Humber Acute Service Review
Targeted Engagement Report

HWRA

Undertaken by Humber and Wolds Rural Action on behalf of Humber, Coast and Vale Health and Care Partnership

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1. Executive summary

Humber, Coast and Vale Health and Care Partnership is undertaking a systematic review of acute hospital services at the five acute hospital sites across the Humber region: Hull Royal Infirmary, Castle Hill Hospital, Diana Princess of Wales Hospital, Grimsby, Scunthorpe General Hospital, Goole Hospital.

The review is considering how to provide the best possible care for local people who need to use acute hospital services within the resources (money, staffing and buildings) that are available to the local NHS. This may include delivering some aspects of care out of hospitals in GP surgeries or other community settings to better meet local peoples' needs.

The Partnership wished to ensure that, not only did they raise awareness with the general public and seek people's views and opinions but also to work with a local partner to deliver early targeted engagement with seldom heard communities across the Humber area.

Humber and Wolds Rural Action (HWRA), based in Barton but with a geographical coverage of East Riding of Yorkshire, Hull, North East Lincolnshire and North Lincolnshire was commissioned to undertake the engagement work utilising their existing relationships and networks

The range of services to be reviewed changed prior to the period of engagement with Cardiology, Complex rehabilitation, Critical Care, Stroke and Neurology being those agreed as the focus from November 2018 to July 2019.

In addition to seeking views and opinions, individuals and representatives of groups were also encouraged to join the Citizen's Panel which is playing a key role in scrutinising the work of the clinical design groups and ensuring a diverse range of perspectives are considered by the review team.

Each engagement session was summarised, and the key themes extracted to create this Humber Acute Service Review Targeted Engagement Report. There was limited interest in the potential specific service changes, the main focus of discussion was in relation to quality, customer service, communication and infrastructure:

- People saw hospital services as part of the wider system of health and social care support, they did not distinguish between providers but believed in a 'whole system approach'
- A quality service was paramount and where it was delivered was of less importance. People made decisions on where they attended hospital appointments based on a range of personal and local circumstances
- The infra structure (access, transport, parking, costs, appointment systems, customer service etc.) is as important to patients and carers as the clinical intervention. People wanted to receive quality, personalised care and have a good experience
- Delivering services closer to home was seen as a positive development as long as this created additional capacity in the system. People recognised that 'local' could not mean local to everybody and therefore when planning out of

hospital/community service delivery it should include access and transport infrastructure taking into account the needs of patients and carers

- People with particular vulnerabilities i.e. Learning Disabilities, Mental Health issues, Dementia and carers felt that investment in community and preventative services would reduce pressure on the acute system and create localised support that was more appropriate to prevent or respond to a health crisis.

Although there was reluctance from some groups to become engaged with the review, those that did felt that this was a very important piece of work, not only in the content of the discussion, opinions, issues, concerns and compliments put forward but also in the engagement process itself. Participants felt truly involved with the review and it is important that Humber Coast and Vale Partnership continue to engage with the range of hard to reach groups identified in this report to provide regular feedback on how their comments and suggestions have influenced the service design and outcomes

Early engagement in the potential design of future services prior to formal consultation promotes transparency in decision making, improves relationships with the communities they serve and in so doing increases the integrity of the NHS.

Moira Harrison, Associate
Humber and Wolds Rural Action

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Humber and Wolds Rural Action

2. Background

Humber, Coast and Vale Health and Care Partnership are working together as local health and care organisations, to improve services for local people, finding new ways of improving the health and wellbeing of local people through transforming care and support in our communities.

As part of this work, the NHS are looking at how to provide the best possible hospital services and make the best use of the money, staff and buildings that are available to them. This may include delivering some aspects of care outside of hospital altogether to better meet the needs of local people.

As a group of health and care organisations, facilitated by Humber, Coast and Vale Health and Care Partnership, they are working together to conduct a review of acute hospital services across the five acute hospital sites in the Humber area:

- Diana Princess of Wales Hospital, Grimsby
- Scunthorpe General Hospital
- Goole and District Hospital
- Hull Royal Infirmary
- Castle Hill Hospital

Since late September 2018, the Humber Acute Services Review programme has focused on reviewing five clinical specialties, using a clinically led design approach.

The five specialties are:

- Cardiology
- Complex rehabilitation
- Critical care
- Neurology
- Stroke

The input of healthcare professionals, patients and the public is vitally important to the success of the review. In order to ensure that the widest range of people have been included in the review, Humber, Coast and Vale Partnership commissioned a voluntary and community sector organisation to utilise their current relationships and networks to engage with 'seldom heard'* people and organisations who would not naturally become involved in such a review process. As the result of a commissioning exercise, Humber and Wolds Rural Action (HWRA) was contracted to undertake the targeted engagement process.

To find out more about the review and keep up to date on progress visit the Humber Coast and Vale website: www.humbercoastandvale.org.uk/humberacutereview

*'Seldom heard' is a term used to describe groups who may experience barriers to accessing services or are underrepresented in healthcare decision making. Traditionally, some of the groups identified in engagement activities include rural communities, black and minority ethnic (BME) groups, gypsies and travellers, lesbian, gay, bisexual and transgender, asylum seekers and refugees and young carers. However, in reality, teenagers, employees, people with mental health issues and many others may be considered as seldom heard, due to the fact engagement may not be straightforward (definition provided by NHS Involvement 2017).

3. Who are Humber and Wolds Rural Action (HWRA)?

Humber and Wolds Rural Action (HWRA) formerly and officially known as Humber and Wolds Rural Community Council was established in 1975 as one of 38 Rural Community Councils covering the whole of England. Although based in Barton upon Humber, HWRA's boundary is co-terminus with the East Riding of Yorkshire, Hull, North East Lincolnshire and North Lincolnshire local authority areas.

A registered charity and voluntary organisation which works closely with local communities, organisations and individuals, town and parish councils and private sector. Listening to views and opinions, facilitating and empowering communities to identify solutions to the problems that they may be facing.

HWRA also works at a strategic level across health, social care, housing, energy and transport, representing the voluntary and community sector and working in partnership as part of the whole system approach seeking innovative and practical responses to system issues.

HWRA currently provides the following services across East Riding of Yorkshire (ER), North Lincolnshire (NL) and North East Lincolnshire (NEL):
Men in Sheds (ER/NL)
Voluntary Car Service (NL/NEL)
Village Halls Advisory Service (ER/NL/NEL)
Bulk Oil Buying Co-operative (ER/NL)
Wheels to Work (NEL)
Community Led Housing (ER)
Action Towards Inclusion/BBO (ER)
Community Led Planning/Neighbourhood Planning/Community Review (NL/NEL/ER)

4. Methodology

The purpose of the engagement was to capture the views of the "hard to reach" or 'seldom heard' groups, those people who are often unable to have their voices heard because of cultural differences, disability, gender or simply because they are considered to be somewhat 'different' or difficult to engage with.

For example, the 'hard to reach' groups most commonly identified are sex workers, drug users, people living with HIV and people from lesbian, gay, bisexual, transgender and intersex communities but there are a number of other groups to which the description applies including asylum seekers, refugees, black and minority ethnic communities, children and young people, disabled people, elderly people and traveller families.

HWRA created a grid identifying the geographical spread and range of groups and group characteristics needed to meet the targeted engagement requirements utilising existing direct and indirect relationships with a range of individuals, groups and individuals to stimulate interest in taking part in the review. Where possible, personal contact was made to explain the targeted engagement purpose and process, where the group was not directly known an intermediary was used

(infrastructure organisation, multidisciplinary meeting, network lead or specialist worker etc.).

An explanatory letter and supporting, easy to read, marketing material was provided to group leads to distribute to potential participants.

Group leads were key in identifying the most appropriate approach and venue. Rather than creating a specific 'event', the majority of engagement formed part of existing meetings and group activities. This enabled people to feel comfortable and provided the group with the leader support needed at times of communication difficulty.

Recognising that engagement sessions would need to be adapted to meet the needs of the group and individuals within groups, a range of engagement 'tools' were created and utilised.

Because HWRA did not have immediate access to the developing discussions within the specialist services identified for review, it was agreed to provide a "General Approach" in order to capture peoples experience of using the acute specialist services identified and their ideas for service improvements.

A formal PowerPoint presentation included:

- An overview of the Humber Acute Services Review
- The 4 key challenges
- The speciality services under review
- Citizens Panel

This was supported by a handout which provided additional information about the review and included guidance on who to contact if the participant has specific concerns (PALS, Healthwatch etc.). When a more informal approach was required this handout was utilised to stimulate discussion. See appendix 3 for the Handout.

A map of the geographical area, flashcards of the hospital sites, specialist and existing community-based services were created and utilised to facilitate discussion with people with limited communication or understanding.

Participants were asked their views and encouraged to share their experience with the group. The following key questions were used to stimulate discussion when required:

- If you or members of your family or friends are receiving one of these services, what works well and what is not working well
- If this service transferred to a different site – how would that impact on you and your family/ carers or the people that support, you?
- What changes in service or location would cause you concern and why?
- What ideas do you have for how the service could be improved?

All participants were encouraged throughout to come up with suggestions for how care could be improved for patients in the future as well as how to address some, if not all the four key challenges that the acute services are facing today.

Comments and opinions, summarised discussions and quotes were captured on flipchart and each session was summarised in a separate paper.

At the commencement of each ‘session’ participants were asked to sign in (or their name was written onto the form where necessary) and complete an Equality Monitoring form if they felt comfortable doing so. Participants chose to complete, partially complete or not complete forms as necessary.

At the end of the session, the role of the Citizens Panel was explained and if people were interested in finding out more, they provided their contact details on a separate document which also contained the Privacy Statement.

Participants were asked to complete an Evaluation Form which utilised a visual grading system to capture people’s views of the engagement session content and presentation.

The information from these monitoring documents are summarised below.

5. Who took part in the targeted engagement activities?

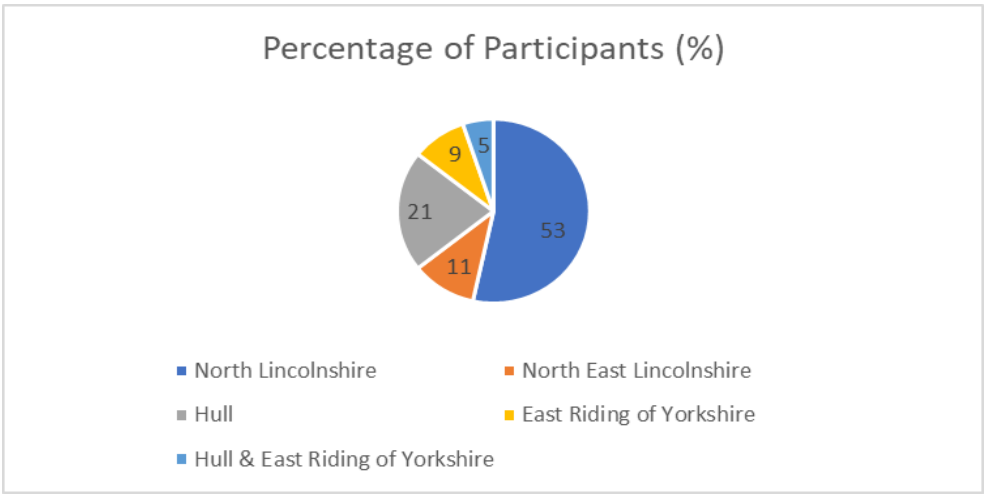
Organisation	Area	No of attendees	Group characteristics	Date completed	Citizens panel Nos
Carers group - Barton	North Lincolnshire	16	Men and women, over 50's, previous and current carers	12th February 2019	1
Men in Sheds - Winterton	North Lincolnshire	4	Men, over 50 with physical and mental health issues	31st January 2019	3
MIND - Scunthorpe	North Lincolnshire	12	Men and women with mental health issues age range 35 to 62	10th April 2019	1
MIND Ambassadors - Hull	Hull & East Riding of Yorkshire	3	Men and women with mental health issues and their supporters age range 19 to 42	25th April 2019	1
The Forge - Scunthorpe	North Lincolnshire	8	Men and women who are homeless or at risk of becoming homeless age range 31 to 55	7th May 2019	1
Redwood Glades - Hull	Hull	14	Men and Women with a range of physical, mental health and learning difficulties living in an 'extra care' facility age range 33 to 79	8th May 2019	
Cecil Gardens - Hull	Hull	7	Men and Women with a range of physical, mental health and learning difficulties issues living in an 'extra care' facility age range 48 to 88	9th May 2019	1
Choices and Rights – East Riding and Hull	Hull & East Riding of Yorkshire	6	Men and Women living with a physical disability and/or mental health issues age range 43 to 59	14th May 2019	2
Stroke Association - Scunthorpe	North Lincolnshire	30	People who have had a stroke and their carers/supporters- meeting to generate interest	3rd June 2019	
Stroke Association - Scunthorpe	North Lincolnshire	6	People who have had a stroke. Age range from 49 to 86.	20th June 2019	
Hull Independent Advisory Group (Humberside Police)	Hull	16	Multi-agency partners including members of the LGBTQ community	3rd June 2019	

Organisation	Area	No of attendees	Group characteristics	Date completed	Citizens panel
Options Autism	North Lincolnshire	6	People with learning difficulties and disabilities age range 22 - 54	18th June	
Cloverleaf Advocacy Scunthorpe - Time 4 Action	North Lincolnshire	3	People with a learning disability and their cares age range 34 - 44	19th June 2019 10.30am	
Youth Council	North Lincolnshire	18	Young people and multi-agency attendees	20th June 2019	
Carers Group Goole	East Riding of Yorkshire	8	Carers support group	9th July 2019	
Eppleworth Travellers Site, Skidby	East Riding of Yorkshire	8	Gypsy and Travellers age range between 30 and 80	Tuesday 16 July 2019	
Advocacy group Crowle	North Lincolnshire	8	Learning Disability age range 28 - 69	Tuesday 23th July 2019	
Centre 4	North East Lincolnshire Grimsby	19	People with a physical disability & Older people and carers age range 66 - 83	Thursday 3rd October	

There were 18 targeted engagement sessions that took place across the Humber region.

6. Percentage involvement for each area across the Humber region

The following graph shows the percentage involvement for each local authority area across the Humber region.

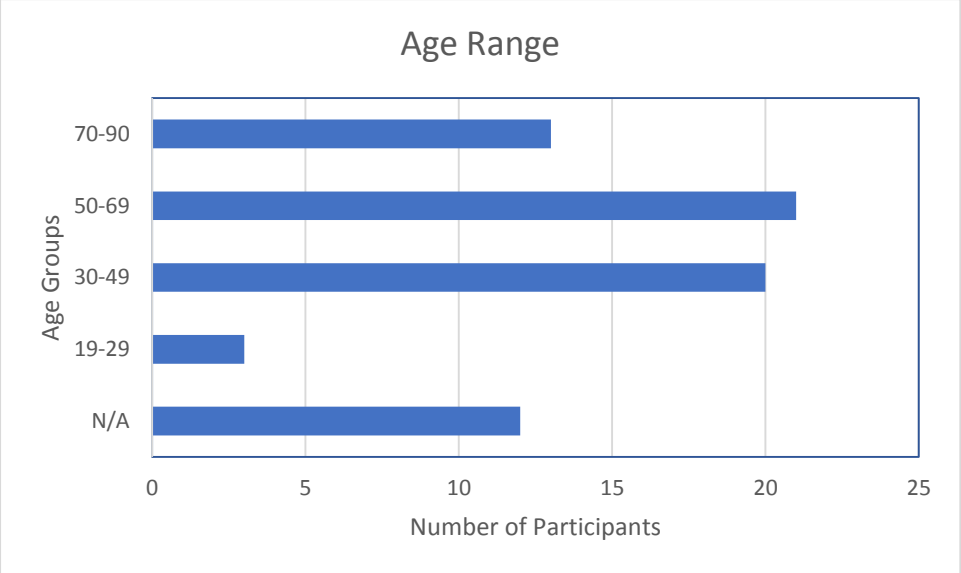


7. Equality Monitoring Evaluation

192 people engaged with the process of which 128 took part in the targeted engagement discussion activities. Not all participants completed the characteristic forms.

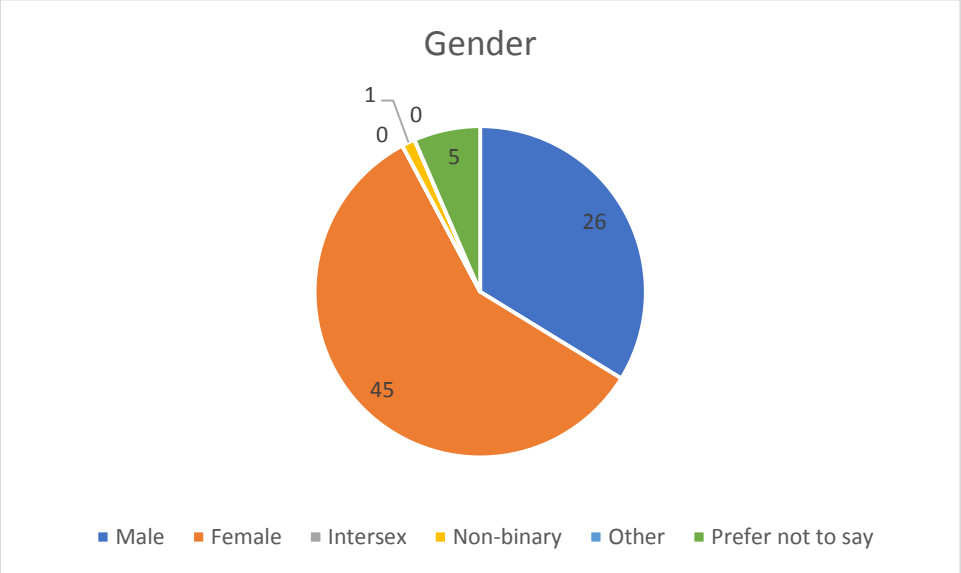
The following graphs provide an overview of age range, gender, gender identity, sexual orientation, religious belief, disability and ethnic group.

Age range



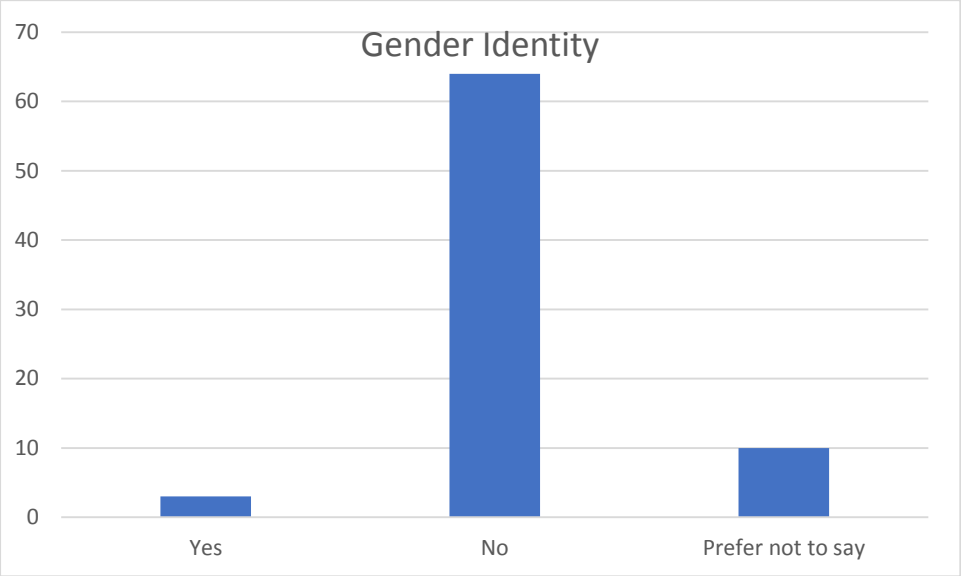
Participants ranged from 19 to 90 years. There were a few people who did not want to divulge their age.

Gender



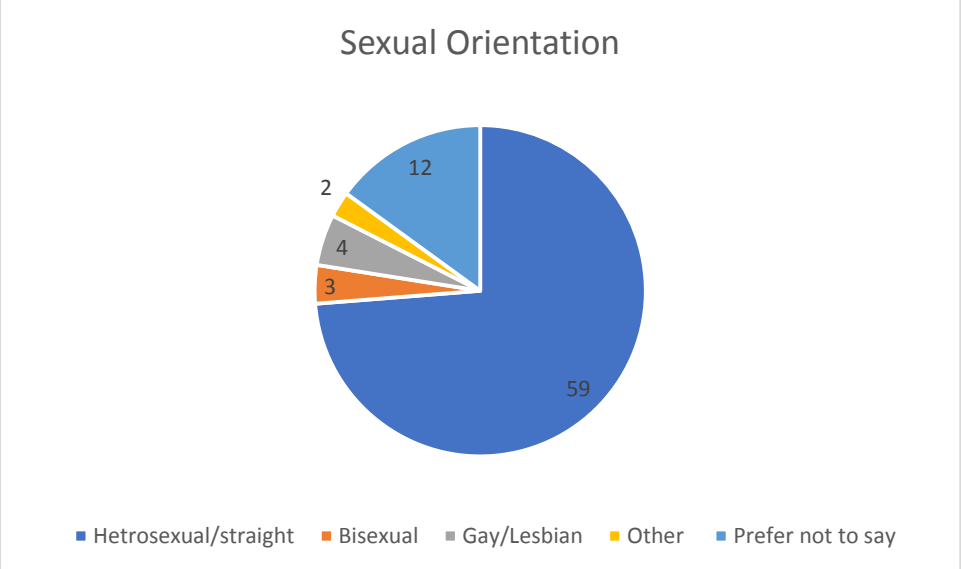
The graph above identifies the gender of the people who participated in the communication and engagement.

Gender Identity



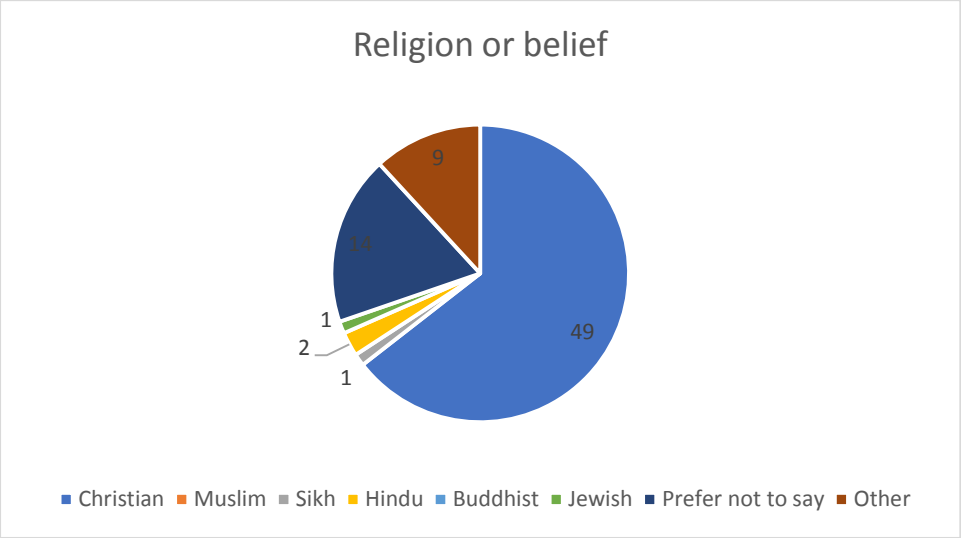
The above graph identifies the gender identity of the people who took part in the review. There were a few people who preferred not to say if they had gone through a process (including thoughts or actions) to change the sex they were described as at birth to the gender they identified with. There were several people who did answer yes to this question and had either changed their gender, intended to, or who had changed their name.

Sexual Orientation



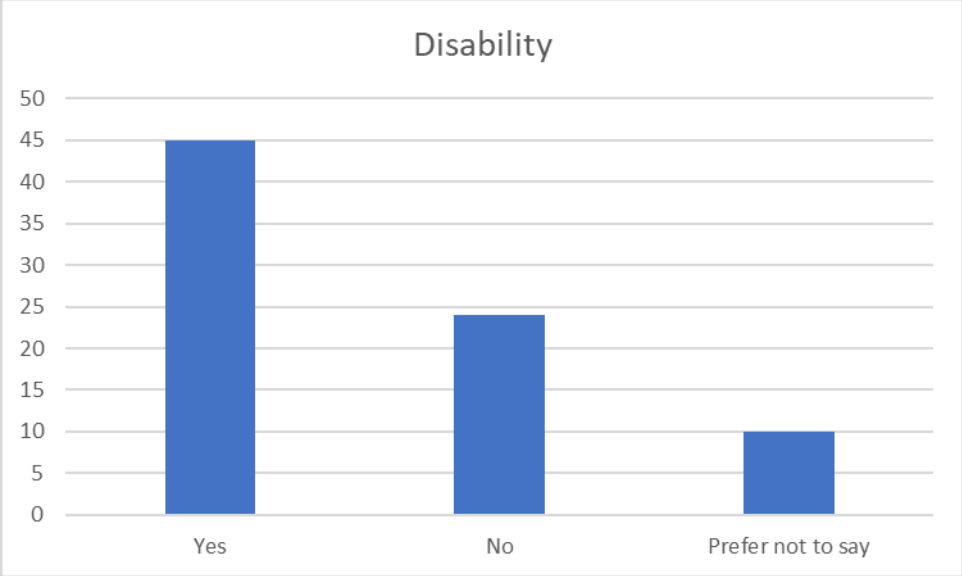
The above graph identifies the sexual orientation of the people who were willing to complete the characteristics form. There were a few people who preferred not to respond to this question and are not included in this graph. One person identified themselves as Pansexual.

Religion or Belief



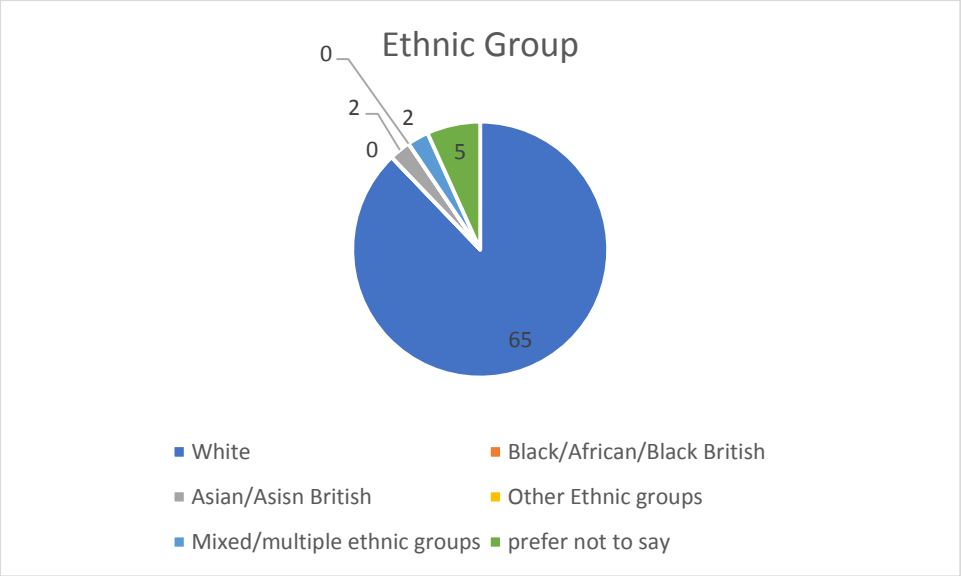
The above graph identifies the religion or belief of the people who were willing to complete this section. There were a few people who identified themselves as Atheist, Spiritless and Pagan.

Disability



The graph illustrates that the majority of people completing the form identified themselves as disabled indicating the following: Deaf, Mental Health, Learning Disability, Autism, Dyslexia and post Stroke. A few people preferred not to answer this question and are not included in this graph.

Ethnic Groups



The above graph provided an indication of the ethnic groups that took part in the targeted engagement. There were a few people who did not respond to this question. For a copy of the Equality Monitoring for see appendix 4

Participants were also asked if they had experienced any difficulties accessing or communicating with any health services as a result of their race, disability or sexual orientation.

The following examples were provided, please note the responses are anonymous;

"*I was not allowed to take my own wheelchair on the Ambulance which affected my access to GP services and hospital services"*

"I am deaf, I find it difficult making appointment. Lack of understanding and assistance".

"I need level access and toilet" "I had Counselling from Relate. I had to have it at another GP surgery to get access to one".

"Me being an immigrant had been an hinderance in the past". "Often things are sent to me in the wrong name and appointments get missed". "A diagnosis was missed because of this".

"I only got access to staff because my mum or sister act on my behalf". "I am fobbed of by professionals because they think I'm stupid/lazy".

"They don't look at me as a person just what they think what is wrong with me".

"The NHS has not supported me being trans". "The NHS do not care at all about what they have done to me".

8. Possible reasons for not taking part

The table below identifies some of the “hard to reach” groups across the Humber area that were contacted and asked to take part in the Humber Acute Service Review targeted engagement process but unfortunately did not engage.

Refugees	BME	Employees
Veteran’s	Rough sleepers	Young carers
Rural groups various	Older people’s various groups	Young peoples – Youth Council

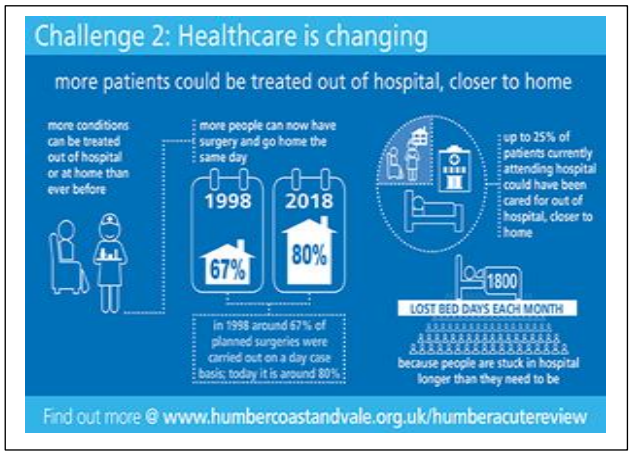
Despite a contact name and direct emailing and telephone calls, we had limited response from some groups. Presenting at multi-agency meetings attended by the target groups to generate interest had little impact other than providing information about the review. The lack of response and interest from some in engaging with the review was disappointing and created a high workload for little return. The following provides some reasons why people and groups did not engage:

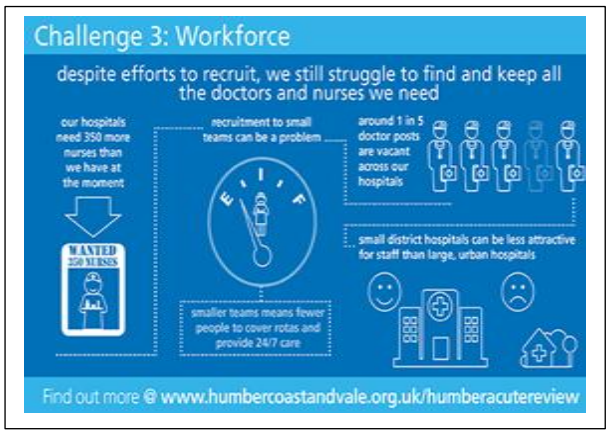
- Groups have ‘activities’ planned well in advance
- Organisers thinking that their participants ‘won’t be interested’ (when we’ve found the exact opposite)
- Groups/individuals in crisis so cancelling sessions
- People not responding to telephone calls and emails (other priorities)
- Session agreed and planned then cancelled due to lack of interest
- Poor weather cancelled one arranged event
- Making decisions based on assumptions that people are too vulnerable or disinterested, unable to understand or be able to partake in the ‘discussion’
- Not seen as a priority.
- “A waste of time, nothing will change”
- People thinking it was a consultation and not contributing to the review itself

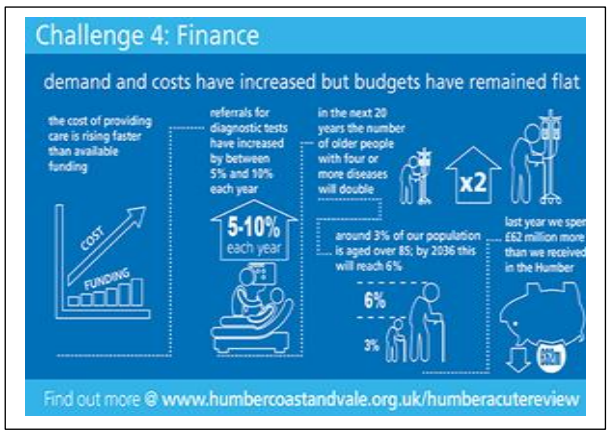
9. The Four Key Challenges

The Four Key Challenges slides were used to facilitate discussion with each group and have been utilised to summarise the main themes that have emerged from each targeted engagement session.

Discussions have been collated into common themes which sit under each Key Challenge. However, the interconnectedness of the themes is evident and the impact of one challenge (or solution) on the whole system is also recognised.







Participants were asked to describe their own, and others, experiences both good and poor and also, where they felt able to, provide possible solutions from their perspectives.

Where appropriate, direct quotes are used to illustrate opinion and experience.

10. Challenge 1: Quality of Care

In hospital care

People gave examples of receiving excellent care within the acute hospital system particularly at times of crisis.

It was acknowledged the important role that nursing staff play in the persons recovery and in "lifting the spirits" of the patient not only in relation to medical need and treatment but in treating the whole persons wellbeing.

"Going outside in the Hospital garden and people supporting me to walk there. All helped to aid my recovery". Quote from Stroke Association, Scunthorpe

"Had a brain haemorrhage/stroke, sent to Scunthorpe A&E first and then on to HRI. Excellent specialist care" Quote from The Forge Homeless Project in Scunthorpe

"The A & E department at Diana Princess of Wales hospital at Grimsby worked on my husband nonstop for 12 hours and the DIU department were amazing" Quote from NELLES, carers group at Grimsby

However, there were concerns over the level of general care:

- Slow responses to the nurse call system
- Patients not able to get washed for many days (16 days quoted)
- Patients not having their teeth cleaned
- Patients only able to have a shower when the informal carer visited
- Catheter bag left full including blood and only emptied after the carer persisted
- Patients feeling cold and waiting for some time to be provided with a blanket
- Lack of access to a (free) television, a main source of company and entertainment for people especially those living alone
- Cleanliness of the environment

"There was no-one cleaning areas and there was blood on the floor" Quote from Extra Care in Hull

- Lack of access to fluids

"I was waiting for a bed to become available at Pinderfields, when I got there the staff expressed a concern about patients being admitted to them with impacted bowels". Quote from Choices and Rights, Hull and East Riding

Patient at the centre of care

The need for patients (and carers) to be central to the care provided and for the care to be individualised to create the best experience (and recovery) for all concerned was highlighted:

- Staff understanding and being sensitive to individual patient and carer situations, recognising that the language used, and delivery method, can have an impact on the person both positively and negatively
- Communication in relation to end of life care and available options. Where people wanted to die at home, conversations needed to take place much sooner to enable funding and appropriate care to be put in place and to grant the patient's wishes
- Clarity and honesty around the reasons for a delayed discharge which included, transport, medication and care packages not in place. Patients and carers needed to understand the issues and also be part of the solution
- Do Not Resuscitate (DNR) needs explaining clearly to people, some didn't understand the reason this was in place and were concerned that the hospital would not treat them when they became ill but was unsure how to reverse the DNR decision
- Lack of understanding of the Mental Capacity Act 2005, the procedure for decision making and the supporting documentation.
- Poor knowledge of Patient Advice and Liaison Service (PALS), what it is and how to access it. One person stated it had taken a year to gain an acceptable response to their concern.

Centralisation of specialist services:

Some people we spoke to implied that they needed to understand the reason for bringing specialist (and support) services together. It was evident during the engagement and communication process that some people were keen to talk about their positive experiences of 'specialist' services and overwhelmingly supported the centralisation of such services. In general, people felt that if specialist services were required then people would travel to receive them.

"Specialist care for grandson in Sheffield children's hospital was excellent, happy to travel there with the rest of the family. Had support at the time so transport was provided. Would have found it difficult to visit if this had not been the case. Understand that specialist centres are important". Quote from Gypsy Travellers in Skidby

However, some people identified the following concerns and felt these would need to be taken into consideration:

- Impact on carers/family etc. is greater as they need to travel to visit/family visiting is an important part of recovery
- The need to return 'closer to home' for re-cooperation
- Will only work if it increases recruitment/attracts professionals
- Would rather travel than go to HRI/Scunthorpe etc.

Access and environment:

Generally, people told us that they were happy to travel from north bank to south bank, from east to west and out of area to receive specific treatments and for some people they preferred to travel further to gain what they considered to be a 'better experience' but this was based on practical aspects of parking, transport availability, cost and access to the building.

The reason people (patients and visitors) gave for not attending appointments at hospital sites included:

- The location and size of car parking spaces for people with disabilities (permanent and temporary)
- The cost of parking, particularly when appointments are delayed or waiting for treatment, results, equipment or medication
- Lack of access to public transport
- Lack of access to other forms of transport or knowledge of alternative options
- The cost of transport
- Lack of secure facilities for cyclists

"I cannot afford to travel it costs too much" Quote from The Forge Homeless Project, Scunthorpe

Participants believe that there are some 'simple' changes that can make a real difference to accessing and experiencing acute hospital services, these included:

- Flexible visiting times (different times for each ward) reducing the demand for car parking at key times
- Making buildings more attractive and welcoming
- Removing glass screens from reception areas which make it difficult to communicate and removes confidentiality
- 'Meeters and greeters' to welcome and assist people who are 'lost' or anxious
- Signage (simple language and visual) which makes it easier to navigate around the site/building
- Easier access to onsite facilities (location of accessible toilets was particularly important)
- Creation of a quiet, comfortable physical space to respond to people's needs, enable them to relax and prevent escalation of behaviour

Access and sharing Information

People felt that when elective and outpatient appointments are allocated, particularly when they are early appointments, they should take into account the whole person and their circumstances: where they live, transport needs, if they are taking medication at a specific time, require Community Nurse or home care visits, need assistance with personal care, physical or mental health issues etc.

Recognising that this would be difficult for the volumes of patients that flow through the hospital (although it was felt that the IT system should record and flag this),

having information on how to change an appointment or request longer appointments, should from part of the information provided to the patient.

There was an overwhelming expectation that the access and sharing of information across teams should now be in place, but our discussions found the opposite and people told us about their frustrations and concerns:

- People told us they had to repeat themselves
- The use of several, noncompatible IT systems, creates barriers and is time consuming for the person trying to access the information
- GP's were not informed of the persons admission to hospital and/or diagnosis
- Information was not shared with the Residential/Nursing homes
- The security of information and the potential for hacking the system and accessing personal data.

"My appointment letter that I received contained another patients letter" Quote from NELLES Carers group Grimsby.

The following example was provided were information is held on different systems;

"My blood tests and medication are on a different system to acute setting - at outpatients they always ask the person what medication they are taking". Quote from Extra Care in Hull

Overall, people were dissatisfied with the current IT system and the lack of sharing information and felt this could be improved with some investment in new technology, people told us that there should be one system that is accessible to all.

"Communication needs to improve and joined up communication systems would help, I cannot speak over the phone so gave my family permission to speak on my behalf, this could be recorded once only and adhered to, instead of having to repeat this request". Quote from Choices and Rights, Hull and East Riding

"My GP didn't even know I had had a Stroke; he had no record of this". Quote from Stroke Association in Scunthorpe

General communication

Communication in all its forms was a theme throughout discussions and the following suggestions were made to improve the system:

- Information about medical history and needs should be available on patient records and accessible to all relevant parties
- Clarity and instruction for patients on how to use the "Choose and Book" system
- Language to be used in letters is appropriate for the person's needs (and for this to be recorded in patient record)
- Letters clarify who the patient will be seeing on the day of their appointment (people told us they were expecting to see their consultant and were disappointed when this did not occur)
- All communication to avoid jargon or explain jargon/clinical terminology

- Communication is provided in a range of formats including “Easy Read”
- Patients able to record consultations in order to understand the content and for this to be seen as acceptable practice

Equality and Diversity

There were examples of practices that raised concerns regarding equality and diversity. People felt that there was an assumption that everyone could see, hear, write, be fully able-bodied and understand or, were they couldn’t, that they would have someone with them to support and or interpret. For example, there was an expectation for a deaf person to use the phone to book an appointment and for them to hear their name being called at the clinic:

“I attended the Hearing-Impaired Clinic and was waiting over an hour to see the consultant. When enquiries were made, I was told your name was called out 40 minutes ago”. Quote from Disability and Rights. Hull and East Riding.

There is an assumption that people can read and that all letters should be written in English.

Some group participants felt stigmatised and discriminated against due to their lifestyles i.e. homeless or Gypsy Travellers and as a result felt they received a lesser service in either quality and/or quantity. Alternatively, they felt that they were not seen or treated as a ‘whole person’ only as the medical condition they were presenting and this then had an impact upon the intervention both within the acute setting and also follow on care which may not be easy to administer due to their lifestyle, environment or general wellbeing.

“Mental Health issues come secondary to my physical health” Quote from MIND in Scunthorpe

In addition to medical training people felt that part of a staff members professional development should include an understanding of Learning Disability, Mental Health, and Dementia particularly with regard to communication and approach.

“Sometimes I don’t feel listened to” Quote Advocacy Group Learning Disability Group in Crowle.

Discharge

People described a very negative experience of hospital discharge with long waits, lack of communication, poor planning and a range of reasons for ‘delay’. The following examples were provided:

“It took too long to discharge me waiting over 8 hours for paperwork and medication still wasn’t ready, so I went home without them, my son returned the next day to pick them up for me”. Quote from Extra Care, Hull

“I waited all day in the discharge lounge for my medication, there was a lady who clearly needed attention for dignity reasons and there was nothing to eat or drink”. Quote from Extra Care in Hull

‘Waiting for medication’ was one of the main reasons given for a delay in discharge. The majority of people felt that issuing a prescription that can be taken to a local community pharmacist would prevent this, reduce waiting and staff time and ‘unblock’ beds. It was difficult to understand why a joined-up system could not facilitate this.

The quantity of medication prescribed on discharge, was considered to make the assumption that a GP was aware of the admission or changes to the persons medication and that everyone could access a pharmacy within a restricted time period. It did not take into account people living alone and without support, a lack of transport and rural isolation.

There continued to be concerns about the timing of patients discharged from hospital with an emphasis on the impact on carers and their ability to care for the person with no additional support. One person told us:

“I was discharged recently following two admissions to hospital and on both occasions, I was discharged at 1.30am and 3.45am in the morning”. Quote from Carers Group in Barton upon Humber

Completion of the Discharge Questionnaire was also identified as the source of delayed discharge and could have been done over the phone following discharge or the patient be provided with an iPad so that they could complete it themselves or with the support, if required.

People wanted more information on what to do if they did not improve or if things ’went wrong’ following discharge. Those who had received a telephone number to ‘ring the ward direct’ felt confident on leaving the hospital. Those who lacked knowledge of back up services tended to default back to the GP or A&E.

Working with residential care homes

There is a clear need for a closer working relationship between the acute hospital and residential care homes for the benefit of the service user/patient.

Care staff are familiar with the service users and can identify when and if there is something wrong or any underlying issues, so listening to the formal carer and working together is essential.

Recognising, particularly for people with learning disability, dementia or mental health issues, that attending the hospital is a frightening experience, it is important that, within the confines of the hospital, a calm and supportive environment is created.

Where care staff need to remain with a service user to support them during their hospital stay, particularly overnight, keeping them calm and reassured, explaining what is happening in language they understand, informing health staff in relation to the persons needs and ‘translating’ responses, there needs to be accommodation available to enable the care staff to stay at the hospital. This would also impact upon informal carers, prison officers etc.

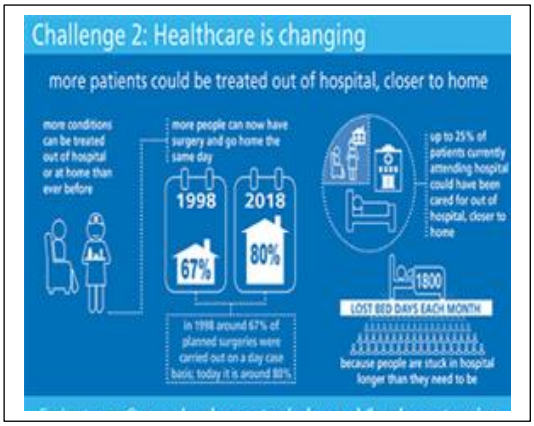
On discharge, the care home is not receiving discharge notes which contain vital information for the persons continued care. These notes could be sent via secure e-mail. Where injections have been prescribed to keep the person calm the care home staff are not trained to administer this and must wait for the District Nurse to attend. This can lead to a delay in provision and increased anxiety, distress and possible challenging behaviour for the service user.

"Care plans are filled in, but the hospital doctors do not work directly with care homes, the information can get misinterpreted and they won't add to the care home's paperwork or provide a copy of the patients' hospital notes". Quote from Residential Home, Barton upon Humber

Learning Disability Liaison Officers in hospitals were considered to play a key role in ensuring people with a learning disability and their carers received an improved service. This included general training and knowledge sharing for hospital staff, supporting individuals and their carers whilst attending hospital, influencing policies and processes and putting practical support measures in place for example the use of the Patient (hospital) Passport.

Because of the pressure on residential care home staffing in accompanying residents to check-up appointments following hospital visits there was a preference for this to be done by telephone, at the GP practice or use of SKYPE. This would provide a cost saving for all parties and minimise any distress.

11. Challenge 2: Healthcare is Changing



In general, participants supported the principle of a service being provided closer to home and could see real benefit in certain circumstances. It was felt that the hospital should be for acute only and not for outpatient appointments or follow up appointments. However, there were concerns in relation to capacity and access.

An alternative to acute

People who had experienced a period of intense treatment in an acute hospital setting expressed a preference to return to a community facility that was closer to home and family support. They saw this as a vital factor to aid their recovery both in creating an environment of 'rehabilitation' rather than 'ill health' and facilitating family and community re-engagement, particularly if the acute hospital stay had been out of the area and/or lengthy.

"I looked forward to seeing my family and grandson, he made me laugh, he later told me, he couldn't understand a word I was saying but it all sound fine to me". From the Sing a Long, Stroke association Scunthorpe.

Services delivered more locally

It was evident that some people we spoke to, would prefer services much closer to home, this would be beneficial in reducing the cost of transport, time in travelling and waiting and would potentially prevent appointments being missed.

Carers, in particular described the constant attendance at a range of outpatient appointments at various venues as stressful and time consuming. Managing and co-ordinating appointments and general social care support was a major task. From their perspective, services being offered locally and under one roof was received positively. For example, the Jean Bishop Centre multi agency/multi specialist model was considered to be a positive way forward.

There were concerns about how local services would work, if there would be increased capacity in the system and whether it would be easier or more difficult to access specialist teams when there is already a workforce issue.

"If there aren't enough staff already to cover what we have, this will mean they'll be spread more thinly". Quote from Extra Care in Hull

More use should be made of travelling clinic's that are strategically located in the community for example chiropody and MRI breast screening, adding services or increasing routes to existing provision. This was of particular interest to those who live rurally and have limited transport options.

The clustering of GP surgeries to provide more opportunity and flexibility in delivering services across a larger geographical area and providing 'specialisms' was also seen positively.

A message from people engaged in the discussion is that marketing newly developed and existing services is key to the success of any service review. Knowing what is provided, where, for what purpose/illness and how to access, it needs to be promoted using all forms of media to the public and amongst professionals.

Access and Transport

Accessing services delivered locally will cause difficulty for some people because not every service can be provided in every locality. People asked that if services where located in community bases the following should be considered during the planning stages:

- Access to public transport
- Flexible alternative transport
- Access to (free) parking
- Adequate appointment times resourced by appropriate numbers and levels of staff
- Expansion of appointment times for example evenings and weekends
- The development and utilisation of existing mobile clinics (take the service to the people)

On the whole, people did not mind where services were provided from, what was important for them was the infrastructure in place to be able to access the services and that they were of good quality.

"Just because things are closer to home, if you are unable to get out of your house then it won't make a difference" Quote from Extra Care Housing, Hull

Use of technology

People told us that they can see a place for the use of Skype in reducing the need for outpatient and post-operative appointments. It was felt that these appointments were a 'waste of time' for all concerned when there was no physical examination and the questions asked and responded to led to being 'discharged'. A virtual appointment could reduce travelling costs and waiting time for the patient and demand on the consultant/registrar time.

"Rather than going to Sheffield, this would help with the cost of travel, parking and petrol which is £50 plus per appointment". Quote from MIND, Scunthorpe

The use of Skype for consultations was considered positively for some people, if there was an option to opt out. It was suggested that having the Skype consultation in a GP surgery where there is access to medically qualified staff, could provide reassurance and interpretation where necessary. If the Skype consultation took place from the person own home due to ill health, learning or physical disabilities

and/or Mental health issues the attendance of a medical professional was considered essential.

It was also acknowledged that Skype could be difficult for some people due to their medical condition such as, following a Stroke and a continued lack of internet connectivity in some rural areas created an inequality in the system.

Perhaps surprisingly, it was the view of some young people that Skype was not as beneficial as face to face. There was concerns that it would not be a holistic assessment, the focus would be on the presenting injuries/illness and other issues may be missed. However, the potential to have access to a specialist whether it was a physical or mental health issue, who may be based many miles away without having to travel particularly if the patient was in pain was considered extremely beneficial.

The potential for "professional to professional" use of skype and the transfer of electronic data and diagnostics was seen as a positive way to reduce the delay in diagnosis and treatment time.

During our discussions the following was proposed:

- Email appointments
- Text reminders – health service needs to catch up with the rest of business community
- Online chat services were advice and information can be provided and that can also be used to monitor the persons progress
- More use of technology to monitor a person's health such as the use of Raspberry Pi to monitor a person's heartbeat/pulse
- Outpatients and post-operative appointments for some people could be done over the phone.

"I live near Scunthorpe and had to return to (Diana Princess of Wales Hospital) Grimsby three times to say "I'm okay" my daughter had to take three days off work to take me, could this just have been a telephone call, there was no physical examination on each occasion". Quote from Carers Group, Goole

Out of hospital support for vulnerable people

Providing services outside the acute hospital setting and into the community was considered extremely important for people with vulnerabilities such as Mental Health, Learning Disabilities, Dementia, Drug and Alcohol issues. Having locally based community services that where available generally and at times of crisis was seen as the preferred delivery location. Peoples experiences of A&E had exacerbated the situation for all concerned including patients and their supporters, other patients and visitors and medical staff. For example, Learning Disabled people would like to have more access 24/7 to specialist nurses and/or Epilepsy Clinics to prevent A&E visits.

There were very strong views that some people being treated in the acute hospitals should be able to access an alternative environment safeguarding other patients and

staff. There was empathy for the medical staff who have to deal with situations as a result of people taking drugs and alcohol. The following example was given;

"Drugs and alcohol issues are causing problems, they should not be treated at the acute hospitals, this is self-inflicted" Extra Care, Hull.

Prevention

There as a clear message that the NHS need to empower people to take control and look after themselves by providing training, support and encouragement. People felt they needed to know more about prevention services and where and how they can access them. There should be:

- More investment in advertising the range of services available (from all sectors)
- An investment and increase in prevention services
- Education starting at an early age (primary school)
- Published criteria for individual services
- More investment in technology to monitor people's health care needs and 24-hour access to support and advice

The following example was provided to demonstrate the effectiveness of technology used to monitor health conditions;

"I can monitor my own heart from home by using the "Raspberry pi" which is linked to the hospital receiver and automatically sends information, if there is a non-urgent issue, I receive a message and advice on what to do. It will also alert someone and myself of something more serious". Extra Care, Hull

It was reported that in some area's prevention services had been reduced or phased out due to lack of funding. For example, day centres and respite holidays for people with disabilities/ill health (and their carers) are no longer free. Day centres addressed health issues associated with isolation and loneliness which in the long run prevented a heavy reliance on other health care services such as access to GP, medication, mental health services, acute services and A&E at point of crisis. It was considered a false economy not to invest in prevention as the alternative merely shifted the issue/cost around the system.

The role of Informal Carers

Informal Carers felt that they needed to be seen as equal partners within the health care system they have a voice and need be listened to particularly as they save the system a vast amount of money. They know the person they are looking after and their idiosyncrasies and need to be part of the care planning process as they are often not only a care provider but also the person coordinating all the service provision.

Informal Carers stated that they were left feeling vulnerable when the person they are caring for is in pain and doesn't appear to be receiving the right medication or treatment or a (professional) decision as been made without their involvement. At these times they appreciate the impartial advice and support of a third party and

have often found this from the voluntary sector for example the Admiral Nurses or Stroke Association.

Informal Carers feel that they have learnt by experience, but they still need to learn and would like the opportunity to increase and update their knowledge and skills.

They can identify situations where they currently have no alternative but to ring 999. It was felt that by working together in partnership, manageable, safe solutions could be identified and prevent unnecessary hospital admissions. For example, a “Just in case box” which provided antibiotics and oxygen and training for the carer in when and how to use it, could have prevented an unnecessary hospital admission for a very frail and disabled lady which resulted in distress for her and her carer.

“Train people to help themselves and others” Quote from the Carers Group in Barton upon Humber

It was acknowledged that the increase in Day Surgery is of benefit to the system, saves money and reduces the pressure on beds. However, from a carers perspective there is an increase in pressure to be able to support the person when they are discharged and quite often without any additional resource. Some Carers told us that they had often seen longer hospital stays as an opportunity for respite providing them with time to recuperate from the challenge of caring.

12. Challenge 3: Workforce

Workforce:

People empathised with workforce issues understanding the reasons for difficulties around the recruitment and retention of staff.

"People don't want to come to Hull". "How do you sell Hull, to attract professionals?". Quote from Extra Care, Hull

The following were identified as factors which make a career in health less attractive:

- Cost of degree programmes with student loans too expensive to repay on the qualifying salaries
- Twelve-hour shifts were considered too long
- Lack of support for staff members' physical health, emotional stress and wellbeing
- The cycle of staff shortages which places pressure on remaining staff to cover vacancies and sickness leading to stress, sickness and ultimately resignation leading to staff vacancy
- When looking at the range of career options for young people there appears to be a culture of seeking work that is least pressurised and well paid which is not conducive to a career in health. It was also considered that apprenticeships are more attractive, less pressure and better paid
- The change in nursing staff training from ward to University, and the emphasises an academic ability could dissuade more practical people from pursuing a career in the NHS
- Staff leaving their 'day job' and signing up on the "Bank", it was suggested that this is due to better terms and conditions being offered e.g. more flexibility and increased pay
- The quality of the training in the NHS is very high and there were concerns that once staff had been trained, they would leave and seek employment in other countries such as America. It was felt that the NHS needed to offer much better terms and conditions in order to retain and attract staff to the NHS.

"No time to talk to patients, no time to eat" MIND Ambassadors, Hull and East Riding

"Brightness, willingness and caring wanes as the twelve-hour shift goes on". Quote from NELLES Carers Group in Grimsby

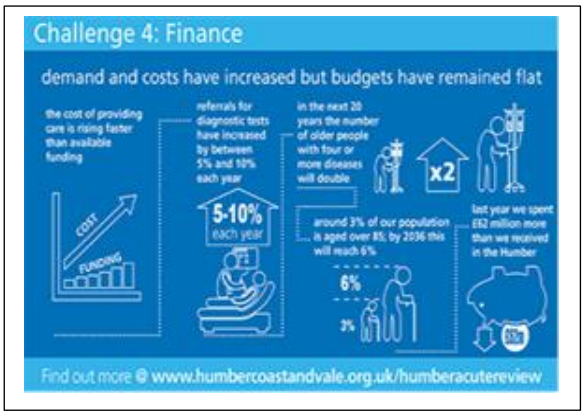
Proposed solutions;

- Reintroduce the Bursary Schemes
- Make the job and the place more interesting and attractive and provide accommodation
- Improved packages including improved pension
- Emphasis on promoting work life balance including flexible working patterns and improved hours of work to support professionals who are also informal carers
- More input from the Nurses Union to provide support to health staff particularly nursing staff
- Training and recruitment of the workforce needs to begin at school to encourage people at a young age to think of a career in the NHS covering the whole range of career opportunities
- Training should provide a balance of theory and the 'hands on' approach to attract a range of people
- The NHS should take measures to recoup all monies when newly qualified staff leave and put it back into the "NHS pot" and/or draw up a contract to say they must stay and work in Britain for 'x' amount of years or they have to pay the full amount back. Then, if or when they do leave, the NHS does not lose out financially.

"A second-year nurse who had qualified at University didn't know how to change a drip; the patient who just happened to be a qualified nurse showed her how to do it". Quote from the Carers Group, Goole

The use of locum and bank staff were not only considered to be costly but also unfamiliar with the building, staff team or even patient care which impacts on the quality of the service provided.

13. Challenge 4: Finance



People had a good understanding of the financial issues facing the NHS and the purpose behind reviewing current service provision and delivery in an attempt to reduce cost, redistribute available money and make savings whilst improving services.

There was recognition that changes in service delivery and cost (or savings) in one part of the system often had a knock-on effect to another service or part of the system. Acute services cannot therefore be seen (or reviewed) in isolation. There was a firm belief that the "system" is the problem and gate keeping does not save money, people's health continues to deteriorate which costs the 'system' more in the long run.

Some older people were offended by the statements that they were costing more to the health service, they weren't seen as saving the system money because in many instances they were providing free care as informal carers.

There was some concern about the impact of Brexit on the NHS and how that would affect the current costs and delivery of services.

"If targets are not achieved, they get fines, so this reduces the money available to provide services". Quote from Extra Care, Hull

Participants were keen to promote their ideas to help reduce the deficit:

- Missed appointments should incur a cost, the result being a reduction in non-attenders, creating capacity in the system
- All (health and social care) organisations should work together "pooling budgets" and sharing the costs of services
- The cost associated with the use of bank nurses and locums to cover vacancies, staff sickness and annual leave, which is potentially triple the cost to cover shifts should be used to attract and recruit permanent staff
- Improving waiting times means that targets are met and 'fines' are reduced
- Listen to the workforce i.e. nurses they know were savings can be made
- Don't make money out of the things that patients' value (the television and telephone) or patients and visitors cannot manage without (parking/parking fines)
- Although the NHS does not charge for its services, it was emphasized that the people who should pay, do pay
- To increase National Insurance contributions.
- Introduce a means testing system, whereby the "Super Rich" pay for services provided.
- Review procurement rules and practices to promote "value for money".
- Prescription medication and current practice needs challenging for example:

- cost of prescribing paracetamol
- Dossett boxes costing approx. £31 per week whether there is one tablet in or 100
- the disposal of medications that could be recycled
- issuing paper prescriptions versus digital
- move from six to twelve monthly medication reviews (where appropriate)

There is a belief that there are too many managers and not enough investment in the medical staff for example, nurses. One person described this as the 'upside-down affect':

> *"Too many at the top of the pyramid, showing investment in managers and not enough at the bottom". Quote from the Carers Group, Goole*

14. It's the simple things

Throughout the targeted engagement and discussion with individuals and groups it has been interesting that, although people understood the need to review and revise the clinical service areas identified, it was often the 'customer service' element of delivery that had the greatest positive and negative impact:

- Listen to patients and their carers

"They didn't listen to me or my family what I liked and disliked, my daughter had to leave a written message for staff, saying 'She likes tea'" Quote from Stroke Association, North Lincolnshire.

- Treat people as individuals and tailor the support to the person

"They assumed that because I couldn't speak, they didn't speak to me". "They made decisions without including me. They moved me to a side ward and didn't tell me why. I was frightened and felt isolated. I was left with no nurse call in easy reach. On more than one occasion they put me in a wheelchair and took me off for further tests without asking or explaining to me where I was going and why. I felt ignored" Quote from Stroke Association North Lincolnshire

- Information is in a language that can be understood (written, signage and spoken)

"My son had to read my smear test results out to me". Quote from Disability and Rights, Hull and East Riding.

- Hospital is a caring environment

"The nurses made me feel human and often made me laugh, this is important for recovery". Quote from the Stroke Association, Scunthorpe

15. Wider system issues and suggested solutions

It was impossible to isolate the engagement to only the services identified in the acute services review, people see and experience 'health' as part of a whole system without boundaries and separate service providers. Therefore, we have also included wider concerns and solutions raised as part of the targeted engagement process.

GP practices

The GP receptionist role has been enhanced to signpost people to more appropriate provision. However, a small number of people in our discussions experienced being advised to go to A&E in situations they considered not to be an emergency.

It was also felt that GP practices needed to ensure receptionist staff received updates in relation to changes in services and provision to prevent shifting the issue (and patient/carer) around the system. For example the annual flu jab for a young person with a heart condition which had previously been provided by the GP would now be provided from the school, who informed them it would be provided by the pharmacy, the pharmacist sent the person back to the GP who informed them that the GP provides the injection up to age 15 years.

There were some concerns raised regarding being asked questions about the reason for requesting a GP appointment in an open reception area.

It was felt that there was little familiarity at the GP surgery now and the personal touch and familial history and knowledge that was evident in bygone days no longer exists. The use of locums was thought to exacerbate this.

There continues to be difficulties in some areas for people to obtain a GP appointment at the right time and date for the illness being presented.

"You have to have an appointment to be ill and that is wrong on so many levels". Quote from The Forge Homeless Project, Scunthorpe

Conversely, there were examples of GP practices who have well-managed and effective appointment system.

Although GP practices are working together better and practices have merged people in the engagement sessions felt that this had not increased the capacity within the appointment system. There was a belief that when GP appointments were difficult to get, people went direct to walk in clinics and A&E.

People could see a real advantage in an investment in mental health services at a GP practices and local community level. There were examples of people's mental health deteriorating due to lack of capacity, resources or knowledge at a GP practice level. This had led to people being sectioned under the Mental Health Act, ambulance use and attendance at A&E which was considered to be an inappropriate response and waste of resources if it could be dealt with locally and de-escalated.

"I was sent to A & E as I couldn't get an appointment with my GP. I was in a room with only a sink and nowhere to sit, it was like I was in a cell" Quote from MIND in Scunthorpe

Other suggestions for ways in which investment in GP practices could relieve pressure on acute hospitals included:

- GP's providing results following tests and treatments rather than attending the hospital for a 'check-up' when no further intervention was required
- Increase the number of minor procedures carried out
- Undertaking blood tests which currently require patients to travel to hospital (this was considered to be a training issue)
- An increase in 'out of hours' appointments
- 200 people residing in a unit, all with health issues could have their own health care practitioner, this would reduce the pressure on the hospital and GP surgeries.

"Need more services in GP surgeries and in the community". Quote from Ambassadors Hull and East Riding

Utilisation of existing Community Services

There was felt to be an underutilisation of exiting community services for example X-Ray at North Bransholme Health Centre (Hull) and East Riding Community Hospital (Beverley) which would prevent people attending A&E and the Ironstone Centre (Scunthorpe) for minor procedures e.g. cyst removal, reducing pressure on Scunthorpe General Hospital.

More information is required for the public about "drop in clinics", who should attend, for what reasons, how to access them, where they are located and their opening times.

There were a number of positive comments about the Jean Bishop Centre. The location was pleasing especially for the people residing in the east of Hull. It was felt that more of this type of services were required. Bringing services together under one roof rather than patients receiving several appointments and a 'fragmented' service.

"The Jean Bishop Centre is a brilliant idea" Quote from Extra Care in Hull

Community Pharmacy

Concern was raised over a lack of stock on site to fully dispense prescriptions leaving customers to ring around other pharmacies to complete the prescription.

It was suggested that Pharmacists should ask customers to check their bag of medication prior to leaving the counter so that any discrepancies can be rectified, and any over prescription can be removed and recycled.

Awaiting medication was often identified as responsible for delaying discharges from hospital. A proposal was that a hospital prescription is sent electronically to a local pharmacy for dispensing.

Access to pharmacy on a weekend and bank holidays was difficult for people without transport, carers and those living rurally.

Ambulance Service

People complained about having to wait for Non-Emergency Patient Transport, which would impact on their appointment time, they would arrive late and in a distressed state. Waiting for transport for discharge was seen equally frustrating and distressing due to the length of wait and time spent on the ambulance.

"Ambulance arrived late which had a knock-on effect for my appointment, you have to wait ages to get back home, then you have to drop other people off on the way". Quote from Men in Sheds in Winterton

"Following a 10-minute morning appointment, we had to wait until 8pm for transport home when none was available they paid for a taxi". Quote from NELLES Carers Group in Grimsby.

We were told that the Ambulance service refused to take a patient's individual wheelchair. This had an impact on the patient resulting in a loss of independence. It also had wider implications and placed unnecessary pressure on hospital staff and their time.

We were given an example where an informal carer was not 'allowed' to travel in non-emergency transport to provide support and reassurance to the person they cared for who had Dementia. This would appear detrimental to all concerned.

We received examples of length of delay in relation to emergency transport which ranged from 4 hours to 11 hours delay. There were three reports of ambulances being brought in from out of area, (Castleford) to respond to emergencies.

Triage for emergency ambulance was described as 'time consuming' when in a crisis and some of the questions feel inappropriate. This can lead to frustration for both parties. There is an expectation from the caller that the call handler will be able to respond immediately and have a level of understanding about what the caller is experiencing.

NHS 111

There were reports that calling 111 was considered a 'waste of time'. This was in relation to the advice provided and a tendency to send people to hospital which they had hoped to prevent by calling 111.

A question was raised whether NHS 111 has the capacity to hold information about accessing a range of appropriate local services (health, social care and general wellbeing). This could divert people away from acute services to receive the right intervention in the right place at the right time.

Adult Social Care

People who need 1 to 1 or additional support when accessing health appointments are having to use their personal budgets/health care budgets to pay for staff attendance therefore reducing the allocation for social interaction which in turn impacts upon their general wellbeing.

In residential care there is an expectation and good practice would be that a staff member would support the person to attend health care appointments but the cost of this is being met by the Residential Home which impacts on the budget and staff capacity.

The care call systems were considered to work very well, and people were reassured to know that there was somebody to call upon when needed.

People felt that there was fragmentation between services and that closer working between health and social services was needed.

There was concerns that older people do not get enough support to be able to return home from hospital quicker or to move to an alternative environment if required. This included a lack of night sitter services reducing access to night-time respite for informal carers.

"Delay in getting home from hospital I had to wait for banister rails to be fitted before I could go home". Quote from Stroke Association Scunthorpe.

Voluntary and Community Sector

The voluntary and community sector was seen as an important network of support particularly when acute and community services were withdrawn following a health crisis.

For example, the Stroke Association (North Lincolnshire) was seen as an important element of continuing recovery for the person with the stroke and also their carer. When intensive physiotherapy, speech therapy and occupational therapy is completed people described feeling 'abandoned' but the Stroke Association had provided the encouragement and support to continue their recovery. A 'simple' service, for example the Singing Group, helped to reduce anxiety, depression and isolation.

"We are all very different but have an understanding of what it is like to have had a Stroke because we have experienced it". Quote from Stroke Association, Scunthorpe.

There was an identified need for extended hours (early mornings, evenings and weekend), increased volume, flexibility and investment in the voluntary and community transport to respond to the wider range of appointments available.

Although people used the Medibus service and felt the cost was really good, they were concerned that, due to the circuitous routes into the hospital, they could be late for their appointment or, if there was a delay in their appointment or their appointment was too late in the day, that they would be unable to return home.

Local carers groups were seen as important for informal carers to share their experiences and get support, receive information and care for each other. When 'professional' health and social care services 'leave' this places reliance on the informal carer and the network of local carers groups was seen as essential to their ability to provide continuous support to the person being cared for.

Through discussion the following roles were identified that are or could be undertaken by volunteers within and external to hospital:

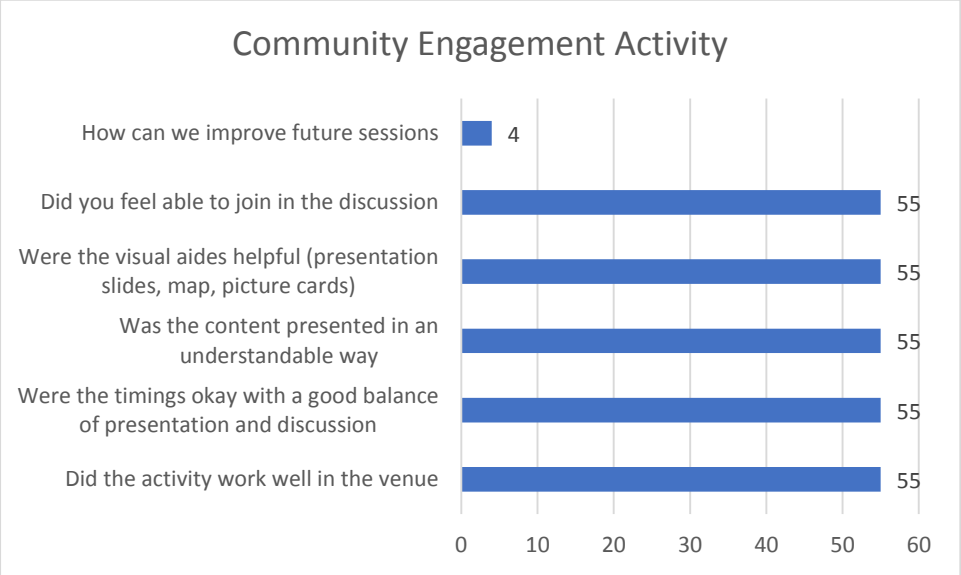
- Providing 'meet and greet', directions, accompanying people to their waiting area
- Within waiting areas: serving drinks, assisting people to remain calm
- Explaining the purpose of the discharge questionnaire, how to complete it and provide support for those people that need it, acting as an independent person
- British Red Cross provision of the pressure stockings service could be provided within and external to the hospital to prevent delayed discharge
- Work with local Joiners' builders and handy men to make and fit minor adaptations e.g. handrails and ramps and furniture removals and relocation.

"I was waiting 4 hours for some white stockings". Quote from Men in Shed in Winterton.

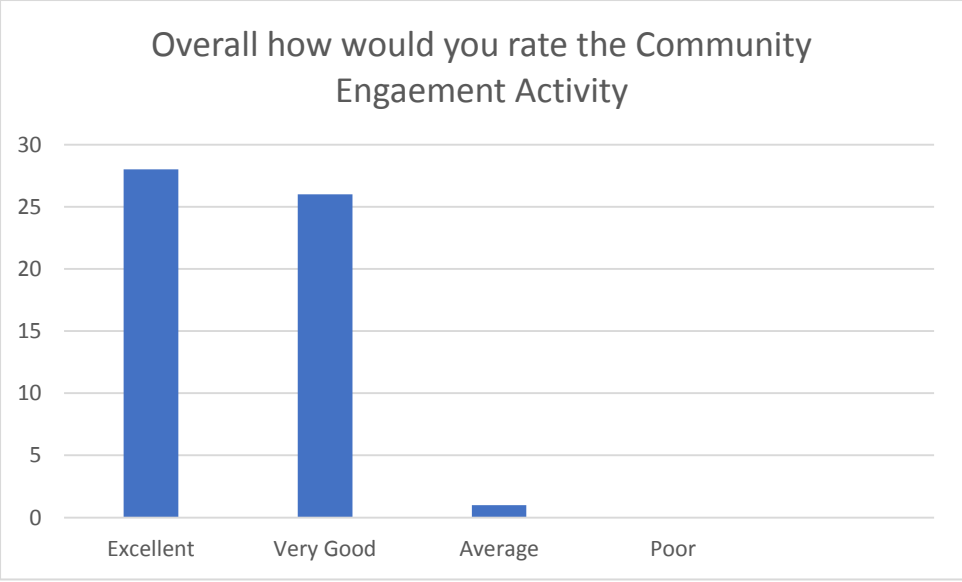
16. Evaluation of the Targeted Engagement process

The following evaluation provides an indication of how well the Community Engagement was received. The graph below identifies the areas and key questions that were asked of all participants. There were quite a few people who did not complete the form, some people left before the form was distributed, some people declined to complete the form as they had already focussed their energy on completing the Characteristics Form. Nevertheless, the evaluation provides some very pleasing results.

In all there were 55 people who agreed to complete the form. The results below speak for themselves. All 55 people responded overwhelmingly “Yes” to the identified areas below.



All participants were asked to rate the overall Engagement Activity. The results can be seen below.



The following are examples of some of the comments made by participants about the Community Engagement activity;

Quotes from participants:

"Good presentation and ability to have discussion"

"Very insightful, explained well with the ability to contribute ideas"

"Enjoyed the discussion"

"Tailored really well for the residents at Applegarth"

"Really friendly speakers"

17. The Citizen's Panel

Throughout the Targeted Engagement activity, we were keen to promote the Citizen's Panel and encourage people to put themselves forward to attend and represent their local communities. This would also ensure their feedback and experiences were reflected in any recommendations made. All participants were provided with a verbal summary and written information on the Citizen's Panel.

We were surprised by the number of people who put themselves forward (nine), to the point where we have had to look at ways in which we could reduce the number of people attending the panel whilst also ensuring that groups feel they are being represented (one person per group/geographical spread).

Interested representatives were invited to attend a pre-meeting to further explain the role of the Citizen's Panel and the activities undertaken to date prior to the formal Citizen's Panel meeting taking place on Wednesday 24th July 2019.

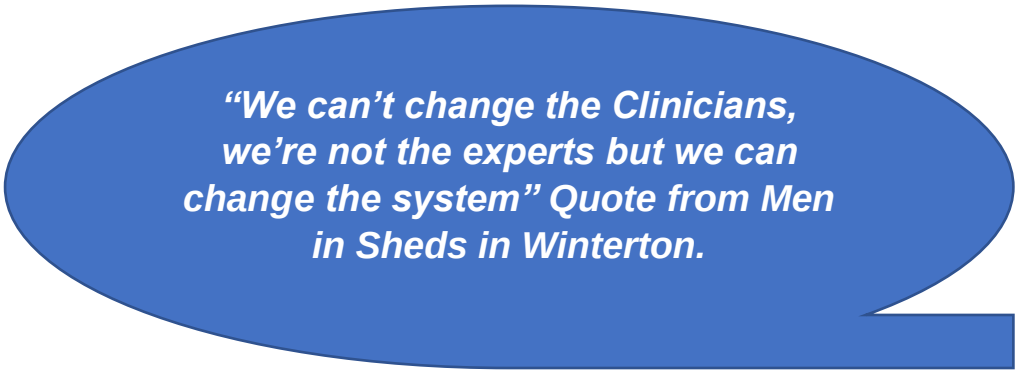
There were places for four Citizen's Panel Representatives from the Targeted Engagement activities and two people attended on the day.

18. Targeted Community Engagement as a tool to developing services

When first approached, some groups and group 'leaders' thought that this engagement activity and topic would not be appropriate to them but as shown in the evaluation, the majority of people really engaged with the discussion and are very interested in how their comments and suggestions will influence the service review, design and outcomes.

To give this process credibility it is important that Humber, Coast and Vale Health and Care Partnership remain in contact with the groups providing feedback on progress. This will mean putting in place an accessible communication mechanism in addition to the Citizen's Panel as not all groups and communities are represented.

Early engagement in the potential design of future services prior to formal consultation promotes transparency in decision making, improves relationships with the communities they serve and in so doing increases the integrity of the NHS.



Appendices

Appendix 1 - Letter

Dear……

My name is Moira Harrison and I work for Humber and Wolds Rural Action (HWRA). We are undertaking the ‘Targeted Community Engagement’ element of the Humber Acute Services Review on behalf of the Humber, Coast and Vale Health and Care Partnership. The review is being conducted across the Acute Hospital Services in the Humber region.

We would particularly like to speak to those people who are often unable to have their voices heard because of cultural differences, disability, gender or simply because they are considered to be somewhat different or difficult to engage with. For example, the 'hard to reach' groups most commonly identified are sex workers, drug users, people living with HIV and people from lesbian, gay, bisexual, transgender and intersex communities but there are a number of other groups to which the description applies including asylum seekers, refugees, black and minority ethnic communities, children and young people, disabled people, elderly people and traveller families.

It is important that we capture the views and ideas from those people who do not normally partake in public reviews. Therefore, I would be grateful if you would assist us in identifying such groups and organise a suitable date for us to come along, explain about the review and, through discussion, find out what are the things that concern people the most about the potential changes.

The session can take between 30 minutes and 2 hours dependent upon how much people engage in the discussion and the time available.

Appendix 2 – Marketing leaflet

Humber Acute Services Review Targeted Communication and Engagement

Have you or someone you care for used any of the following hospital services? • Stroke • Neurology • Cardiac • Critical Care • Complex Rehab Do you have experience of using any of the services or support someone who does? Are you interested in helping your local NHS to shape the future of the services in the Humber area?	The Humber Acute Services Review is looking at a range of hospital services across five hospitals in the Humber area: • Scunthorpe General Hospital • Diana Princess of Wales Hospital, • Goole Hospital • Castle Hill Hospital • Hull Royal Infirmary You can find out more about the review on our website: www.humbercoastandvale.org.uk/humberacutereview We would like to speak to people who do not normally take part in public consultation to find out your views

If you are interested, please contact me on 01652 637700 or email me moira.harrison@hwrcc.gov.uk

Appendix 3 Handout

Humber Acute Services

Review

“Finding out what you think”

HWRA

The Humber Acute Service Review

What is a service review?

A service review involves examining a service area thoroughly to understand which parts of the service are working well and which are not working as well, to find ways to improve the service further for the good of the patient. This may involve looking at department policies and processes, data analysis, speaking often and regularly to the people who use the service and the doctors and nurses who provide them. Once all this information has been gathered, it is used by managers of the service to help them plan for improvement.

Why do we need to review hospital services in the Humber region?

Advances in medical knowledge and technology have allowed our doctors to develop fantastic services for our hospitals, which, in part, is helping people live longer and survive illnesses that their parents or grandparents might not have. These developments have also enabled more healthcare services to be provided away from hospitals — at GP practices and in the community, for example — while hospitals continue to focus on looking after the most seriously ill patients.

As the ways of delivering care to patients change, an extensive hospital services review is needed to ensure we provide services that are safe and patient-centred, both now and in the future. NHS services need to constantly adapt to provide the best possible care for patients with the resources available. Current challenges, such as rising demand, workforce challenges, finance and quality of care mean that change is necessary to ensure the future of our health services.

Who is Humber and Wolds Rural Action?

We are a voluntary organisation, which works with local communities and other voluntary groups and statutory organisations. We cover the East Riding of Yorkshire, Hull, North Lincolnshire and the North East Lincolnshire areas, providing a range of services and projects, for example:

- Voluntary Car Service
- Wheels to Work
- Men in Sheds
- Community Led Housing
- Village Halls Advisory Service

We have been asked to speak to groups and individuals who don't normally get involved with hospital and health service reviews to make sure as many people as possible have their say.

If you like any further information about what the HWRA do, you can visit us on our web site: **www.hwrcc.org.uk**

Email us: **infor@hwrcc.org.uk**

Phone us: 01652 637700

Write to us: Baysgarth House, Caistor Road, Barton upon Humber, North Lincolnshire, DN18 6AH

What services are being reviewed?

Stroke

Neurology

Cardiac

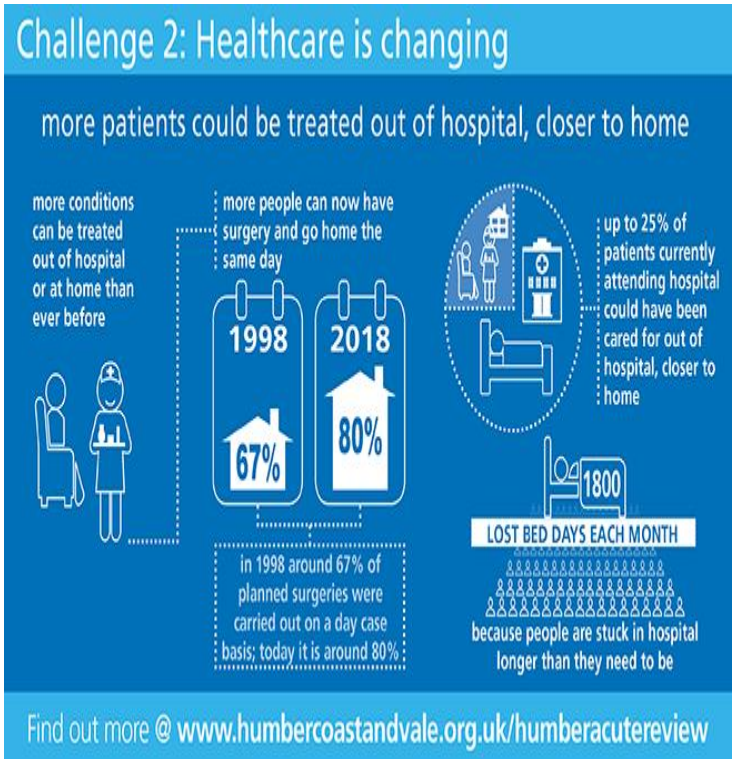
Complex Rehabilitation

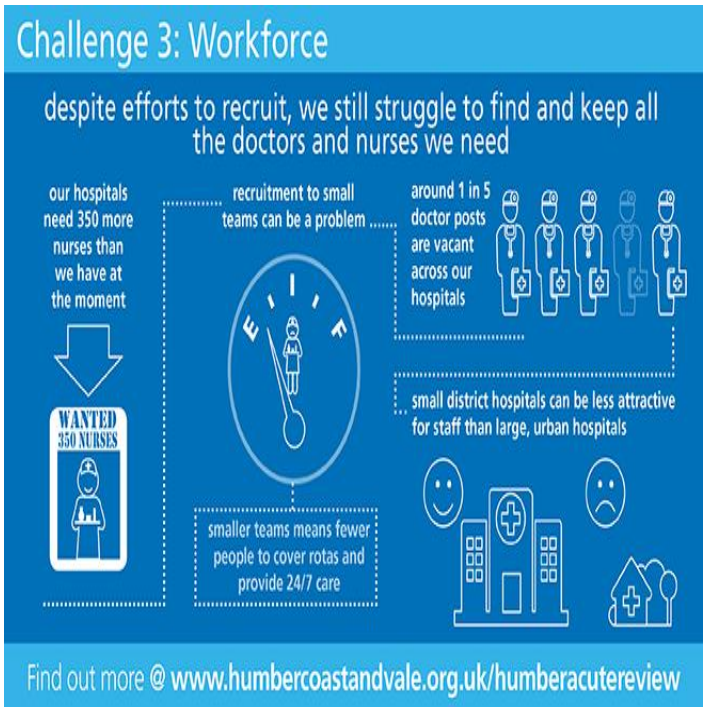
Critical Care

The key challenges for the acute services in the Humber area

All patients should get the best possible care, but the quality and safety of all the NHS health care services varies enormously and depends on where and when you are treated. For example, senior doctors are not always available round the clock for patients admitted to hospital in an emergency. This can cost lives, and people cannot always get the help when they need to, for example from their GP or another

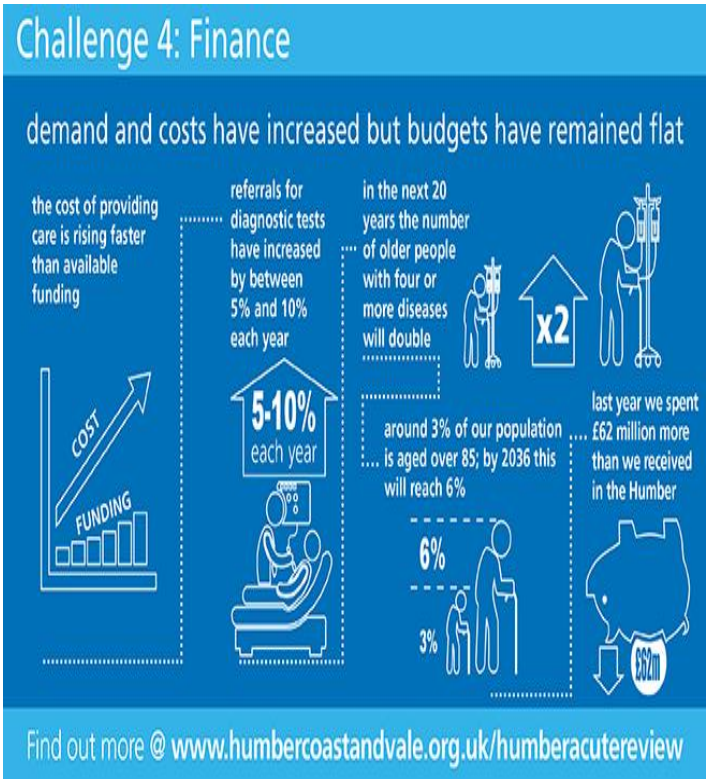
The needs of our population are changing and what the NHS can do within healthcare is changing, so the
NHS need to deliver services differently. For example,
people are living longer and many more people are living with long term
conditions such as Diabetes, heart disease or Dementia.
This means we need more care outside hospital and more support to help people stay well





The NHS do not have the staff to go on as they are, Our hospitals are struggling to find and keep the expert clinical staff they need in a whole range of specialities this is despite active recruitment both Trust continue to struggle to recruit to key roles i.e. Doctors and nurses without these the Trusts cannot run the safe, high quality services local people deserve

The cost of delivering health services is rising much faster than inflation and our local NHS is already under significant financial pressure. Without changes, the financial position of the local NHS will continue to deteriorate, and it will become increasingly difficult for us to continue to provide the services our population needs in years to come. While the financial and staffing challenges are huge and urgent, there is evidence that if the NHS spend money differently, they can get services that are both better and more affordable



What is the Citizens Panel?

The Citizen's Panel is a group of local people who will be provided with detail about the review and asked to provide a view from their perspective as members of the public representing their local community. The Panel will be involved in developing and reviewing possible solutions to the challenges presented. The views and ideas put forward by the Citizen's Panel will be considered by decision makers. If you would like to find out more speak to Moira Harrison at HWRA, details below;

Telephone: 01652 637700

Write to us: HWRA, Baysgarth House, Caistor Road, Barton upon Humber, North Lincolnshire, DN18 6AH

Email: moira.harrison@hwrcc.org.uk

Have your say

Throughout the review process we are keen to hear from members of the public to ensure their feedback and experiences are reflected in any recommendations made.

You can do this in several ways:

Email: humber.acutereview@nhs.net

Phone: 01482 344711

Write: Humber Acute Services Review, c/o NHS Hull CCG, 2nd floor, Wilberforce Court, Alfred Gelder Street, Hull, HU1 1UY

Who to contact if you have any concerns about any of the acute services?

If you have concerns about the care and treatment you or your family member has received at one of the following hospitals, then you can contact PALS.

PALS is the Patient Advice and Liaison Services. They are located at each of the hospitals in the Humber area, please see below for their contact details.

North Lincolnshire & Goole Hospitals NHS Foundation Trust

Diana Princess of Wales	Scunthorpe General	Goole
Tel: 01472 875403 Scartho Road Grimsby DN33 2BA	**Tel: 01724 290132** Cliff Gardens Scunthorpe DN15 7BH	**Tel: 01724 290132** Woodland Avenue Goole Yorkshire (west Riding) DN14 6RX

Hull & East Yorkshire Hospital NHS Trust

Hull Royal Infirmary	Castle Hill
Tel: 01482 623065 Anlaby Road Hull HU3 2JZ	**Tel: 01482 623065** Anlaby Road Hull HU3 2JZ

If you prefer, you could contact one of the Healthwatch organisations. Healthwatch is an independent organisation that has statutory powers. If you are concerned about the treatment or care you or your family members have received from Health or Social Care services, please see below for your local Healthwatch contact details.

Healthwatch Hull

Telephone: 01482 595505

Post: Healthwatch, CVS 75 Beverley Rd, Hull HU3 1XL

Email: enquiries@healthwatchkingstonuponhull.co.uk

Healthwatch East Riding of Yorkshire

Telephone Office: 01482 665684

Office hours Monday - Friday 9am-5pm. Out of hours please leave a message.

Address: Unit 18 Brough Business Centre Skillings Lane, Brough HU15 1EN
Email: enquiries@healthwatcheastridingofyorkshire.co.uk

Healthwatch North East Lincolnshire

Telephone: 01472 361459

Address: Office Suite 4 Alexandra Dock Business Centre Fishermans Wharf, Grimsby DN31 1UL

Email: enquiries@healthwatchnortheastlincolnshire.co.uk

Healthwatch North Lincolnshire

Telephone Office: 01724 844986

Office hours Monday - Friday 9am-5pm. Out of hours please leave a message.

Address: Unit 36 & 37, Normanby Gateway, Lysaghts Way, Scunthorpe, DN15 9YG

Email: enquiries@healthwatchnorthlincolnshire.co.uk

Alternatively, you could contact your local areas Independent Health Complaints Advocacy Services. They are available to provide support for people making, or thinking of making, a complaint about their local Health or Social Care Services. Please see below for details;

East Riding of Yorkshire
Telephone: 0303 303 0413/01482 880160 **Email:** enquiries@cloverleaf-advocacy.co.uk **Address**: Hesslewood Hall, Ferriby Road, Hull. HU13 0LH **Website**: www.cloverleaf-advocacy.co.uk
Hull
Phone: 01482 880160 **Email:** enquiries@cloverleaf-advocacy.co.uk Address: Hesslewood Hall, Ferriby Road, Hull, HU13 0LH
North Lincolnshire
Address: Ashby Clinic, Collum Lane, Scunthorpe DN16 2SZ. **Phone:** 01724 854952 Fax: 03006660125 Text: 07860021502 **Email:** northlincs@cloverleaf-advocacy.co.uk **Web referral form**: www.cloverleaf-advocacy.co.uk/content/referral-form
North East Lincolnshire
Local Independent Complaint Advocate for Health and Social Care **Contact:** Karen Smith **Telephone:** 01472 361459 **E-mail:** Karen.s@carersfederation.co.uk **Website:** www.carersfederation.co.uk

Following the session today, what do you think are the most important things for those involved in reviewing hospital services to take into account:

-
-
-

If you are interested in joining the Citizens Panel, please provide contact details below:

Name:

Contact telephone number:

Contact email:

If you would like to receive feedback on the review, please provide your contact details or those of your local organisation or group:

Name/organisation

Contact telephone number:

Contact email: