at Darlington Memorial Hospital (Darlington event)
- Travel & transport
- Community care provision
- Rapid emergency treatment
- Ambulance service
- Resources and funding
- Public behavior / education / prevention
- Voluntary sector role

- GP access
- Privatisation
- Discharge arrangements
- Mental health
- Lack of skilled staff
- Lack of detail in the presentation
- Current state of A&E
- NHS111
- Fait accompli
- Workforce morale / stress / resource
- Vulnerable groups excluded from model
- Model is excessively optimistic
- Propaganda
- Keeping services local
- Presentation too difficult for public to understand.

3.3 FAQs

Attendees raised a number of questions about the Better Health Programme. Some of these questions are listed below:

Raised under Principles of Care section

- Where is the evidence this will work or is achievable?
- What about the impact on patient/visitor travel?
- What about the impact on the elderly?
- What role will the voluntary sector play?
- Will BHP be totally honest in its communication about the full impact of the programme?
- Who decides when the patient needs to go to hospital?
- Will this be patient and not service focused?
- Is there funding in the right places to support this programme?
- Will new technologies be part of the solution?
- Are the relevant support services available when patients are discharged?
- Can fewer A&E's cope with the additional burden?
- Will patients with multiple healthcare needs be treated simultaneously?
- Isn't much of this already happening?
- What happens to patients who are yet to be properly diagnosed?
- What does community mean – location, clinical response?

- Can community services cope with the additional burden?
- What will this actually look like?
- Is there full trust and confidence from all clinical and healthcare partners in this programme?
- What about the Golden Hour – stroke and heart?

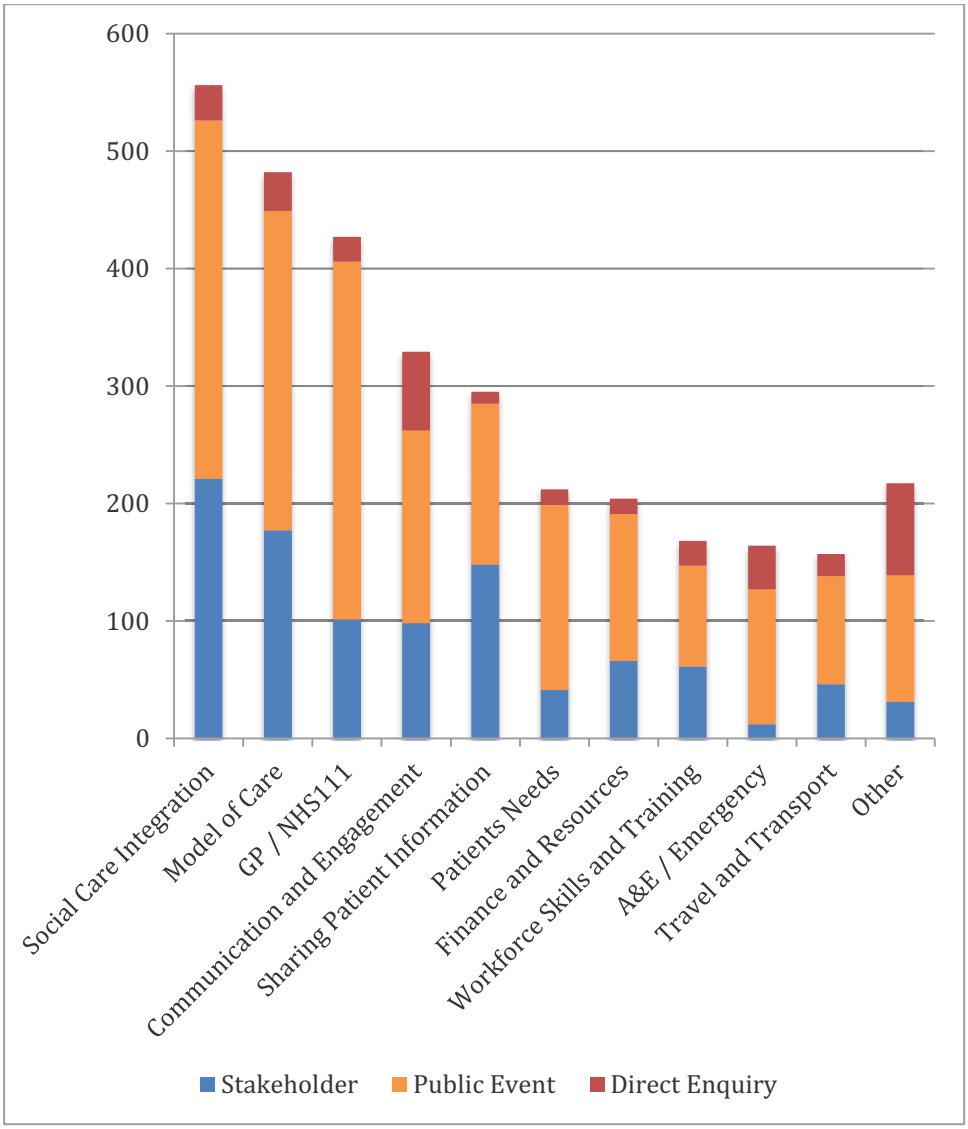
Raised under Framework of Care section

- How does mental health fit in?
- How does social care fit in?
- Is there a clear patient pathway infrastructure from access to discharge and social care?
- Define specialist services and where exactly will they be located?
- Are GP, community and voluntary services collaborating fully in this programme?
- Have you considered the inequitable access to GPs?
- Will there be unified documentation and a single IT system across all services?
- Will patient choice be affected by these changes?
- Who will ultimately be responsible for this joined up system?
- Who can assure us that an integrated approach could work?
- Does the system recommend better use of technology?
- How will you ensure patient data will be shared to ensure a joined up care plan?
- Could we see worked examples to clarify and apply the principles?
- Where are A&E and Trauma going to be located?
- Where are the doctors and nurses coming from?
- What is the timescale for the project?
- Would DMH continue to deliver planned care?

3.4 Analysing the comments and grouping into themes

There were 3,211 comments recorded in the Phase 2 Engagement Programme.

3.4.1 Total Comment Themes (stacked)



The above table groups comments together from the Stakeholder Forum, the 17 public events and from individual direct enquiries.

The **Social Care Integration** theme generates the most comments (556 or 17% of all comments). This theme covered comments about the need to successfully integrate community services, care at home, the role of the voluntary sector and admission and discharge for the BHP programme to work.

The second largest number of comments were around the **Model of Care** theme (482 or 15%). This theme covered comments about the benefits of using hospitals for specialised services and queries about scenarios around the Model of Care.

The third largest number of comments were around the **GP / NHS111** theme (427 or 13%). This theme covered comments about the importance of the role of GPs and GP access to the BHP programme and the relative merits, weaknesses and opportunities of the NHS111 system.

The fourth largest number of comments were around the **Communication and Engagement** theme (329 or 10%). This theme covered comments about the importance communicating to the public about specific changes to specific services, the need to improve signposting amongst healthcare professionals, the need to fully consult with the NHS workforce, the need to educate the public (self care) and the need for service deliverers to promote confidence in the BHP programme to staff and public.

The fifth largest number of comments were around the **Sharing Patient Information** theme (295 or 9%). This theme covered comments about whole system unified IT and documentation systems, the uses of IT and technology and the healthcare professionals networking opportunities and their importance in delivering the BHP programme.

The next largest number of comments were around the **Patient Needs** theme (212 or 7%). This theme covered comments about how individual services would fit into the new BHP programme and the impact it would have on patients' needs.

The next largest number of comments were around the **Finance and Resource** theme (204 or 6%). This theme covered comments about the need to properly fund the BHP programme, the extended GP role and the reliance on funding for Voluntary sector involvement.

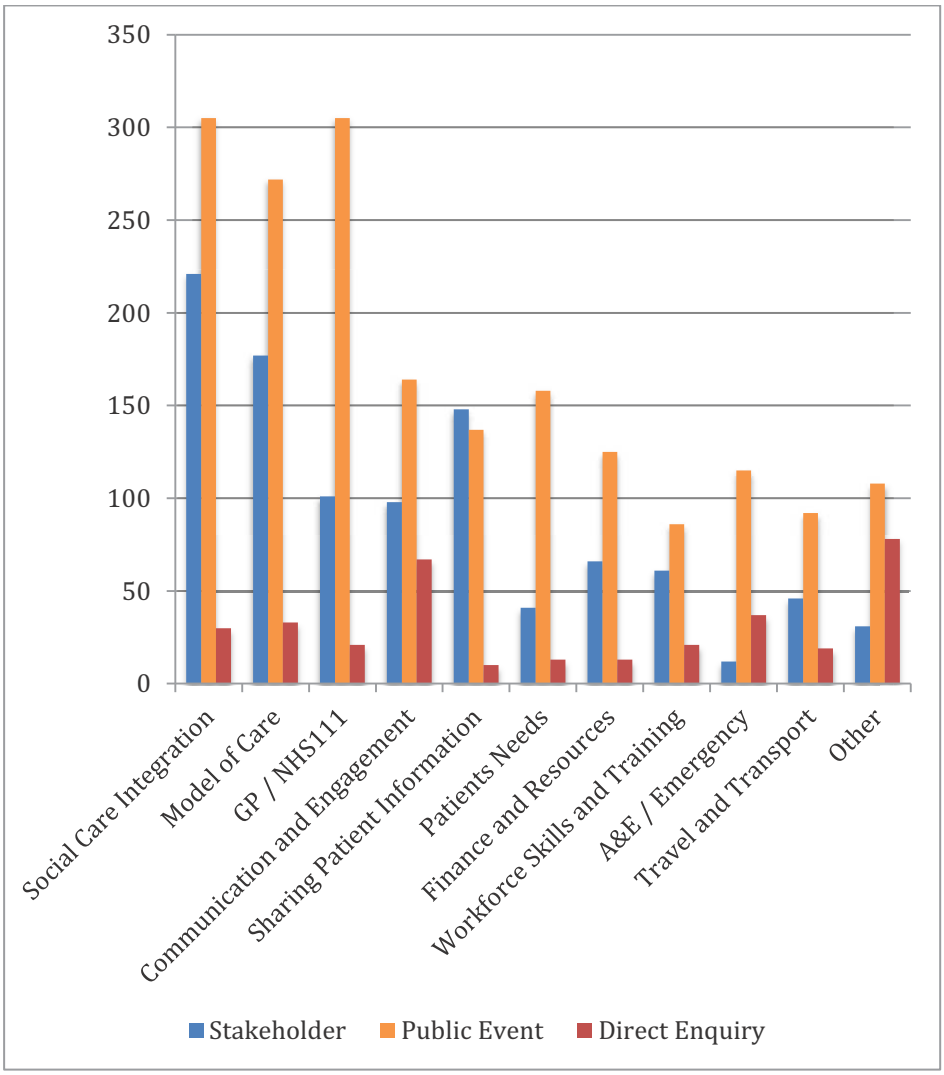
The next largest number of comments were around the **Workforce, Skills and Training** theme (168 or 5%). This theme covered comments about the need to address the shortage of doctors and nurses and to provide healthcare staff with the skills and training required to understand, support, collaborate, network and deliver the new Model of Care.

The next largest number of comments were around the **A&E and Emergency** theme (164 or 5%). This theme covered comments about the perceived loss of A&E services at Darlington Memorial Hospital and about the improvements to Emergency care (and reduction in pressure on Emergency services) that was anticipated as a result of delivering the BHP programme.

The next largest number of comments were around the **Travel & Transport** theme (157 or 5%). This theme covered comments about the need to consider travel times in the BHP programme, concerns about travel times as a result of the perceived loss of A&E services at Darlington Memorial Hospital and comments around the difficulties and cost of travel (particularly rural, elderly or low-income patients) and the cost of car parking.

All remaining comments were classified as **Other** (217 or 7%). These covered a diverse range of issues such as where mental health/maternity/dementia/elderly care services fitted into the new Model of Care; comments on the relationship with and the performance of the Ambulance service; suggestions for the role of pharmacies and positive and negative comments on the presentation in the public engagement events.

3.4.2 Total Comment Themes (clustered)



Splitting by source of comments (Stakeholder Forum, Public Event or Direct Enquiry) reveals the key areas of comments and concerns from individuals.

Stakeholder Forum comments

Theme	Count	Percentage
Social Care Integration	221	22
Model of Care	177	18
Sharing Patient Information	148	15
GP / NHS111	101	10
Communication and Engagement	98	10
Finance and Resources	66	7
Workforce, Skills and Training	61	6
Travel and Transport	46	5
Patients Needs	41	4
Other	31	3
A&E / Emergency	12	1

Social Care Integration (22%) attracted the most comments at the Stakeholder Forum. Much support for the BHP programme was linked to ensuring that it successfully integrated community services, care at home, the role of the voluntary sector and admission and discharge policies.

Model of Care (18%) was the second most common theme, followed by the imperative to solve the challenge of efficient and effective **patient information sharing** (15%). Comments around the **A&E / Emergency** theme were the least common (1%), followed by **Patient Needs** (4%) and **Travel and Transport** (5%).

Public Event comments

Theme	Count	Percentage
Social Care Integration	305	16
GP / NHS111	305	16
Model of Care	272	15
Communication and Engagement	164	9
Patients Needs	158	8
Sharing Patient Information	137	7
Finance and Resources	125	7
A&E / Emergency	115	6
Other	108	6
Travel and Transport	92	5
Workforce, Skills and Training	86	5

Social Care Integration attracted 16% of comments at the Public Events. Again, much support for the BHP programme was linked to ensuring that it successfully integrated community services, care at home, the role of the voluntary sector and admission and discharge policies.

GP / NHS111 also attracted 16% of the comments at the Public Events. Comments around the **Workforce, Skills and Training** and the **Travel and Transport** themes were the least common (both 5%), followed by **A&E / Emergency** (6%) although this was a major theme at the Darlington events.

Direct Enquiries comments

Theme	Count	Percentage
Other	78	23
Communication and Engagement	67	20
A&E / Emergency	37	11
Model of Care	33	10
Social Care Integration	30	9
GP / NHS111	21	6
Workforce Skills and Training	21	6
Travel and Transport	19	6
Patients Needs	13	4
Finance and Resources	13	4
Sharing Patient Information	10	3

Communication and Engagement (20%) attracted the most Direct Enquiry comments. Attendees were most concerned that the public needed to be aware of the BHP programme and that the changes were clearly communicated and signposted consistently amongst healthcare professionals. The second largest theme was **A&E / Emergency** (11%) where many Darlington attendees reinforced the views at the public events via the Direct Enquiry route, followed by the **Model of Care** theme (10%). Of least concern to those making Direct Enquiries collectively made up the **Other** theme (23%) followed by Sharing Patient Information (3%), **Finance and Resources** and **Patient Needs** (both 4%).

All Themes (Ranked by number of comments)

Theme	Stakeholder Forum	Public Events	Direct Enquiries
Social Care Integration	1	1	5
Model of Care	2	3	4
Sharing Patient Information	3	6	11
GP / NHS111	4	2	6
Communication and Engagement	5	4	2
Finance and Resources	6	7	10
Workforce, Skills and Training	7	11	7
Travel and Transport	8	10	8
Patients Needs	9	5	9
Other	10	9	1
A&E / Emergency	11	8	3

Social Care Integration was most prominent in both stakeholder and public events and the **Model of Care** also ranked highly in both events. Stakeholders raised more comments on **Sharing Patient Information** and **Workforce, Skills and Training** than their public counterparts. The public raised more comments **about GP / NHS111** and individual **patient needs** than their stakeholder counterparts.

4.0 Appendices

4.1 Principles of Care

1. Care delivered through a **network of hospitals and community** services
2. More seamless care **close to or in the patient's home** where safe and effective, access to urgent and community care 24/7
3. Patients only admitted to hospital **where it is no longer safe or effective for them to be cared for in the community**
4. Access to **specialist opinion 24/7** where this improves outcome, e.g. heart attack, stroke, trauma, or internal bleeding
5. Planned care organised so there is **no unnecessary waiting, no cancellations** and patients not exposed to risk of infections

4.2 Framework of Care

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Better Health Programme – a framework for the future

Introduction

The Better Health programme is about how the NHS in Darlington, Durham and Tees can improve outcomes and experience for patients when they need care, especially in an emergency.

The programme is being led by senior consultants from all of our hospitals and GPs across the area because of their ambition to offer the highest standards of emergency care and making sure there is access to a permanent senior clinical workforce around the clock.

The programme is likely to result in significant changes to improve the way services are provided to patients, and to enable our staff to work more effectively.

We want to share with you some of the reasons why change will be better for patients and the public, and to seek your views in helping us develop the way ahead, particularly on the sections marked “YOUR VIEWS”.

Dr Boleslaw Posmyk, General Practitioner, BHP Clinical Lead

Mr Derek Cruickshank, Consultant Gynaecologist, BHP Clinical Lead, In Hospital

Dr Neil O’Brien, General Practitioner, BHP Clinical Lead, Not in Hospital

Our changing needs

We are living longer and have different conditions and health needs: dementia, obesity and cancer, as well as alcohol-related disease, have become major challenges.

More of us will have one or more long-term health conditions, especially as we get older and frailer and need support and management, sometimes for many years.

In the past, much of the care offered by the NHS was in hospital. Caring for long term conditions needs a different approach, with more community based support and services provided by the NHS and social care partners.

Where patients need to be admitted to hospital, they often require care from a range of professionals with specialist skills.

Providing better treatment

In the past, most hospitals could offer people the best treatment available at the time for most conditions. However, clinical practice has taken great strides forward in the last four decades.

As healthcare is becoming increasingly specialised it is becoming more difficult to have that level of expertise available in every hospital for every service.

This is partly due to specialist skills being in short supply and the need to make the best use of this highly specialist resource. But it is also by seeing large numbers of patients with similar conditions that specialist staff can maintain and develop these skills.

The medical evidence shows that where patients are admitted to specialist centres with staff seeing a high volume of patients with similar problems, and meeting high clinical standards, the outcomes for patients are much improved.

Forty years ago, heart attacks were treated with bed rest. The survival rate was about 75 per cent. Today, as a result of advances in medical science, we now mechanically unblock the artery which was causing the heart attack. This treatment has seen survival rates increase to 95 per cent. But this improvement has required very expensive diagnostic equipment and cardiologists with special skills.

The treatment of strokes has also evolved. Effective treatment requires rapid transfer to a highly specialised unit with expensive diagnostic scanners and clinical expertise so that drugs can be given to minimise the brain damage that occurs.

This highly effective, advanced treatment of serious heart attacks and strokes cannot be provided by every hospital

The recent national reorganisation of major trauma services which resulted in the designation of 25 major trauma centres has produced, in its first year, a 20%

increase in survival despite increased travel time for patients who now bypass A&Es that previously treated only a handful of these very serious and complicated cases.

Our clinicians believe there are other patients who would benefit from treatment in a specialist environment, where there is senior staff on duty seven days a week in the emergency departments, medicine, maternity, neonatal intensive care gynaecology, paediatrics, emergency surgery, orthopaedics and intensive care, supported by diagnostic services (Radiology, Laboratory and Endoscopy) and therapists and social care.

Despite these developments, there are still patients who are being admitted to hospital as emergencies unnecessarily, because there is not an alternative NHS service available in the community.

Implementing the national vision

The national vision, which we want to implement locally, is:

- To provide highly responsive, effective and personalised services outside of hospital for people with urgent but non-life threatening needs These should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families

- To make sure people with more serious or life threatening emergency needs are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.

- To provide planned care in an environment, separate from emergency care, which avoids unnecessary delays and cancellations.

This national vision has been developed by engaging with the Royal Colleges, front line clinical staff, and with patients and the public.

As part of the Better Health programme, around 100 experienced clinical staff from the local NHS – including hospital consultants and GPs - have been looking at how we implement this vision locally.

Improving standards of care

They have identified 700 standards developed by the Medical Royal Colleges and other organisations which could improve care.

These standards primarily relate to availability of senior staff across seven days to assess, treat and review patients, including availability of diagnostic tests. Our local services meet around two thirds of these, but the last third cannot be achieved without changing the way we deliver care.

This means that, at the moment, we are not currently delivering access to specialist services for everyone 7 days a week, and where appropriate 24 hours a day. This means that currently patients experience variation in quality of care, depending on where and when they are treated.

Principles for the future – YOUR VIEWS

These 100 clinicians have therefore devised an ambitious draft framework for how care should be provided in the future.

They now want to share this with patients and staff to seek their views on how this could be developed to provide all of our patients with the best care and the best experience, and the best outcomes in the future.

- Care should be delivered through a network of hospitals and community services
- More seamless care should be provided close to or in the patient's home where safe and effective, with access to urgent and community care 24/7
- Patients should only be admitted to hospital where it is no longer safe or effective for them to be cared for in the community
- There should be access to specialist opinion 24/7 where this improves outcome, for example, heart attacks, stroke, trauma, or internal bleeding
- Planned care should be organised so that there is no unnecessary waiting, no cancellations and patients are not exposed to risk of infections

Our clinicians have been clear that the Better Health programme is about quality and improving standards of care.

If supported, however, the framework of care would have to be implemented within our current financial resources. Although additional investment is being made available to the NHS, costs are also increasing and efficiency savings are required. Every pound we spend must offer value to patients by making sure that the services we provide are effective from a clinical as well as a financial point of view.

Education and training

Training for healthcare staff is a vital part of the role of our health services.

Offering outstanding training and development opportunities to staff, helps them develop their specialist skills to support our services, but also encourages recruitment and retention of committed staff.

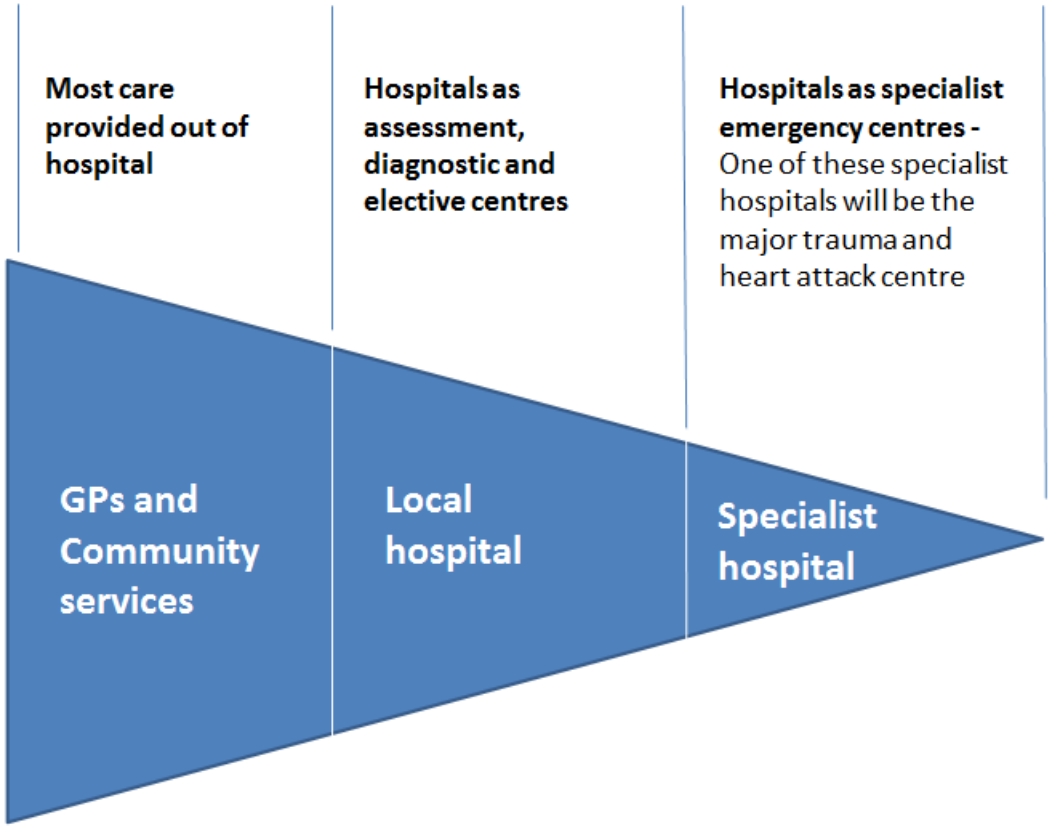
Our clinicians want to make sure that clinical placements for medical trainees exceed the requirements of the new junior doctors' contract, ensuring training remains a high priority.

All junior trainees' work would be supervised and care delivered by trainees would be overseen by a designated supervisor. This will ensure Darlington, Durham and Tees is a place of excellence for training so that, post qualification, this is an area of the health service where doctors and surgeons will want to develop their careers.

The right care in the right place – YOUR VIEWS

When we met with patients earlier this year, they told us about services they believed could be available closer to home, but they also recognised that, for some services, it is better to go to a specialist centre to get the best care. The public recognised how technology can make a positive contribution to more care provided locally, faster access to care and better outcomes by sharing appropriate information. Better access to primary care was encouraged.

Our clinicians are trying to balance these priorities in a draft framework of care on which they would like to hear the views of patients and staff:



- **More care provided out of hospital**

More care could be provided outside of hospital, and as close to the patient's home as possible.

There should be a clear single point of access to healthcare for the public by an improved NHS 111 service so that all patients can be assessed urgently by a skilled health professional.

GPs should focus on patients with complex needs and several long term conditions, supported by a wider range of community services.

An increasing amount of care could be available and provided in patients' homes. This could be treatment such as intravenous medicines including antibiotics.

By maximising use of technology, we could reduce unnecessary trips to hospital for appointments, improving waiting times, and reducing time spent between diagnostic tests and treatment

This would improve the patient experience as fewer patients would require emergency admission to hospital or if admitted, would return home quicker.

Each hospital would have a different range of services, depending on local needs

- **Hospitals as assessment, diagnostic and elective centres**

All hospitals would provide diagnostic facilities and treatment for patients in their areas. This will help avoid many unnecessary admissions. Planned care should be organised so that there is no unnecessary waiting, no cancellations and patients are not exposed to risk of infections. Services may also include rehabilitation. They would work closely with GP's and community services to ensure that as much care as possible is provided in patients' homes or close to their homes. Urgent care centres which may be situated in hospitals or in the community would manage patients with illnesses and injuries that do not require hospital admission. They would be staffed by doctors, other health professionals or both.

- **Hospitals as specialist emergency centres**

Some hospitals may in addition be "specialist" hospitals that could provide emergency and planned care for adults and children who require admission. The staffing and facilities of these hospitals could be designed to deliver better outcomes. This would ensure that seven days a week there are senior staff on duty in the emergency departments, medicine, maternity, gynaecology, paediatrics, emergency surgery, orthopaedics and intensive care. They would be supported by the diagnostic services (Radiology, Laboratory and Endoscopy) and therapists. This would ensure that these specialist hospitals meet all ambitious clinical standards for healthcare.

One of these specialist hospitals would be the major trauma and heart attack centre. It would have the facilities and staffing of the other specialist hospitals. In addition it

would be able to manage patients who have had heart attacks and major trauma and are taken there directly by the ambulance service.

YOUR VIEWS

We want to seek your views to help us in developing the way ahead. We have indicated two areas in particular where we would like you to share your thoughts on the draft framework of care.

We would like you to tell us:

- Do you support the principles of care as a reasonable direction of travel?
- Do you support the draft framework of care as a reasonable direction of travel?
- Any ideas or questions you have to enhance the draft framework for care, or issues raised?
- What are your priorities for improving care for patients and for decision making criteria?
- Any other comments/suggestions?

We can then use your feedback to help us develop the decision making criteria and the scenarios for how care could be provided in the future. The next phase of engagement is being planned for during June/July.

There are a variety of ways to share your views and these are:

Email: necsu.betterhealthprogramme@nhs.net

Twitter: www.twitter.com/NHSBetterHealth
Facebook: www.facebook.com/nhsbetterhealthprogramme

For more information about the Better Health Programme:
www.nhsbetterhealth.org.uk

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The Better Health programme is about how the NHS in Darlington, Durham and Tees can improve care for patients, especially in an emergency.

In the past, most hospitals could offer people the best treatment available at the time for most conditions. However, health care has taken great strides forward in the last four decades.

The medical evidence shows that where patients are admitted to specialist centres with staff seeing a high number of patients with similar problems, the results for patients are much improved.

Around 100 clinicians - including senior consultants, nurses, GPs and other health staff across Darlington, Durham and Tees - have been working together to look at how we provide services.

They have identified 700 standards developed by the Medical Royal Colleges and other organisations which could improve care.

These standards primarily relate to availability of senior staff across seven days to assess, treat and review patients. Our local services have been working hard to improve the care they provide and now meet around two thirds of these. The last third cannot be achieved without changing the way we deliver care.

This means that currently patients experience a different quality of care, depending on where and when they are treated.

This year, these clinicians have been talking to patients, public, and colleagues in the NHS and other partner organisations, sharing ideas and seeking views.

Some of them met with patients and the public in February to ask what the local NHS does well, and what we could do better.

People told us about services they believed could be available in a community setting closer to home, but they also recognised that, for some services, it is better to go to a specialist centre to get the best care.

This already happens for patients who have had heart attacks, strokes, or have suffered serious injuries.

Our clinicians believe there are other patients in serious or life-threatening situations who would benefit from treatment in a specialist environment, where there is senior staff on duty, 24 hours a day, seven days a week, for example in emergency departments, maternity and intensive care.

In May, our clinicians went out to talk to patients and the public again. They asked them about a set of draft principles for how care could be organised:

- Care should be delivered through a network of hospitals and community services
- More seamless care should be provided close to, or in the patient's home where safe and effective, with access to urgent and community care 24 hours a day, seven days a week.
- Patients should only be admitted to hospital where it is no longer safe or effective for them to be cared for in the community.
- There should be access to specialist opinion 24 hours a day, seven days a week, where this improves results, for example, heart attacks, strokes, serious injuries, or internal bleeding.
- Routine care should be organised so that there is no unnecessary waiting, no cancellations, and patients are not exposed to risk of infections

They also shared a draft framework of care, based on these principles:

More care could be provided outside of hospital, and as close to the patient's home as possible.

There should be a clear single point of access to healthcare for the public by an improved NHS 111 service so that all patients can be assessed urgently by a skilled health professional.

More of us will have one or more long-term health conditions, especially as we get older and frailer and need support and management, sometimes for many years.

In the past, much of the care offered by the NHS was in hospital. Caring for long term health conditions, such as heart disease, or diabetes, needs a different

approach, with more community based support and services provided by the NHS and social care partners.

Each hospital would have a different range of services, depending on local needs

Hospitals would provide a range of services for patients in their areas.

This would include outpatient clinics, tests - such as X rays, scans and other investigations, and support for maternity cases with low risk of complications.

Urgent care centres, situated in hospitals or in the community, would manage patients with illnesses and injuries that do not require hospital admission. They would be staffed by doctors, other health professionals or both.

Routine care, such as planned surgery, including joint replacement, should be organised so that there is no unnecessary waiting, no cancellations and patients are not exposed to risk of infections. Services may also include rehabilitation. They would work closely with GP's and community services to ensure that as much care as possible is provided in patients' homes or close to their homes.

Some hospitals would be emergency centres for patients with serious illnesses such as strokes, or serious injuries such as hip fractures, which can be life threatening...

These emergency centres would be designed to ensure that seven days a week there are senior staff on duty in the emergency departments, medicine, emergency surgery, orthopaedics and intensive care, supported by investigations such as laboratory tests, radiology and scans.

They could also be the centres for maternity cases which are at more risk of complication.

One of these emergency centres would be the major trauma and heart attack centre. There are currently two of these in the North East, and this number will not change.

Most people who attended our events were supportive of the draft principles and framework:

- There was a broad support and understanding of the benefits of specialist care, and an understanding that this may mean further travel for some patients, which was a concern for some people.

- There was support for more services in community settings and people are keen to have more detail about what these services could look like

- There was concern about the availability of funding and staff, especially GPs. They were receptive to the idea of GP practices working together and other clinicians, such as pharmacists, providing more care

- They wanted assurance that resources will be available for the development of more services in the community, and that these will work together more effectively with social care and the voluntary sector.

- There was a lot of discussion about effective hospital discharge processes, and the services that need to be in place so that patients have the right support when they leave hospital

- They wanted to have confidence in the full range of urgent and emergency services available, including NHS 111 and the ambulance service.

- They supported sharing more information electronically across health services. Many were surprised that, for example, GPs and hospitals still do not share a single electronic record for patients.

- At the Darlington meetings, people were also concerned about the impact of the Better Health programme on services at Darlington Memorial Hospital.

The programme is considering all these issues in developing the way ahead.

We promised to have further discussions about how services might work in the future, and the draft framework of care is the basis for developing possible solutions.

We would like you to help us develop our draft principles and framework into potential solutions to provide better care and agree what will be important in making decisions.

Our clinicians have identified 700 standards which could improve care. We already meet two thirds of these. We think we should only consider potential solutions which help us achieve more of these standards, in particular around staffing, which we know has a significant impact on the quality of care and outcomes for patients.

We think we should only consider potential solutions which improve results for patients, for instance by improving survival from life threatening illnesses, reducing length of stay in hospital, cancellations, post-operative complications, hospital-acquired infections and reducing avoidable hospital admissions for patients with long term health conditions

We think potential solutions we should consider will help us attract and retain doctors in training across a range of specialties now and in the future, and help us reduce use of locum, medical and nursing staff.

We think potential solutions should minimise impact on access to care for the public by car, public transport or ambulance for residents.

We think potential solutions must reduce waiting times at A&E, ambulance handover delays, delays to leaving hospital and reducing waiting times for surgery and cancer treatment.

We must be able to deliver our potential solutions using the available financial resources, and with the facilities we have.

We think potential solutions should support us playing a role in research and development contribution which helps us attract and retain a quality workforce, and improve the care we offer to patients.

We now want to seek your views about these issues.

Do you agree with them? Which are important to you? Are there any you would add?

There are a variety of ways to share your views.