

Agenda

Adults and wellbeing scrutiny committee

Date: **Friday 18 October 2019**

Time: **2.00 pm**

Place: **Committee Room 1, Shire Hall, St. Peter's Square,
Hereford, HR1 2HX**

Notes: Please note the time, date and venue of the meeting.

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Agenda for the meeting of the Adults and wellbeing scrutiny committee

Membership

Chairperson	Councillor Elissa Swinglehurst
Vice-chairperson	Councillor Jenny Bartlett

Councillor Sebastian Bowen
Councillor Helen I'Anson
Councillor Tim Price
Councillor David Summers
Councillor Kevin Tillet

Agenda

	Pages
1. APOLOGIES FOR ABSENCE To receive apologies for absence.	
2. NAMED SUBSTITUTES To receive details of any member nominated to attend the meeting in place of a member of the committee.	
3. DECLARATIONS OF INTEREST To receive any declarations of interests in respect of schedule 1, schedule 2 or other interests from members of the committee in respect of items on the agenda.	
4. MINUTES To approve and sign the minutes of the meeting held on 24 June 2019.	7 - 12
5. QUESTIONS FROM MEMBERS OF THE PUBLIC To receive any written questions from members of the public. For details of how to ask a question at a public meeting, please see: www.herefordshire.gov.uk/getinvolved The deadline for the receipt of a question from a member of the public is Monday 14 October 2019 at 5.00 pm. To submit a question, please email councillorservices@herefordshire.gov.uk	
6. QUESTIONS FROM COUNCILLORS To receive any written questions from councillors. The deadline for the receipt of a question from a councillor is Monday 14 October 2019 at 5.00 pm. To submit a question, please email councillorservices@herefordshire.gov.uk	
7. ONE HEREFORDSHIRE AND INTEGRATION BRIEFING To provide an updated overview of the Sustainability and Transformation Programme (STP), One Herefordshire and the integration agenda for health and social care.	13 - 108
8. WORK PROGRAMME To consider the committee's work programme for 2019-20.	109 - 120
9. DATES OF FUTURE MEETINGS Monday 18 November 2019, 10.30 am Monday 16 December 2019, 9.30 am (provisional) Monday 13 January 2020, 2.30 pm Monday 2 March 2020, 2.30pm Monday 11 May 2020, 2.30 pm	

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Minutes of the meeting of Adults and wellbeing scrutiny committee held at The Council Chamber, Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 24 June 2019 at 2.30 pm

Present: Councillor Elissa Swinglehurst (chairperson)
Councillor Jenny Bartlett (vice-chairperson)

Councillors: Jennie Hewitt, Helen I'Anson, Kevin Tillett and William Wilding

In attendance: Councillors Pauline Crockett, Carole Gandy, Kath Hey, Phillip Howells, Jim Kenyon, Felicity Norman and Diana Toynbee

Officers: S Vickers – director for adults and communities, A Pitt – head of partnerships and integration, P Smith – assistant director all ages commissioning, K Wright – director of public health, J Coleman – statutory scrutiny officer.

Herefordshire Clinical Commissioning Group:
Dr A Talbot-Smith Director of Strategy and Transformation (Herefordshire CCG and One Herefordshire), Joint Programme Director (Herefordshire and Worcestershire Sustainability and Transformation Partnership – STP), Dr I Tait – Chairman of NHS Herefordshire Clinical Commissioning Group, and Mr S Trickett (Accountable Officer for the NHS Clinical Commissioning Groups in Herefordshire and Worcestershire).

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Bowen and Summers.

2. NAMED SUBSTITUTES

Councillor Hewitt substituted for Councillor Bowen.

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 5 March 2019 be confirmed as a correct record and signed by the chairperson.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

6. QUESTIONS FROM COUNCILLORS

There were no questions from councillors.

7. THE FUTURE OF THE HEREFORDSHIRE AND WORCESTERSHIRE NHS CLINICAL COMMISSIONING GROUPS (CCG) CONSULTATION

The committee considered proposals, by Herefordshire and Worcestershire CCGs to merge the existing four NHS CCGs (in Herefordshire, Redditch and Bromsgrove, South Worcestershire and Wyre Forest) to form a single CCG footprint for the whole of Herefordshire and Worcestershire by April 2021, with the (preferred) option to undertake this change earlier, by April 2020.

Given the nature of the business to be discussed members of the children and young people scrutiny committee had been invited to attend and contribute to the meeting.

Dr Talbot-Smith gave a presentation to the committee. The slides had been circulated as a supplement to the agenda papers.

The chairperson invited comments and questions. The principal points included:

- In relation to consultation on the proposal, Mr Trickett commented that the proposal was a back office, administrative reorganisation that did not involve service change. It was change to services or access to services that legally required consultation to be undertaken. NHS England should have run any consultation on the current proposal because it would ultimately be their decision. They had decided that as a matter of national policy CCGs would become bigger and merge. However, the CCGs wanted to maintain good relations with stakeholders and welcomed their views hence the current consultation exercise.
- The four CCGs had been working together closely for some years on the Sustainability and Transformation Partnership. Local authorities had been closely engaged in this process seeking to achieve a local answer to the challenges faced.
- The proposal would reduce the number of commissioning manager posts. He himself was already the sole accountable officer for all four CCGs. This reduction in duplication and cost was a big contribution to achieving the 20% saving in running costs by March 2020 that all CCGs were being required to make under national policy.
- The timing of the current consultation had been constrained by the local government elections. He outlined the consultation process.
- Given the national policy meant that merger would take place, one question was over the timing of any merger. He noted that delaying merger for one year to March 2021 would mean finding a way to achieve the required savings to which merger was expected to contribute.
- He considered that it would be most productive if the committee were to focus on what type of larger organisation was formed, what worked as a place based service for Herefordshire, and how to protect a constructive working relationship.
- He believed that there would always be an office presence in Herefordshire. There would also be a managing director working in the County whose main job would be to build relationships with the local authority. There would always be separate S75 legal agreements for the two counties because there were different things the CCGs wanted to do, different ambitions and different ways of achieving those ambitions.
- Dr Tait commented that clinicians were keen to see services as close to the user as possible. Instead of funding administration some of the required saving would allow additional expenditure on frontline services. Most GPs saw the merger as an opportunity to achieve this aim of bringing services closer to the user, removing some pressure from GPs and practice nurses and district nurses. He gave a number of examples.

- It was questioned whether pooling the funding available to the four CCGs would result in a reduction in the resource available to Herefordshire which currently had a higher per capita funding level than the other three CCG areas.
- In response it was acknowledged that the four CCGs had different levels of per capita allocation. Herefordshire was the highest. It was funded at about the right level having regard to the national funding formula. Each of the three Worcestershire CCGs was about 5% below the funding level the formula said they needed. No CCG could be funded at more than 5% below the formula. The biggest increases in funding on the base level that had been set would be directed to those CCGs furthest away from the target. This meant that whilst growth in the funding of the three Worcestershire CCGs was at a higher level than the growth in funding for Herefordshire the new CCG as a whole would be below the formula level. This meant that the area as a whole could expect a higher level of funding growth. He clarified that if the merger application was accepted a formula funding calculation would be made for the new area as a whole. Whilst the CCGs could not lobby for additional money, in discussions, for example with local MPs, efforts were made to try to ensure that the funding formula took full account of rurality and demography. It was recognised that transparency of local finances was important and the new body would continue to calculate and report individually on the finances of the four CCG areas. He would expect expenditure from 1 April 2020 would continue as current per capita levels given the level of assessed need would not have changed simply as a result of organisational change.
- It was noted that Herefordshire CCG was facing an £8m deficit at the year end. All the Worcestershire CCGs were looking to break even. One of the three Worcestershire CCGs had a cumulative deficit the other two had a cumulative surplus.
- The NHS guidance for CCG mergers stated that consultation with local authorities was required and prescribed various actions that had to be taken. It was questioned whether the consultation had been conducted in accordance with the guidance and sufficient time allowed.
- A comparison was also drawn between the information that had been provided to Worcestershire Health Overview and Scrutiny Committee and that provided to Herefordshire scrutiny committees and reference made to attendance of the accountable officer, based in Worcestershire, at meetings of the Worcestershire Committee but not at the relevant Herefordshire committees.
- It was asked how options had been selected from an original list of possibilities and why the option of retaining a CCG for Herefordshire had not been included in the consultation.

Mr Trickett replied that the options had been considered by the CCG Governing bodies. The possibility of having separate CCGs for Herefordshire and Worcestershire had been considered. NHS advice was that an application that was not based on the formation of a single CCG would not be acceptable. The CCG's view had been that engaging in a lengthy process seeking to pursue two CCGs in the light of that advice would have been unproductive.

Account also had to be taken of the national requirement to reduce running costs by 20% by 1 April 2020. In Herefordshire this amounted to some £600k. He did not consider that the CCG could fulfil its statutory duties if reductions to what was a small team in Herefordshire were to be attempted. Across the four CCGs the saving was £2m. The way in which CCGs were funded with a specific budget for staff meant that funding from other budgets could not be used to support staffing costs. The national policy therefore compelled CCGs to become bigger and was the biggest determinant in the proposed merger.

- In relation to Shropshire and Telford and Wrekin CCGs he commented that the proposal was for the two of them to merge. Although the population the merged body would serve would be comparatively small the current STP encompassed both areas and part of the national policy was that CCGs would match the STP footprint. The Herefordshire and Worcestershire merger would similarly align with the STP area.
- The consultation document stated that it was not imagined that the current CCG office presence would change over the next few years. In terms of a continued presence in Herefordshire Mr Trickett commented that the current office in Herefordshire was held on a long lease and was the cheapest of the three offices and probably the best accommodation. Bearing in mind the travel distances involved in serving the two counties he could not see how the CCG could work effectively without an office base in Hereford.
- Dr Tait commented that he considered the focus should be on what best met Herefordshire's requirements under a merged CCG. He wanted a strong relationship with the local authority to help remove barriers between health and social care and outlined other areas for development that he would like to see.
- Dr Talbot-Smith commented on the development of the STP and the partnership working that was taking place across the county with the local authority and others.
- It was noted that the deadline for submission of an application to merge had been extended by the NHS and was now mid-August. This allowed time for consideration to be given to the outcome of the consultation exercise.
- In terms of protecting Herefordshire's distinctiveness and a voice for Herefordshire Mr Trickett commented that there would still be a clinical leader for Herefordshire, and a managing director for Herefordshire to maintain a focus on Herefordshire and the relationship with the local authority and other partners.
- Regarding the required savings Mr Trickett indicated that he wished to avoid staff redundancies. Currently when vacancies arose the aim had been to allocate those duties to current staff with the appropriate skills, recognising that this would require them to prioritise their work. The merger would generate savings by removing some of the duplication arising from the bureaucracy required to support the interrelationship between the existing four CCGs. He hoped that the majority of the remainder of the savings could come from a reduction in senior level posts. There was currently a lack of transformation and programme management resource in Herefordshire. He hoped the proposal would increase that capacity.
- He acknowledged concerns expressed about how the interests of the two counties could be balanced given the larger population of Worcestershire.
- Dr Tait was invited to comment on the Joint Commissioning Committee that had already been in place for some 2 years. He commented that proposals had been modified in response to comments made by Herefordshire representatives. In addition to a clinical lead for Herefordshire he understood work was ongoing to obtain lay member representation as part of the future arrangements. Support for securing that representation would be welcome. Lessons could be learned from previous and existing working arrangements between the two counties.
- In terms of evidence as to the effectiveness of such mergers in practice Mr Trickett noted that Members could seek feedback from the merger of Birmingham and Solihull CCGs if they wished, noting that whilst an urban context, the strong sense of identity in Solihull may provide some insight. He emphasised the challenge to financial resilience that small CCGs faced. He noted the significant costs continuing healthcare packages could generate and the ability of a larger organisation with a bigger budget to absorb these unpredictable costs. There were also potential benefits in primary care commissioning drawing on the experience of South

Worcestershire CCG that had taken on a delegated role as commissioners of primary care for 4 years developing a sophistication of approach leading to allocation of resources to primary care. Herefordshire had taken up the same delegated power about a year ago.

- Regarding the timing of the proposed merger Mr Trickett commented that the CCGs wish to transfer by April 2020 in preference to 2021 was governed in particular by the fact that on 1 April 2020 the four CCGs would have 20% less funding and that the process was unsettling for staff, stakeholders and partners. The longer the uncertainty the greater the risk of losing key people. He believed that there was an opportunity to conclude the process and return to the focus on services. He acknowledged that working to the shorter timescale did, however, involve challenges. He did not consider that operating in a shadow form from April 2020 would be of benefit. In effect a shadow approach had been in operation for the past year. A number of senior appointments had been made working across all four CCGs. Governing body meetings were being held in common. The STP work was being run jointly.
- It was suggested that it would be important to have performance and quality measures in place to assess whether services in Herefordshire improved as a result of the merger alongside shorter term measures during implementation. Mr Trickett commented that he considered it would take some years to make a full assessment of the outcome of the change. Dr Tait added that he understood there would be quality reports by area.
- It was asked how the new arrangements would take account of projected population growth in the county and the demographic with an increasingly larger proportion of older people in the population. Mr Trickett commented that predicting health needs formed part of service planning. He outlined additional provision that was already being made in Hereford City. The benefit of the merger was the greater financial resilience that it provided to meet additional emerging costs. Health care integration would be an important part of meeting demographic pressures.
- Mr Trickett commented on how savings would be made in addition to reduced staff costs. As an example he noted that securing a combined contract for support services for all 4 CCGs had secured an annual saving of £600k.
- In terms of possible risks and downsides he was concerned about ensuring promises in terms of local place based commissioning, for example, were met. Unproductive travel time was a concern he had in this regard. Efforts were being made to use technology in place of face to face meetings where practicable. He was also concerned about losing good staff while uncertainty persisted.
- It was noted that Hereford GP practices would be asked to vote on the proposal. The feedback to date had been positive with interest in more sophisticated primary care commissioning. Concerns which had been raised reflected those raised in the committee's discussion.

RESOLVED: That

- a) The committee would like to see benchmarking and performance/delivery data (as set out in the Draft Operational Plan 2019/20) brought back to this committee in 12 months' time; exploring current and future commissioning outcomes, including tracking of the amount and spend in each of the four CCG footprint areas;**
- b) The committee recommends that the CCG are invited back in April 2020 to outline their detailed funding and implementation plans for the proposed new CCG footprint;**

- c) **The committee would like to see built in to the new arrangements the commitment to keep a Herefordshire office presence in the new future single footprint area;**
- d) **The committee welcomes and would expect to see Herefordshire place based clinical and lay representation at the appropriate level within the new CCG administration; and**
- e) **The committee recommends that when there are significant variations of service delivery, including significant financial changes, the appropriate scrutiny committee is consulted and given adequate time to review these changes.**

(The meeting adjourned between 16:35 and 16:50)

8. ONE HEREFORDSHIRE AND INTEGRATION BRIEFING

The agenda provided for the committee to receive an updated overview of the Sustainability and Transformation Programme (STP), One Herefordshire and Integration agenda for health and social care.

Given the detailed consideration given to the previous item and the importance of the subject the Chairperson suggested that the best course would be to receive a brief overview of the issues and the matter then be brought back to the next meeting.

Dr Talbot-Smith gave a short presentation highlighting selected slides from the presentation circulated with the agenda papers.

In addition to considering the issue in detail at the next meeting, it was suggested that in discussing the work programme consideration might usefully be given to the five year Place Based Integration Plan at a future meeting.

RESOLVED: That consideration of the matter be deferred until the next meeting.

9. COMMITTEE WORK PROGRAMME

The committee considered its work programme.

It had been suggested during the consideration of the previous item that consideration might usefully be given to the five year Place Based Integration Plan at a future meeting.

A representative from Healthwatch requested that consideration be given to the sexual health service that had recently been recommissioned. The chairperson indicated that consideration would be given to including this in the work programme once further information on the matter had been provided and considered.

RESOLVED: That: the draft work programme (appendix 1 to the report) as amended to include consideration of the five year Place Based Integration Plan be approved, and consideration be given at the next meeting to whether to include discussion of the sexual health service within the work programme.

10. DATE OF NEXT MEETING

Noted.

The meeting ended at 5.07 pm

Chairperson



Meeting:	Adults and wellbeing scrutiny committee
Meeting date:	Friday 18 October 2019
Title of report:	One Herefordshire and Integration Briefing
Report by:	Director of adults and communities Director of strategy and transformation (NHS Herefordshire Clinical Commissioning Group and One Herefordshire)

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose and summary

To provide an updated overview of the Sustainability and Transformation Programme (STP), One Herefordshire and the integration agenda for health and social care.

The report and presentation seek the views of the scrutiny committee on the progress of the programme to date, and any elements of the programme which may benefit from inclusion in the committee's future work programme.

Recommendation(s)

That:

- (a) **performance and plans be reviewed and the committee determine any recommendations it wishes to make to the executive and/or relevant health bodies to secure improvement; and**
- (b) **the committee identify any items for inclusion in its future work programme.**

Alternative options

1. There are no alternative options to the recommendations as it is a function of the committee to review and scrutinise any matter relating to the planning, provision and operation of the health service within its area. The committee also has the function to make recommendations to a responsible NHS body on any NHS matter it has reviewed or scrutinised; and to make reports or recommendations to the executive with respect to the discharge of any functions which are the responsibility of the executive.
2. As the integration agenda continues to progress across the Herefordshire and Worcestershire STP footprint and with the future merger of the Clinical Commissioning Groups (CCG) an option to explore joint scrutiny work across Herefordshire and Worcestershire could be considered by the committee on identified key health and social care agendas, and/or the integration programme as a whole. If a joint scrutiny committee is to be sought, a recommendation will need to be made to Council to approve the establishment and membership of the joint committee.

Key considerations

3. This paper and the attached background presentation provide an overview of the current plans for the Herefordshire and Worcestershire STP, One Herefordshire and the integration plan delivered by the Better Care Fund Plan (BCF). More information on STPs, Herefordshire and Worcestershire STP, One Herefordshire and the BCF can be found on the following links:

www.england.nhs.uk/integratedcare/stps/fags/

www.england.nhs.uk/integratedcare/stps/view-stps/herefordshire-and-worcestershire

www.herefordshireccg.nhs.uk/who-we-are/publications/strategies-and-plans/sustainability-and-transformation-plan

www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
4. The evolving landscape of STPs and integration has been cemented in the recently published NHS Long Term Plan (www.england.nhs.uk/long-term-plan/) where the key five themes include:
 - A new service model for the 21st Century
 - People will get more control over their own health and personalised care when they need it
 - Local NHS organisations will increasingly focus on population health and fulfilling their duties in reducing health inequalities whilst moving to Integrated Care Systems everywhere
 - Digitally-enabled primary and outpatient care will go mainstream across the NHS
 - Reducing pressure on emergency hospital services
5. The new service model for the 21st Century describes a change for General Practice, moving to Primary Care Networks (PCNs) to deliver care to a population of 30-50k. In Herefordshire this would be 5 PCNs across 4 localities (2 PCNs in Hereford city). The

plan commits funding to the networks for additional resources to support the vision to improve population health, support self-care and reduce the length of stay in hospitals by providing more support in locality areas.

6. STPs have been evolving over the past few years, and developed across Herefordshire and Worcestershire based on an NHS footprint. The next step is STPs transitioning into Integrated Care Systems (ICS) across the country by April 2021. This will involve a shift of decision making to a partnership approach across commissioners and providers, to drive integrated care delivery, better utilise resources, improve population health and reduce inequalities.
7. Key changes are also emerging for CCGs, to streamline commissioning arrangements which could typically involve a single CCG for each ICS/STP area. CCGs will become leaner and more strategic, and will support providers to partner with local authorities and other organisation on population health, inequalities and service redesign.
8. The priorities in the NHS Long Term Plan are areas we are already working, both within the Herefordshire and Worcestershire STP and the work of One Herefordshire.
9. During 2019/20 the Herefordshire and Worcestershire STP will be transitioning into the new ways of working, and developing to absorb NHSE/NHSI responsibilities as these are devolved. This includes developing partnership forums – that enable us to work through a partnership approach whilst recognising that accountability and responsibility of individual organisations won't change.
10. As part of the development of STPs into ICSs the local 'place' will need to be developed, as the NHS seeks to engage in a meaningful manner with the council and local communities to address wider wellbeing, population outcomes and inequalities. This concept of 'place' is best described as being co-terminous with health and wellbeing board boundaries, making One Herefordshire our local vehicle to drive this forward. This will include supporting the development of PCNs at more local level, as well as working with the council and local communities to address wider wellbeing.
11. One Herefordshire is our place based partnership, and we are currently developing our five year integration plan. Our vision is for Herefordshire to be a county of healthy individuals living within healthy communities:
 - Herefordshire residents will be supported and enabled to keep themselves well at home.
 - When needed they will have joined up care and support, underpinned by specialist expertise, delivered in the best place by the most appropriate people.
 - Our services will be clinically and financially sustainable, working in partnership to make best use of the 'Herefordshire pound' within the Herefordshire and Worcestershire Integrated Care System (ICS).
12. There are a number of priority areas that are being developed within One Herefordshire for the next two years and these are:

Year 1 Priorities

- Community resilience
- Integrated primary, community and mental health services

- Urgent care, including frailty, dementia and end of life
- Elective care: musculoskeletal, ophthalmology, dermatology and outpatient redesign
- Digital and population health management

Year 2 Priorities

- Prevention
 - Psychological interventions
 - Complex mental health needs
 - Back office and infrastructure
 - Estates
13. The Better Care Fund and integration plan is an integral part to the delivery of the One Herefordshire programme. The plan was refreshed last year to provide an overview of the key areas of focus for partners. The 2019/20 national guidance is yet to be published, however the national framework is available for the BCF which explains that 2019/20 will be a transition year where the BCF will be reviewed and full details expected for 2020 and beyond later in the year.
 14. The quarterly performance report for BCF shows that delayed transfers of care (DToC) and the urgent care system remains a challenge for health and social care, this includes providing the appropriate level of support to keep people at home and admissions into care homes, which is an area the committee could consider in the future work programme.

Community impact

15. In accordance with the adopted code of governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining, the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure our outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review.
16. The changes described are aligned and integral to delivering the NHS Long Term Plan and by providing services at a locality level also supports the local authority's corporate objective to 'enable residents to live safe, healthy and independent lives'.
17. The plans are intended to move our health and social care system to a new service model in which patients get more options, better support and properly joined up care at the right time in the optimal care setting will support communities to remain within their own homes and reduce the need for hospitalisation and long term care. This will support our objectives of building community resilience and tackling health inequalities.
18. One Herefordshire recognises 'Talk Community', the community plan that the adults and communities directorate, as a critical underpinning component of One Herefordshire and its 5 year strategy. It will support One Herefordshire partners in improving wider wellbeing and population outcomes, as well as addressing their statutory duties around health inequalities. Citizens have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet

those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

Equality duty

19. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to -

- (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

20. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. The STP is developing a more joined up approach to its equality duties, and has an STP equality work stream which is developing a robust and uniform approach to equality impact assessment across Herefordshire and Worcestershire.
21. The council and CCG are committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. All equality considerations are taken into account.
22. It is not envisaged that the recommendations in this report will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender, reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
23. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities. There are no negative impacts for looked after children or with respect to the council's corporate parenting role.

Resource implications

24. The One Herefordshire 5 year integration plan is currently in development, and will demonstrate how we will work collectively to use our resources more efficiently.
25. The BCF is considered within this programme of work however the guidance has yet to be published for 2019/20 and the BCF has clear national conditions and metrics on the funding and allocations of the budget.
26. The BCF has clear national conditions and metrics on the funding and allocations of the budget and is considered within this programme of work. The BCF plan has been agreed with the CCG for 2019/20 and the BCF, IBCF and Winter Pressures funding for 2020/21 has been confirmed in the budget.

27. Additional funding has been committed by the Department of Health to support the development of the PCNs, increasing resources across the networks for a number of professional roles.

Legal implications

28. Article 6 of the council's constitution provides that the role of the scrutiny committees is to help develop policy, to carry out reviews of council and other local services, and to hold decision makers to account for their actions and decisions.
29. If a joint scrutiny committee is proposed it will require the agreement of full Council and, in this instance, Worcestershire County Council. Under Herefordshire Council's constitution, provision is made to establish joint arrangements with one or more local authorities to exercise Council, or a mixture of Council and executive functions, or to advise the council on any matter. These arrangements may involve the appointment of a joint committee with these other local authorities, including the determination of terms of reference and the appointment of members to that committee.

Risk management

30. There are a number of risks associated with the changes described and these will be managed through the One Herefordshire executive body (the One Herefordshire Health and Care Partnership), the Integrated Care Alliance Board, which are health and care partnership boards as well as through council directorate boards and within the council via the directorate and/or corporate risk register.
- 31.
- | Risk / opportunity | Mitigation |
|--|--|
| STP and NHS undertaking timely and appropriate engagement with stakeholders and key partners on key issues. Often due to conflicting priorities this can result in limited time for consultation/engagement on key issues. | Where possible the local transformational programme and timescales are being carefully scoped to ensure full engagement/consultation is undertaken. |
| The STP focusses on a Herefordshire and Worcestershire integrated care system model rather than placed based solutions. | Development of the place based model through One Herefordshire will ensure that local people continue to receive the appropriate level of care. It will also ensure care is more joined up for service users, and that we are supporting prevention and wider wellbeing. |
| Unable to recruit to the planned posts to deliver the PCN model, in the context of local and national workforce challenges. | Recruitment campaign is underway and this will continue until posts are filled. Portfolio careers and shared roles across organisations will support recruitment. |

Planning guidance for the BCF is delayed further resulting in lack of assurance of future funding and uncertainty of the future programme and funding for BCF

Council officers continue to work with local health partners to develop a local health and social care integration plan to mitigate where possible.

Consultees

32. With the launch of the NHS Long Term Plan in January there was also a national requirement to engage with the public and stakeholders. The engagement process was set out to seek views and comments on the local priority areas in the LTP. Engagement activity, face-to-face and an online survey was undertaken by Healthwatch Herefordshire (on behalf of Healthwatch Herefordshire and Worcestershire) and STP engagement teams. See appendix 2 for the full engagement report. All feedback is published on the STP and scrutiny is asked to consider how they would like to use the information to inform their work.
33. There has not been a need to undertake consultation on this paper as there are no specific service change proposals to be consulted on. Any changes resulting from implementation of specific areas of the presentation will be consulted on fully with the council and other key stakeholders.

Appendices

Appendix 1 Scrutiny committee presentation

Appendix 2 NHS Long Term Plan 2019: Healthwatch engagement report

Background papers

None



Integrated Care Systems and One Herefordshire

Adult and Wellbeing Scrutiny Committee

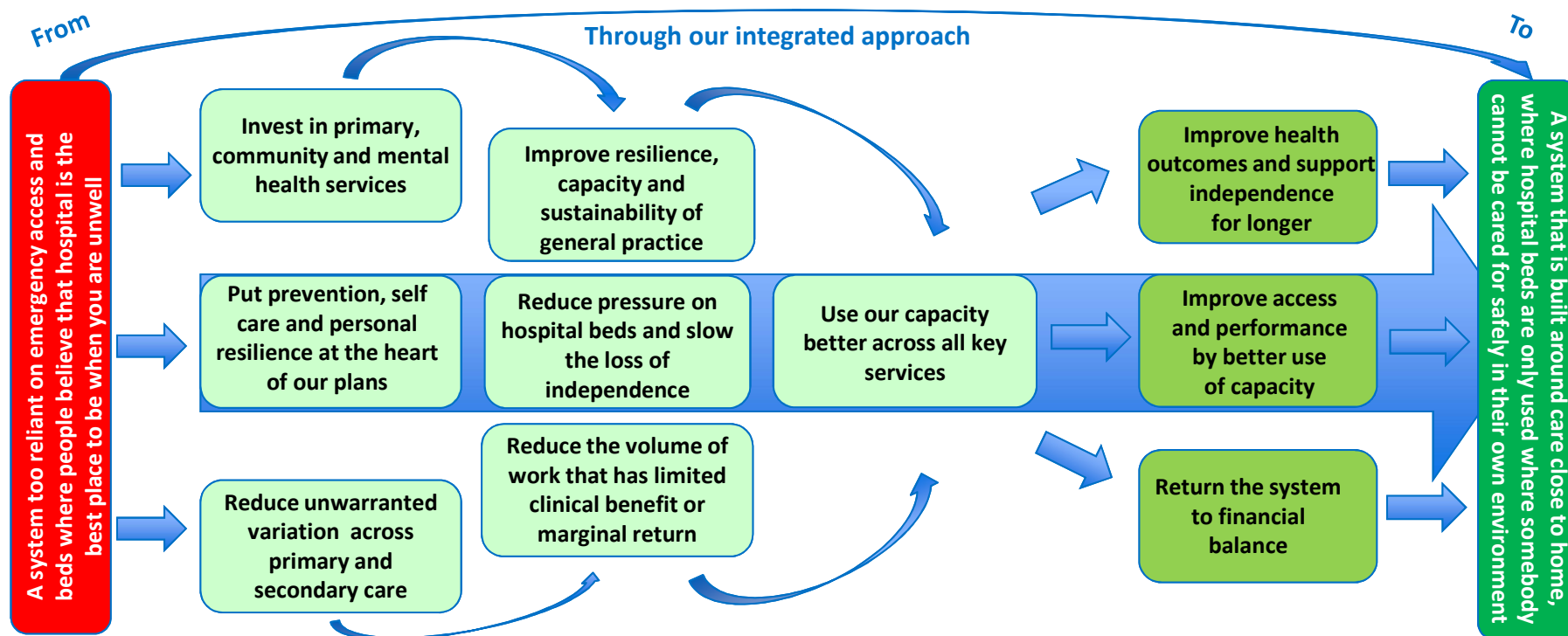
Integrated Care Systems (ICSs)

- Evolution of STPs - ICSs to cover the whole country by April 2021
 - ‘Commissioners will make shared decisions with providers on how to use resources, design services and improve population health’*
- Streamlined commissioning arrangements:
 - typically involving a single CCG for each ICS/STP area
 - CCGs will become leaner, more strategic organisation
 - CCGs will support providers to partner with local government and other organisations on population health, inequalities and service redesign.
- Funding flows and contract reform will support the move to ICSs
 - Local alliance contracts or giving one provider lead responsibility
- Full review of the Better Care Fund concluding in early 2019



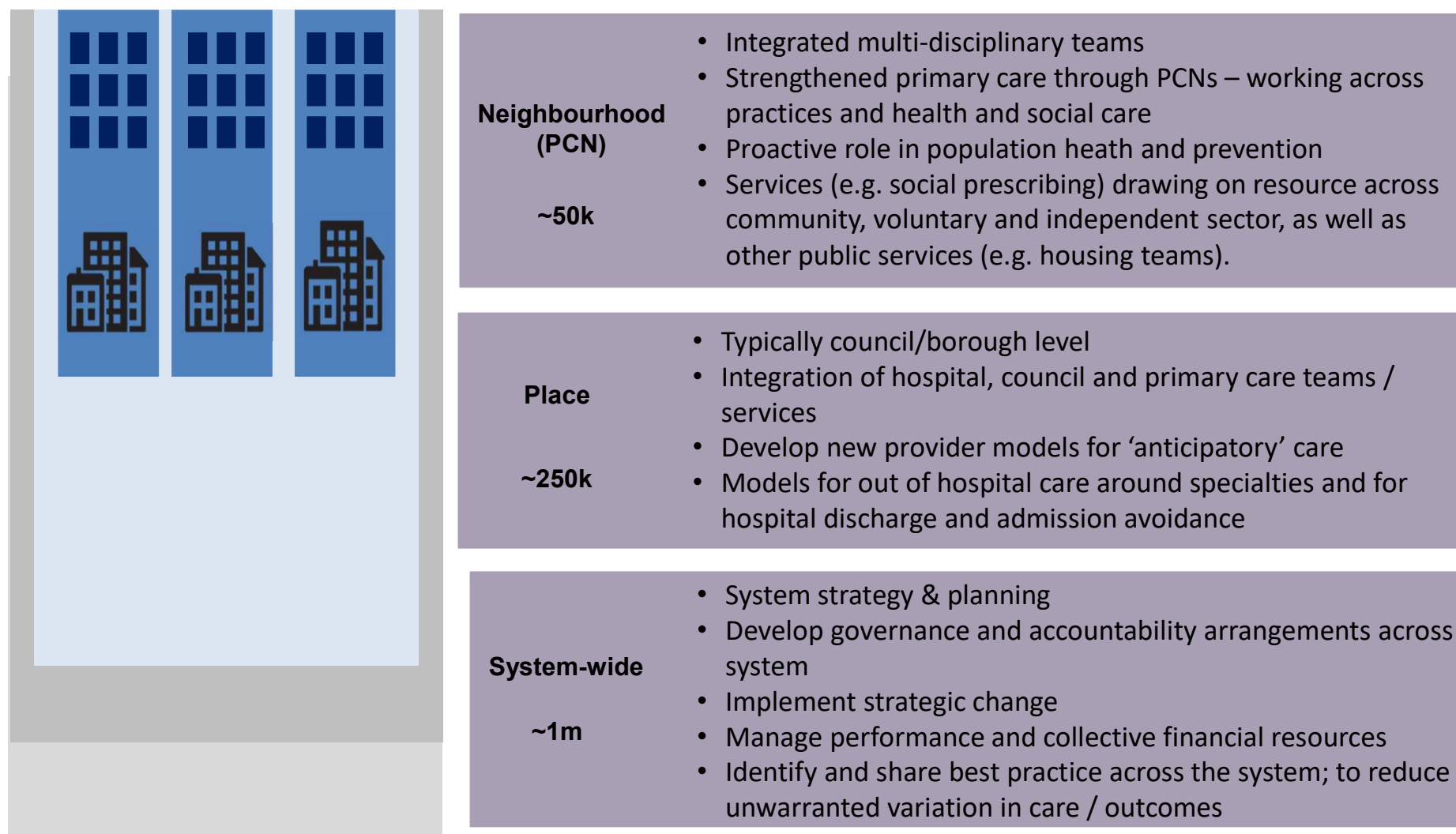
H&W STP Vision

“Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people”



(Work In Progress)

The Tiers in an ICS



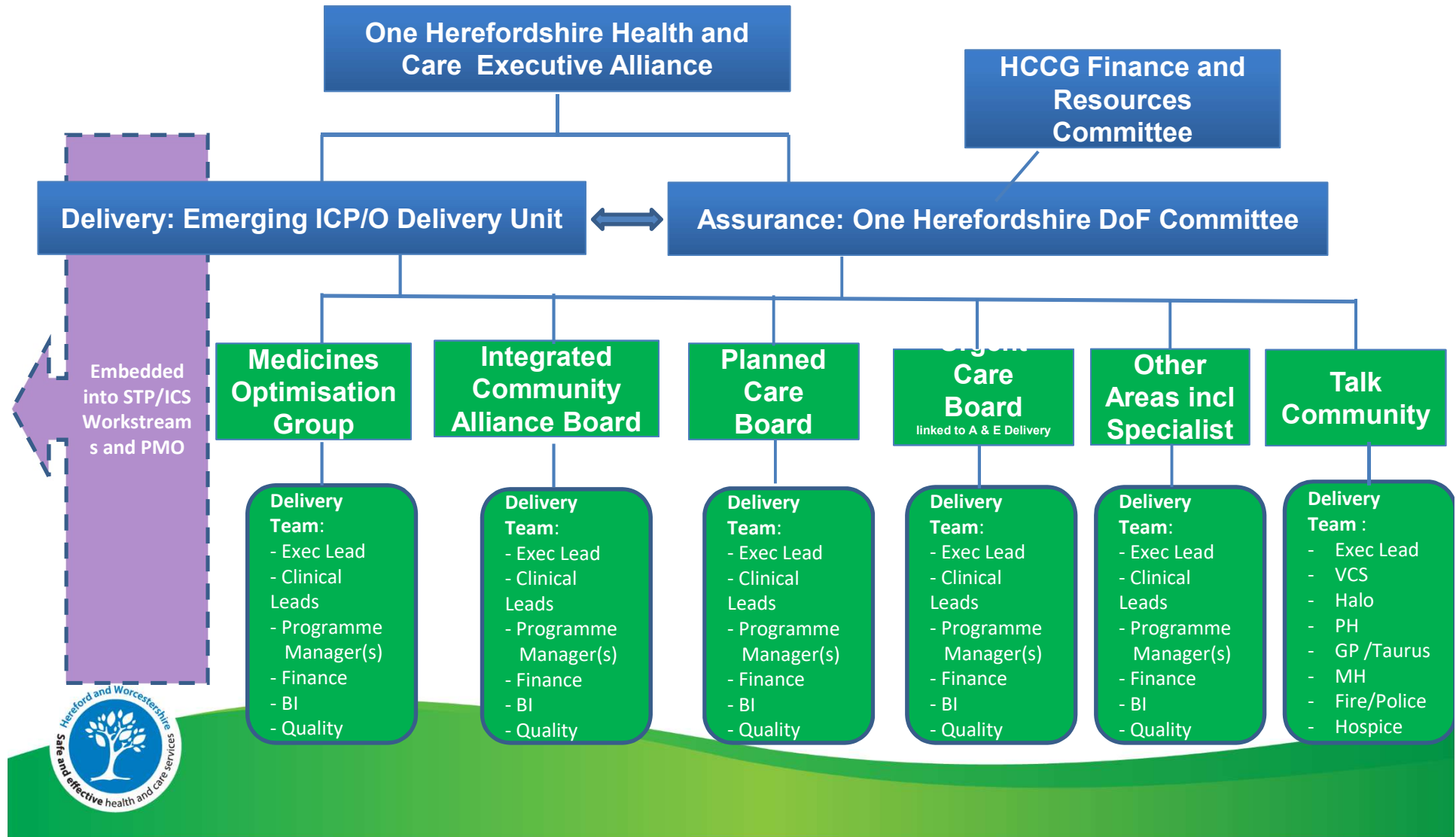
One Herefordshire

- Our 'Place Based' Integration Plan – within the Herefordshire and Worcestershire ICS
- Herefordshire Partners 'Whole System Plan'
- Functional Integration:
 - Integrating at the point of delivery
 - Looking for shared efficiencies
 - Not about Shifting Risk
- This is a 5 Year Plan





2019/20 Delivery and Assurance



Scrutiny Focus Session

A focus on wider wellbeing and prevention – the work of:

- *Talk Community*
- *Integrated primary and community services*
- *Urgent care*



Talk Community Key Programmes

Talk Community will be implemented through detailed plans in six key areas;

- ☐ Talk Community Hubs
- ☐ The Commissioning approach
- ☐ Talk Community Business
- ☐ Talk Community Safety & Cohesion
- ☐ Talk Community public health
- ☐ Operational developments



Integrated Care Alliance Board Work Plan

Project	Lead Organisation
Development of locality Management Teams	Taurus/WVT
Development Support	Taurus
Primary Care Network Development	Taurus
Integrated HF team	Herefordshire Council
Integrated Out of Hours	WVT/Taurus
Integrated Discharge team	Herefordshire Council
High Intensity User	System approach
End of Life dementia pathway	CCG
Discharge to assess	Herefordshire Council
Integrated Psychological therapies	CCG
Community bed right sizing	CCG
BI and KPI	Taurus and system approach



Accident and Emergency Board

Overarching Programme	Projects for delivery
Hospital projects	Ambulance response and conveyances
	Pharmacy and GP access to data systems
	Reviewing Directory of Service (DOS)
Integrated Urgent Care	Out of House Primary Care
	Summary Care Record
	EMIS Access
Emergency Department	Frailty Front Door
	Ambulance handover
Hospital Bed Based	Red2Green
	7 day services
	Stranded and super stranded review of patients
Patient Discharge	Out of county delays
	DToC reduction
	Joined up advanced care planning RESPECT

The Better Care Fund

- BCF and Integration plan 2019/20 approved and refreshed last year
- Could be changes for 2020/21 depending on review
- Key deliverables and schemes:
 - Integrated hospital function
 - Alignment of Homefirst and Hospital at Home
 - Integrated care home quality team
 - Digital solution for integrated working
 - Increased funding in urgent care and care home market



Achievements to Date

- Delayed Transfer of Care system improvement
- Increased number of people supported at home rather than community hospital facility
- Implemented a Discharge to Assess facility
- Front door frailty team supported improvement of flow at the front door
- Integrated discharge function
- Developments of Talk Community hubs

Questions?



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Background

What is the NHS long term plan?

In January 2019, the NHS in England published a ten-year plan detailing how the NHS should evolve over the next decade. The government has also announced that the NHS budget will be increased by £20bn a year

These developments are in response to the growing demand for NHS services. More people have long-term conditions for which they need ongoing support. Illnesses linked to inequality and to lifestyle choices are also adding to the pressure on the NHS. The NHS wants to get better at understanding what people need, at using technology and providing support tailored to them as an individual.

The plan sets out the areas the NHS wants to make better, including:

- Improving how the NHS works so that people can get help more easily and closer to home. For example, being able to talk to your doctor on your computer or smart phone; access more services via your GP near to where you live; use other community services which could improve your health; and leave hospital without delay when you are well enough.
- Helping more people to stay well. This includes things like helping more people to stay a healthy weight or to stop smoking. It covers helping to tackle air pollution and making sure your health isn't worse because of where you live, the services and treatments available and the amount of money you have.
- Making care better. The NHS wants to get even better at looking after people with cancer, mental health, dementia, lung and heart diseases, learning disabilities and Autism.

More money invested in technology so that everyone is able to access services using their phone or computer, and so that health professionals can make better, faster decisions.

Why have these eight priorities been chosen?

For this piece of engagement, the Sustainability and Transformation Partnership (STP) have chosen the following eight priorities to focus on;

The eight priorities are:

- Out of hospital local care
- Emergency services
- Prevention & Self-Care
- Specialist services
- Health Inequalities
- Mental healthcare for children & young people
- Learning disability and Autism services
- Mental health care for adults

In 2016 Healthwatch and partner organisations across Herefordshire and Worcestershire NHS and voluntary sector engaged with the public about the STP at the start of its journey.

The formal STP engagement was extensive across both Herefordshire and Worcestershire. It sought to light some key themes which have been incorporated into the workstreams.

The recently produced NHS Long Term Plan affords the opportunity to build on the engagement that has taken place to date, to progress conversations and understanding around the key issues that will be pertinent to the partnership moving forward.

The eight priorities chosen for this current piece of work across our STP footprint are areas emphasised in the plan that require more feedback locally from the public. The work of the STP will involve a wider range of priorities than these eight, but it was felt the eight topics are the areas of focus to move on the conversations from the 2016 engagement and gain greater insight from the public, which will inform the implementation of the NHS long term plan.

Healthwatch England and NHS England agreed to a partnership to engage the public across England to see how the public thought that the plan should be delivered in their local STP area.

Healthwatch Herefordshire and Healthwatch Worcestershire have undertaken this work in collaboration with the Herefordshire and Worcestershire STP organisations.

What was involved in this engagement exercise?

The survey priorities and questions were agreed by the STP in March 2019. Healthwatch Herefordshire coordinated the work across both counties and undertook the analysis and reporting of the project.

Healthwatch teams worked together to undertake the same engagement work from March 15th to June 3rd, 2019. The body of this report is the analysis of the focus group and online survey responses which contained several thousand comments. Representative comments from the public have been selected and highlighted in each of the eight topic sections.

Focus groups:

Engagement officers attended existing community groups in both counties and arranged focus groups to ask the public about the 8 priority areas. Appendix 2 lists a breakdown of the groups, locations, number of people and the priority topic discussions which were undertaken.

Online survey:

A collection of eight short online surveys, one for each priority, was promoted widely across both counties by all partner organisations in the STP. The questions for each survey were the same questions as those used in focus group work. The survey was open from 15th March - 1 June 2019. Postcode data was collected for respondents which is detailed in Appendix 2.

Existing Healthwatch work:

Appendix 3 outlines key findings and recommendations from additional recent Healthwatch work in both counties which is relevant to priorities in the NHS long-term plan, which are;

- Dementia
- Outpatients
- Autism
- Homefirst and Hospital at Home
- Complex and multiple conditions
- Living with and beyond cancer
- Children & young people's mental health
- Mental health home treatment service

Executive Summary

Out of hospital local care

26 focus groups engaging with 314 people 60 people responded online

83% Of people agreed with avoiding hospital care where possible

1. Avoid words such as 'crisis', 'social prescribing'.
2. Early assessment of those who are at risk to help with early intervention and prevention.
3. Good communication and listening with patients and carers when caring for them.
4. Good quality, timely communication about care plans.
5. Ensure there is resource and capacity to deliver care out of hospital 24/7.
6. Increase access to GP's.
7. Ensure the patient's home environment is safe to be discharged to.
8. Ensure robust discharge planning involves patients and carers.
9. Improve timely discharge and coordination.
10. Clinical digital patient information system for professionals to deliver integrated care.
11. Provide digital solutions whilst continuing to deliver alternatives to digital.
12. Provide support and training to use digital technology.
13. Locate local services around GP practices and community hospitals.
14. Improve transport to central locations.

Emergency Services

14 focus groups engaging with 179 people 126 people responded online

72% Of people agreed with new approaches to same day emergency care

1. Use term 'urgent care' not minor injury.
2. Walk-in or better alternatives to A&E.
3. Good publicity about available options for urgent care.
4. Effective triage system.
5. Improved health education for prevention and self-care.
6. Increase access to GP's.
7. Improved access to mental health care, in particular young people and transgender.
8. Locality and accessibility of alternatives is important.
9. Multi-disciplinary community teams in a hub for services.
10. Ensure the services meet the needs of older people and those who need emergency mental health services.
11. Digital technology is useful and should be used to improve sharing of information for professionals and patients, e.g. results, records.
12. Use video conferencing for appointments and triage.
13. Online symptom checker for self care and choosing where to go.
14. Ability to check real time waiting times at locations.
15. Ensure NHS IT is designed for future development and provide training and support.

Specialist Services

13 focus groups engaging with 123 people 57 people responded online

56% Of people agreed with centralisation of specialist services

1. People understand the principle of centres of excellence but are concerned about the transport availability and options.
2. Consider the perspective of patients and transport when choosing locations of centres.
3. Consider the implications for patients on the borders of counties when choosing locations for centres.
4. Specialists could offer day visits to hubs around smaller hospitals for pre op or post op appointments.
5. Consider how patients are managed outside of the centres of excellence, strong view that after care should be local with a seamless transition for patients.
6. To recruit and retain staff conditions need to be improved; not overworking and providing supervision, training and support. Recruit to train people and offer career development.
7. Increase information for patients on how to help themselves and make use of expert patients.
8. Ensure that older people, vulnerable or disadvantaged are not unduly affected by any changes.
9. Use of digital technology welcomed particularly records being shared across organisations and teams.
10. Consider connectivity and access to IT.

Prevention & Self-Care

21 focus groups engaging with 181 people 62 people responded online

84% Of people agreed with the prevention approaches proposed

1. Make support groups more attractive and accessible.
2. Use role models to make prevention more relatable.
3. Healthy messages need to be constant across various media channels.
4. Education through young people in schools and target parents.
5. Recognise that people need to wish to make changes to their lifestyle.
6. Doctors need to be more direct with patients about need to change.
7. Regular consistent support, low level screening and increase reviews of long term conditions.
8. Increase efforts to overcome language and cultural barriers in communities.
9. National campaigns, legislation and taxes on unhealthy food.
10. Professionals to support local community initiatives.
11. People should take responsibility for their health, however good neighbour schemes can help.
12. Consider prevention of mental ill health.
13. A lot of potential in apps and information digitally. Reminders for 5 a day, monitoring apps which link to doctors notes, advice and support online.

Health Inequalities

12 focus groups engaging 46 people responded
with 164 people online

Of people agreed that health
89% inequalities need to be
addressed

1. Targeted resource needed in disadvantaged areas.
2. Increased education, target schools to support parents teaching children about healthy lifestyles and increase physical activity.
3. Community work identifying those at increased risk, support them to develop local support networks.
4. Improve access to GP. Clear information about where and how in alternative formats and languages.
5. Consider wider determinants such as housing, benefits and employment opportunities.
6. Increase free access to sports.
7. Increase front line professionals; an over 75's GP, health visitors, community matrons and community development workers.
8. Use technology for promotion and sharing of information, to improve communication such as reminders, prescription services, videos and advice for management of long term conditions.
9. Technology particularly important to use for hearing loss and learning disabilities.

Mental Health Care For Children & Young People

11 focus groups engaging 59 people responded
with 174 people online

Of people agreed with the
79% approach considered for
these services.

1. Improve waiting times for all levels of support.
2. Increase service access times to 24/7 and promote what is available.
3. Work in schools and colleges to reduce stigma and build resilience.
4. Make use of peer support models.
5. Tackle bullying as a major cause of poor mental health.
6. Increase whole family support and improve the environment for the young person.
7. Individually designed services. Person centered approach.
8. Improve the transition from children's to adult's mental health services and increase the service to 25 years old.
9. Increase the accessibility of counselling and talking therapies.
10. Consider improving support for particular groups such as: LGBTQ+, those under 18, those likely to self-harm or attempt suicide, those with Autism and anxiety.
11. Use digital technology with caution. Use for information sharing, connecting patients with specialists, out of hours support and information and self help apps.

Learning Disability and Autism Services

9 focus groups engaging 54 people responded
with 72 people online

Of people agreed with the
81% approach considered for
these services.

1. Quick access to an early diagnosis which listens to family members.
2. Training for medical staff to recognise hidden disabilities and have more specialist knowledge to aid diagnosis and assessment.
3. Reasonable adjustments at GP surgeries.
4. Home visits by GP's to avoid crisis.
5. Increase awareness of learning disability and autism in the general population.
6. More information for schools to recognise conditions and understand referral process.
7. Multi -agency approaches to support.
8. Increase support for families, particularly during the diagnosis process and shortly afterwards.
9. Providing a safe, calm, neutral space for assessments and also in schools and other settings.
10. Provision of 24 hour services, including Doctors, phone lines and messaging services.
11. Improve communication and listening to patients by staff. Use of health action plans, providing info to take away.
12. Communicating directly about healthy lifestyles, support groups, using apps and fit-bits.

Mental Health Care For Adults

11 focus groups engaging 64 people responded
with 84 people online

Of people agreed with the
84% approach considered for
these services.

1. How and who defines a crisis?.
2. Provision of an accessible service 24/7. Immediate access in a crisis and reasonable waiting times otherwise.
3. Place of safety available anytime.
4. More staff needed to improve access.
5. Improve joined up working and integration with other services.
6. Improve training of workforce to understand mental health and impact of physical health on mental health.
7. Increase low level prevention to prevent crisis.
8. When people with mental health issues present to a medical professional provide an holistic approach looking at the person, situation and environment.
9. Support services for the family of people living with mental health illness.
10. Clear information, knowing where to go when needed is key.
11. Face to face support essential.
12. Increase talking therapies as alternative to medication where possible.
13. Digital technology only useful in this area for information and signposting, sharing information across teams, and 24/7 support.

Engagement results for the 8 priorities

1.) Out of Hospital local care

In 2016, local people told us that they wanted as much routine, non-urgent, non-specialist care as possible, to be provided at home, or in the local community. Since 2016, we have been working to respond to this by developing local teams which for the first time in our area are bringing together nurses, therapists, social workers and GPs into single teams responsible for supporting vulnerable patients in the local community.

Whilst this work is keeping many more people at home, there is still much pressure on hospital services. Over the coming years, we want to help as many people as possible to avoid going into hospital by offering them timely crisis care and recovery support in the community. This will also mean that when people are admitted to hospital, the care they get will be much more focused and purposeful and we will be able to discharge them back home quickly.

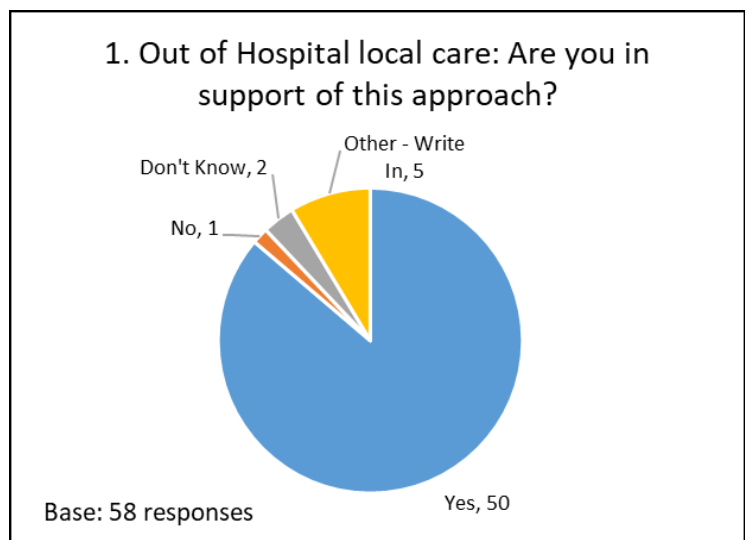
Quantitative results from online survey

There were 26 focus groups held about out of Hospital local care, which engaged with approximately 274 people.

There were 60 responses to the online survey, in which 58 answered whether they agreed with the priority.

There was a clear majority who supported this approach:

Over the coming years, we want to help as many people as possible to avoid going into hospital by offering them timely crisis care and recovery support in the community. This will also mean that when people are admitted to hospital, the care they get will be much more focused and purposeful and we will be able to discharge them back home quickly.



There were five 'Other, write in' responses which can be seen below, but in general they do support the approach but concern around the support it would need to make this happen in reality. Comments below:

"A 'qualified' yes, but there needs to be far more information provided about the value and service capability of this."

"The discharge arrangements at the Prince of Wales Community Hospital in Bromsgrove can be absolutely deplorable."

"Yes but the approach needs to be better supported by professionals."

"Yes I support it, but needs community staff to support primary care more closely - by being based and available for GPs and practice nurses to refer to them and discuss patients daily as needed face to face."

"Depends on case scenario."

Detailed results of the engagement:

1. What do you think are the important things that we need to consider, as we develop crisis community care services to prevent people being admitted to hospital?

There was some concern about using the word 'crisis' in the community care services title, about its definition and use.

"Who defines a crisis? Be useful to refer to supporting people to better manage risk."

However, there was a strong view that respondents did want to avoid people having to be admitted to hospital wherever possible. Some of the important points to consider were around better, joined up plans; early assessment of those at risk; better communication with patients and carers; the sustainability, particularly the capacity and funding of this plan; access to a GP and location of services and the service being 24 hours a day. Also mentioned were the availability of home visits, information about services available and information/advice about their own medical condition or medicines. Working together and sharing information also emerged as a theme.

Joined up planning - this is primarily around integrated care plans, ensuring services are in place coming out of hospital, prevention planning and the softer side of making sure people can cope at home. This is particularly critical about the timeliness of the plan and the follow up action.

"Social assessment - to make sure they can cope at home and have enough support."

"Occupational Therapists - the waiting list to have an assessment is 6 - 8 months (e.g. if you are vulnerable, had a fall, then people wait 6 - 8 months to be assessed) within this 6 - 8 months some people have more falls and have to go back to the hospital. If there was a triage system where people can be assessed straight away after fall, if they have a high risk of falls again, then they should be able to get the equipment installed straight away to avoid repeat admissions to hospital."

"Ensuring people have adequate care at home at reasonable cost to enable them to be SAFE in the home environment. Not everyone has relatives or close neighbours to keep an eye on them."

"We get told we will get support.....but we DON'T get it!!!! Kicked out of hospital with no support!!! It's happened to me and to my husband.....admitted again within days!!!"

There was also some concern around planning for homeless people, where they have been discharged without a proper plan, i.e. back onto the street. Also, specific planning around particular conditions e.g. Dementia and Multiple Sclerosis (MS).

Early assessment of those at risk - This somewhat links to the above point where prevention is important. There were also specific points about who could do this either a GP, Nurse Practitioner or a specialist service, and how to word some of these services that will help reduce barriers to accessing those services.

"Identify who might benefit from additional support before a critical incident like a fall."

"GP role to help identify - if became more involved in earlier identification it would reduce their workload."

"Regular health checks at GP to identify issues before they escalate - routine and reminders sent, as some may have issues or concerns, but not want to bother the doctor with them."

“GP could give info / leaflet to carers with number to ring for assessment. As some older people may be reluctant to seek or accept help themselves.”

“Assessing need and identifying what support is available could be carried out by Nurse Practitioner or another member of staff within GP Practice.”

“Social prescribing - don’t use the word social as this may have implications for older people of ‘charity’ and may be rejected. Make it sound like health rather than ‘social’ support.”

Better communication - This was particularly around how patients and family are spoken to. Additional ‘softer skills’ training was suggested for some specific professions e.g. district nurses, but it was more in general about making sure patients felt listened to, that patients understood what they were being told and what is happening next.

“An easily accessible means of communication between the patient and a named person responsible for the care at home...not an ever-changing group of staff.”

“People need to feel as if someone cares about their problem and is taking action. That you are kept informed about what is happening and why.”

“Important you know what is happening and when - different people who are coming in to the home to treat and support you.”

“Make sure that people have information and explanation about any equipment that they might need to use at home, so they understand what it is for and who they should contact if they have any problems.”

There was some difficulty identified with the script used by the NHS 111 service, about how this was limiting and for specific conditions such as MS that it added to the pressure of an exhausting condition.

The sustainability, particularly the capacity and funding of this plan - There was a general concern that services are stretched already with no local access to services, limited access to Drs and home visits. If services were going to be moved from acute hospitals to the community, the funding needs to follow.

“A guaranteed sustainable service so that the patient at home feels secure.”

“Making sure there is enough money to deliver the alternative services closer to home. If the funding is not enough to cover the service, then it means it will not be financially viable. Also making sure providers have flexibility to deliver the new service in a way that meets local population needs.”

“Ensure there is capacity in community services - not simply taking on extra work without being resourced.”

This very much links into the next few themes which talk about the **difficulty in accessing a GP**; either by getting there or getting an appointment, time allowed during an appointment and the ability to see the same Dr again. Walk-in centres, the NHS 111 service and an alternative to A&E or the current out of hours service were mentioned. Walk-in centres are seen as a positive option, an out of hours service was requested, although some were aware of the already available extended hours GP service, although not all respondents were aware of this service. Concerned around the NHS 111 service was that they were very quick to send you to A&E or send an ambulance whereas residents felt other options should be available such as seeing a GP or referring onto local teams.

Location of services - there were varying views about this but much of it was about accessibility, with more services being clustered around GPs, or community hospitals with a wish that non-life threatening conditions be dealt with locally, alternatively make sure there is better transport provision to help patients get to 'central locations' or community NHS vans similar to the library bus.

"Develop the use of Minor Injury Units so that they become a hub for support. More diagnostics and longer opening hours."

"All services should be clustered around the GP."

"That there are local in-patient services available in the market towns. De-centralising provision for those who need nursing care rather than medical interventions would be cost-effective, keep people in their home communities and improve outcomes."

24-hour 7 days a week support was raised, somewhat linked to being able to access a GP, but also 24-hour support being available in general.

"System to support more 24/7 emergency care for care homes to reduce hospital admissions."

"The service will need to be 24 hrs a day 7 days a week. Inconsistent at the moment regarding services on weekends and bank holidays."

"Immediate response needed - if not people would need to go to hospital."

"One story was about someone's wife - she didn't want to go into hospital, but the paramedic said she had to go to see a doctor as it was the middle of the night."

Also mentioned is the availability of home visits, particularly for those recently discharged from hospital, older people, those with mobility issues and those who are more at risk.

"As many services as possible to go into people's homes to prevent hospital admission."

"Home visiting and support at home - GP's, nurses and other health professionals, including mental health professionals, willing to do home visits and provide support in the home."

Other points made were about sharing information and being able to access patients' records, encouraging social contact, patients receiving training/support to be able to help themselves, particularly for patients with MS and urine sample kits available on prescription to test for relapses), multi-disciplinary teams and better follow-ups.

2. What do you think are the important things that we need to consider, as we develop recovery support in the community to discharge people back home quickly?

The main thing cited as important by respondents were robust discharge plans and packages being in place before the patient is discharged, followed by capacity of the workforce/volunteers to support this and whether the home environment that they are going to is suitable. Then respondents wanted this to be communicated clearly to the patient, their carers/family.

Discharge plans - There should be a robust plan in place before a person leaves hospital, assessing what is needed in the home in terms of adaptations, if there are people there to support with practical tasks, and that they understand any new medication they have.

"Adequate care packages in place before discharge."

“Better social care for older people so that they are not sent home to try to look after themselves if this is not possible.”

“Care at home after a stroke - professionals were coming and going, didn’t know any of them - it didn’t feel like my own home. One personal carer at night and one in the day would have been better. Must have been about 6 people in the day - didn’t see the need for all of them.”

“Correct people and services in place to ensure a smooth transit from hospital to home with constant ongoing support.”

Another point raised alongside the discharge was knowing who to call if there were any problems. A need was expressed for a 24-hour phone service to query symptoms, medication, care, etc.

“Also, a 24-hour helpline for anyone who has been discharged who may be worried about their symptoms and aftercare.”

“Knowing who to contact when you come out of hospital - doesn’t always have to be the GP.”

“Make sure people are given a list of numbers of people they can contact if they need to.”

Suitable home environment - Suitable discharge plans also linked to there being suitable home environment, whether this is people there to support them, a safe house to return to and even the time of day returning.

“Ensure environment person is being discharged to is appropriate - including equipment and carer capacity.”

“Family / community support / state support to enable discharge to home - is home suitable? is there a home?.”

“Ensuring people have adequate care at home at reasonable cost to enable them to be SAFE in the home environment, as not everyone has relatives or close neighbours to keep an eye on them.”

Previous reablement homes were mentioned positively however acknowledged that these were now closed. It was felt there was still a need for this, especially as care homes were sometimes expected to help in this way when they weren’t always able to do this.

“When ready for discharge - the hospital thinks that the care team at the Rose Gardens Hereford provide medical care, but they don’t. All the care here is domiciliary care so people are being discharged too early, then having to go back to hospital a few days later as they haven’t got the right care. One lady went into hospital at 9pm with a TIA, was then sent home at 4am in the morning - this is no good especially in the winter.”

Better communication - similar to the responses to question 1, communication with patients and residents about the plans and what is happening is important.

“Inform the patient and carer, in writing, what to do if things go wrong after discharge. Inform the patient and carer, in writing, about how their recovery should progress and what symptoms to be concerned about.”

“Communication is key with the patient and their families as well as with other health professionals who are involved.”

Capacity - again there was concern over the capacity and funding available to provide and maintain this type of service.

“Accessible suitable levels of staffing so that things don't fail, and the back stop is ‘phone the GP.’”

“How will the NHS afford this extra support and service - where will the money come from?”

Other issues raised were that modifications in the home needed to be in place, patients were discharged at an appropriate time of day and that medication was ready before discharge so patients were not having to wait in the hospital pharmacy (often in the discharge lounge/waiting room) before they are able to leave. Notes being transferred in a timely manner and ensuring that support is available for carers if needed.

3. What do you think digital technology can do to support this work?

There was a strong message from respondents that the use of digital technology **would not be suitable for all**, for reasons such as the elderly are not as familiar using this, the coverage across the county, the cost of having technology and not trusting the use of it. However, it was suggested that if more people did use this type of digital technology then this would free up time for people who need face to face. Although there was a general positive view that it could help bring different services together and help share information safely and quickly to those who need it.

“Not everyone over a certain age has access to, or the necessary skills to enable them to access digital technology.”

“If younger population can use technology to free up resources etc, it may allow older patients to be treated in a more traditional way, the simpler the better.”

“Save nurses time, reduce paperwork, webinar discharge.”

“Sharing of knowledge of patient needs, quicker communication.”

Support and training - Many suggested that training in new digital technology would be needed to support this, as well as support for when things didn't work.

“Help for people who don't use technology.”

Wouldn't help and don't know - There were respondents who felt that digital technology wouldn't help in this scenario or did not know how it could. There was concern about taking away the importance of face to face assistance.

“Personally, I don't think digital technology has a role in this, unless you count a 24-hour help line for advice/worries. Nothing can replace a friendly, well-trained person visiting a patient just returning from hospital.”

The use of apps/smart assistants - However, there was acknowledgement of where new digital technology could help.

Smart phone apps/smart assistants (Alexa, Echo) - to help with everyday tasks around the home, accessing help when needed and reminders about medication/appointments.

“Alexa - someone who is blind and physically disabled uses an Alexa to control the oven, lighting, heating and phone calls.”

“Phone apps for sight loss can be really helpful.”

“Gadgets available to assist people at home e.g. to turn TV off, close curtains etc.”

“Apps to co-ordinate appointments.”

Digital video calling such as Skype, Facetime and WhatsApp, were seen as potentially of benefit in terms of being able to keep in touch more with family and friends and potentially health professionals to check up on. However, there were also some concerns with this particularly around the diagnosis aspect, with patients either hiding how they are really feeling as not wanting to ‘bother’ the professionals.

“For in home monitoring keeping in touch via video i.e. facetime.”

“Some sort of monitoring system at home for the first few days post discharge?”

“Use of IT for comms e.g. face-to-face counselling.”

“GPs currently do phone calls, have a conversation and if you need a visit then they will come, but a conversation is sometimes enough - can sometimes work well, although with some older people, they will say they are fine on the phone when they are not and don’t want to bother people - this is where face to face would be better as the health professional could see for themselves if they need support.”

“It’s not knowing what’s wrong and whether to phone people (e.g. hit head but couldn’t see the back of head to see how bad it was) - not wanting to bother people and not knowing so observation could be good. Could a skype call help, rather than 111, when not medically trained - observations would be much more important. Could also use Facetime or WhatsApp video messaging.”

IT systems need improvements - The security of the IT systems and their ability to cope with this was a reasonable concern to respondents. Including the ability to share data across different systems in terms of the technology and data protection.

“Sensible approach to data protection, systems that talk to each other.”

“One system of IT to merge records, sort records across health and social care. Electronic prescriptions to pharmacy are a good development.”

“An integrated computer system used by all hospital/community/social care plus some of the various gadgets in use in hospital should be brought into use at home.”

IT was viewed as positive if a solution could **share the information better and quicker** with those who need and use it.

“One clinical system for patient information across all service providers. Better connectivity in the community so that iPad and tablets can be used when the clinician is actually with the patient in their home.”

“Instant communication between all sections of team.”

“Pad tests and sends results automatically - saves a trip to Queen Elizabeth Birmingham.”

Recommendations:

1. Avoid words such as ‘crisis’, ‘social prescribing’.
2. Early assessment of those who are at risk to help with **early intervention and prevention.**

3. **Good communication and listening** with patients and carers when caring for them.
4. Good quality, timely **communication about care plans**.
5. **Ensure there is resource and capacity to deliver care out of hospital**.
6. **Increase access to GP's**.
7. Ensure the patient's **home environment is safe** to be discharged to.
8. Ensure **robust discharge planning** involves patients and carers.
9. Improve **timely discharge and coordination**.
10. **Clinical digital patient information system** for professionals to deliver integrated care.
11. Provide **digital solutions** whilst continuing to deliver **alternatives to digital**.
12. Provide **support and training** to use **digital technology**.
13. Locate **local services around GP practices** and community hospitals.
14. **Improve transport** to central locations.

2.) Emergency Services

The work we are doing to boost out of hospital care is important and this will mean many more patients can be cared for in the community. However, there remain very substantial pressures in looking after emergency patients and we have an emergency care system under real pressure. The engagement work we did in the summer of 2018 when we celebrated NHS 70 showed that local people really understand that the NHS A&E resource is stretched. However, in 2016, people told us that one of difficulties for them was a lack of alternative 24/7 local emergency options and understanding what to use and when.

We want to ensure patients get the care they need fast, whilst relieving pressure on A&E departments. To do this, we need to look at how we could provide better pre-hospital urgent care. One idea is to develop Clinical Assessment Services, which would bring together physical and mental health advice to support health professionals working outside hospital settings to make the best decision about how to support patients closer to home and potentially avoid unnecessary trips to A&E. Another idea is the provision of local urgent treatment where staff would work alongside community based services to provide a locally accessible and convenient alternative to A&E. Finally, there is the idea of having same day emergency care. For those people who do attend A&E, this would look to increase the number who are discharged the same day.

Quantitative results from online survey - Percentages

There were 14 focus groups held about Emergency Services, which engaged with approximately 178 people.

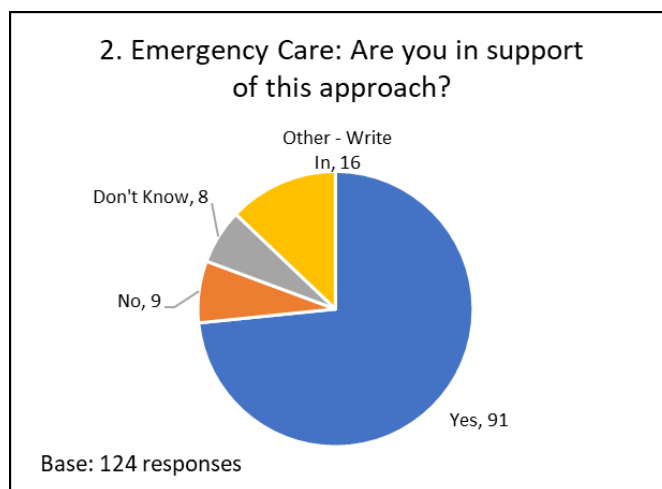
There were 126 responses to the online survey, in which 124 answered whether or not they agreed with the priority.

There was a clear majority who supported the approach described above.

Those who have responded 'other' and have written in - cluster around a couple of points:

Some are not sure what they are commenting on as there are three options detailed above, and some concern about implementing three changes at once.

There was also concern about the cost of implementing these initiatives and the capacity of the staff and the community support needed to make these work.



Detailed results of the engagement:

1. What needs to happen to help reduce the number of people going to A&E?

The most overwhelming response by nearly half of those consulted identified an **increase availability and access to GPs** would help reduce the number of people going to A&E; with two main barriers identified as; out of hours access to a GP and the waiting time currently experienced in getting a GP appointment with their own Dr or Doctors surgery. There were many examples and experiences given which were felt to need urgent medical attention but as there was no doctor available then the only alternative was to attend A&E to ensure that they received urgent medical care. **Walk-in centres** were offered as good alternatives, or more services being available at the GP surgery.

“Quicker access to doctors’ appointments. Out of hours support.”

“Own Doctors to have a better booking service when patients require help and advice. Currently you cannot make an appointment in advance and can only spend lots of time trying to phone from 0800 hrs. This is so frustrating and leaves the only alternative to visit A&E.”

“Need to increase access to GP services, availability needs to include Saturday and Sunday working as part of the normal working week.”

“For non-emergencies our GP practices should be available 24/7 I am happy with not going to A&E but the alternative needs to be freely available and competent healthcare professionals.”

“The walk-in centre took a lot of people that may now go to A&E. Walk in option for advanced nurse practitioners.”

“Broaden availability of services at GP practices.”

“GP surgeries should have professionals from all specialities, e.g. physios, mental health, paramedics etc. to offer all round care/treatment/advice.”

“Easier access to doctors, i.e. more local doctors, open longer hours, with an ‘emergency examination’ system. Maybe a specific doctor who only does this.”

Better alternatives to A&E, such as local urgent treatment alongside community-based services with diagnostics, was cited by the next highest number of respondents. If, you don’t want people attending A&E give them an alternative to attend as it is likely that if they feel they will need medical attention they will seek it wherever, and if there is no alternative then they will use A&E. **Minor injury units** were highlighted as good alternatives if they were open longer and have more facilities.

“Better info about what defines a minor injury and where to go locally.”

“Extend role of Minor Injuries Unit (MIU). Have diagnostic services such as X-ray available at MIU for the same opening hours as the Unit.”

“Improve minor injuries provision develop treat and leave services, to mitigate ‘ambulance queuing.’

“Minor injuries units 24 hour opening and ensure they can deal with minor illnesses perhaps bringing out of hours GP service under the same roof. This would ensure that in a lot of cases, only serious cases would be seen by A&E.”

Once there are better alternatives in place **better information about these options and pathways are needed** and should be **communicated and advertised** to the community so that they know about it.

“Minor injuries Units - Extend hours / X-ray facilities available over longer hours. People may go straight to A&E if they think they will end up being sent there anyway.”

“A 24/7 local healthcare package which allows patients who require immediate treatment (this does not necessarily mean emergency it could just be someone with a bleed that requires stitches) to see a medical practitioner without going to A&E.”

“Alternative local services that are some way between a GP and A&E.”

“Minor injuries units should all be 24x7 and all should have access to diagnostics.”

“More emphasis on Minor Injury Units and increasing facilities at Community Hospitals.”

“Provide alternatives more locally for medical care that is less urgent, but nevertheless needs attention and is “urgent” to the person in pain or discomfort. And tell people where it is and how to get it.”

“More education about what A&E is for. An alternative for people who are not well but not an emergency. For example, urine infection (passing blood) that needed antibiotics. Or severe stomach pains but not an emergency. When people turn up in A&E they are told where else they can get treatment. Having an A&E department close by where people can turn up with a sore finger is not viable.”

“Another idea is the provision of local urgent treatment where staff would work alongside community based services to provide a locally accessible and convenient alternative to A&E’ Such an idea would be good providing the staffing numbers are correct and it is ‘very well advertised’ as the alternative. If people remain unsure as to where they should attend, then they are bound to turn up at the nearest A&E.”

“Clarity on what to do in an emergency - clear info and pathways for public to refer to.”

“Confusion about what the different services do - NHS111, Minor Injuries Unit (MIU), Accident & Emergency (A&E) - better information needed.”

These highlight the need for an **effective triage system**, stopping people from getting to A&E, dealing with them quickly at the hospital to move them to more appropriate care options and also turn away minor injuries that should not be treated at A&E.

“In an accident or emergency, it is preferable to have a single point of entry. People don’t want to have to decide about which service is appropriate for them when speedy attention is needed. The capacity of the emergency system should be sufficient in terms of infrastructure and personnel to enable everyone to be seen as soon as they arrive. Immediate screening and referral onward (or being immediately discharged if they are not accident or emergency cases) will keep the waiting time down for everyone.”

“Individuals deemed not to need emergency attention should be directed to use the correct service i.e. told to attend GP. Is it possible to have a GP perform the triage so patients could be instantly discharged?”

“People need to be categorised e.g. broken limbs or sprains or drunks or heart and strokes. Everyone should have a phone number to ring for their particular problem and would then be directed where to go or what to do.”

This seems to be the role of the **NHS 111 service**; however, many do not feel that this is effective currently - hence the request for an effective triage service.

“NHS 111 so risk averse; they send out ambulances for everything which results in ambulances lined up outside A&E and increased waiting times.”

“Improving the NHS 111 service, proper clinical history taking reducing need to send out emergency ambulance.”

Other suggestions to how to help people avoid attending A&E include better health education to both prevent and self-help, particularly for our young people/through schools, alternative for people who take up much time at A&E; people under the influence of alcohol were specifically mentioned where they would be better served in a space where they could safely sleep it off, those who are frail older people or those with complex medical needs such as dementia should be cared for at home or in care homes.

Quicker/easier access to mental health care was also mentioned in relation to young people, particularly in the transgender communities.

2. What do you think are the important things that we need to consider around the development of local alternatives to A&E?

The most prominent issues raised here were around **accessibility** - in terms of the location of the service being ‘local’ and the hours that it serves, incorporating an out of hours service. With many of the rural areas and small towns across Herefordshire and Worcestershire many respondents were concerned about transport issues, accessing ‘hubs’ by public transport or expensive taxis.

“Access - many people in Hereford and Worcester rely on poor rural public transport services.”

“How easy they are to access, especially by those without their own transport. What services they would offer and hours of opening.”

“Making the alternatives more local, to serve different parts of the county efficiently.”

Other things to consider were making sure there was **enough qualified staff**, enough **advertising to divert people away from A&E**, still **improve access to see people’s own GP**, and having those **local minor injury units** that are able to act as an in-between for GPs and A&E.

“Local Urgent Treatment - support for the idea, but concern that there are not enough staff with the right training available to do this, seen as potentially costly.”

“To do this more staff are required - i.e. more trained. GP and Nursing university bursaries to be reintroduced to encourage parents to apply.”

“More staff, particularly looking at frail elderly population.”

“Responsive social care. Increase resources in neighbourhood teams.”

“The sign at the hospital (Herford) explaining alternatives to A&E is in the wrong place. By the time you have arrived at the hospital it is too late for the message, you’re not going to consider going elsewhere as you have already travelled to the hospital.”

“Communication is key here. there are still people who are unaware of what else is out there and will just go to A&E if they can't get to see a doctor, so education and communication are the most important factors.”

“Education of the public about what is an A&E incident and what isn't, or an on-site assessment that sends them to an alternative venue (minor injuries).”

“Out of hours GP services. GP services to be available within hospital grounds. All GP surgeries to have access to multi-disciplinary teams, including access to social care. Too much emphasis is being placed on 'reactive' care and assessment, this this is usually provided within A and E. Not enough is being done to 'proactively' seek out the most vulnerable patients in the community and for services to be made available to these patients before a crisis.”

“Local hospitals providing a better range of services to reduce visits to A & E - halfway house between minor and acute. Local.”

“Make sure it is clearly understood what they offer as the current MIUs, for example, are largely misunderstood by the general public.”

“Keep the local A&E centres open and running. Maybe not 24/7. I recently had to use the Kidderminster minor injuries as an A&E unit (broken ankle) this saved me calling an ambulance and they managed to treat me there within an hour. Perfect service.”

There was still a need for **better information for patients to know where to go** when they need medical care and a general need to have a **better understanding about how to help themselves** in terms of healthier lifestyles.

“Awareness/campaign about where to go for each condition. Explaining the best route for a specific medical emergency or situation (e.g. NHS 111, pharmacy etc.). Education of health conditions, symptoms and treatment needed.”

“Ensure the public is aware of when to go to A&E, improve health education e.g. eating healthier, taking exercise, developing positive lifestyle and feelings of wellbeing.”

“Have a booklet (hard copy and online) on common issues that people can have / injuries as a reference with a traffic light system on it as to possible actions they can take for self-help and use your primary healthcare workforce to promote it.”

There was concern about **funding** these services and a wish for **multi-disciplinary/agency teams wherever** the ‘hub’ is located, **more services located within a GP surgery**.

“Proper funding bringing together social care, mental health and all other services.”

“Have social services, GPs, mental health and community care teams working together efficiently. Properly funded and yes technology may help.”

“Local GP surgeries to cater for mini emergencies, for example, walk-in cases needing first aid including dressing of wounds.”

“Greater use of GP surgeries/ nurse prescribers/ minor injury care.”

An **effective triage system** was still felt to be needed, **accessible walk-in centres** and **better support in the community** to prevent issues developing into emergencies.

“GP hubs, qualified community healthcare staff on ambulances, retrain NHS 111 staff, I think they are unable to triage properly over the phone; you need to see your patient to do this adequately and they are hung up on litigation.”

“Local walk-in centres to be available and accessible.”

“Same day discharge - only supported if 24/7 community support available.”

Some concern was shown for **older patients** and those who needed **emergency mental health services**.

3. What do you think digital technology can do to support this work?

Overall there were some positive feeling about the improvements that could be made by using technology, particularly around **information sharing**, **sharing patient records** and getting **instant access to results**.

“X-rays available, good sharing of test results MRI, scans blood tests etc across healthcare system.”

“Lose the need for person to repeat and repeat details to each service.”

“Notes on records to flag up lifelong/life limiting conditions that will inform the range of healthcare professionals involved.”

“It must be integrated so that wherever a patient is treated the evidence of that in real-time goes on to a consolidated patient record. At this point in time this is not possible.”

“It could be joined up so that patient care and delivery of care can be accessed by all health professionals to enable holistic joined up service delivery and care.”

Respondents also felt there was some opportunity for video conferencing/ telephone appointments, possibly also with some triage to prevent people going to A&E and finding out about alternatives.

“Could talk on phone or video conference at local surgery? Or somewhere somebody could tell you what to do.”

“The facility to have a webchat would be useful for those with hearing difficulties who find listening on the phone difficult.”

“Maybe use digital chats available with healthcare professionals that can maybe triage cases.”

“Video consultations might help, especially for those who struggle to get out or would call an ambulance unnecessarily.”

Like the video triage, an **online symptom checker or triage system** that you can look at yourself and be told what medical care would be best suited, with an approved list of Questions and Answers related to different conditions.

“Being able to put in what's wrong and for it to tell people where to go, directions and how far it is. Option to accept suggestion so that the surgery/minor injuries/etc. knows you're coming and can manage the amount of people or redirect them elsewhere if full.”

“Effective apps on smartphones/tablets could provide a system of questions and answers to help determine whether or not a patient needs to be seen by a clinician.”

“Health diagnostic app with decision tree? However, the danger of this is that people who are in real need may resort to this, may make a decision error, may not have access to it. Older people, infirm or injured would hate to and should not have to rely on digital technology.”

“Traffic light actions to guide people on what to do to self-help, red indicating further professional help. Consultations online.”

There was concern that the NHS IT system would need updating to be able to handle this.

“Digital technology in any case causes massive complications. Can’t even get a prescription without hassle from technical holdups but national access to medical records would be a boon.”

“There needs to be a national compatibility of all hospital record systems to make sure that patient records can be accessed wherever they are in the Country.”

“It’s man-power that is needed, although an integrated computer system would definitely help.”

As expressed in the point above there were views that technology is not the answer here, manpower and face to face contact are important, and that use of technology would not be suitable for all. There were a similar number of respondents who didn’t know if technology could help or not.

“Very little - give someone an app, they enter their symptoms and are told to seek medical advice - it might even make the problem worse. patients don’t need to have Skype consultations. If they are ill enough to warrant medical intervention they should be examined properly. If a review can be done by Skype it can be done by phone. We need to stop pandering to patients wishes and focus on their needs.”

“I think digital technology will work for the more fit and able amongst us. Also, only those familiar and happy to use digital tech are likely to benefit. I do not believe this will work for those who are at most risk in our community, older people and those patients suffering from chronic, complex and multiple conditions, who are most likely to be overwhelmed by their lot.”

“When you’re in an emergency situation, people do not always think rationally and using technology is not always the first thing you want/need. Technology does not always ask the right question or allow someone to provide the right answer for their personal situation.”

“Digital technology is supposed to save time and be more efficient, without human beings you are losing that human contact, the crisis in A&E is reaching critical point, so is technology really helping? Perhaps we do not have the correct program to run the National Health Service efficiently.”

However, there was still some favour for an **online booking system** for appointments, having a way of checking **real time waiting times** may prevent people from attending A&E if they can see there is a considerable waiting time, and **use of apps** where appropriate - all with **suitable training/support**.

“Making people aware of what's out there at any time, perhaps having digital links to available out of hours services which enable people to make a choice dependent on accessibility, locale and availability. (if people know there is a 6 hour wait at A&E they might look elsewhere!). Communication via digital means is also very useful, the ability to have text messages for appointment reminders has been successful so why not expand the ease of access to information digitally.”

“Could there be a provision to enable hospital staff to book appointments with GPs for the following day. This could placate patients and make them more willing to leave A&E. A re-referral back to the appropriate care provider if you will.”

“Updated digital access pointing to available units /services to attend.”

Recommendations:

1. Improve **access to a GP/doctor**. Many respondents felt that with the current access levels at ‘normal’ times of the day and ‘out of hours’ they had no choice but to attend the local hospital/A&E as there was no other option. Waiting times to see a GP is often weeks away, and many respondents did not know what options there were available to see a GP outside of normal working hours. Examples of these types of cases where they felt they needed urgent medical care but that it wasn’t an emergency, were a wound that needed dressing, and infection/illness that required medication due to pain levels.
2. **Walk-in options** were felt to be a good option and other better **alternatives to A&E** like services at community hospitals or minor injury units. However, it was felt that once it was decided about these options - **publicity** was key in terms of where people should attend for what different cases. Better advertised and communicated throughout the community.
3. An **effective triage system** was felt to be needed. Many did not feel the current NHS 111 triage system worked, as they were done over the phone by people without medical training and without access to patients notes or history.
4. Respondents also felt there was scope for better prevention in terms of **health education** to both prevent and encourage self-help. Also, identifying where is **most suitable for people to be treated**, i.e. those who have had too much alcohol may take up lots of medical time at hospital so better placed elsewhere to be monitored, whereas those who are frail or have complex needs should be cared for at home.
5. Better access to **mental health care** was felt to be needed especially for young people particularly in the transgender communities.
6. **Location and accessibility** of alternatives to A&E was felt to be key - making sure that people could access them easily either in terms of distance and how easy it is to get to using public transport and the hours of service.
7. **Multi-disciplinary teams** were mentioned as being useful if there was a ‘hub’ for services, and **more support in the community**.
8. Need to make sure these services meet the needs of **older people** and those who need **emergency mental health services**.
9. **Digital technology** was felt to be useful if used to improve the sharing of information, access to patient records and immediate test results. Positive suggestions for use of digital technology include:
10. Video conferences appointments; potentially used for triage purposes.

11. Online symptom checker or triage system so that people can check themselves may be of use to some.
12. Online booking system for appointments
13. Able to check real-time waiting times at locations
14. Ensuring that the **current NHS IT system** could cope with any major redevelopments was a concern to respondents. Also, that man-power was needed as opposed to digital technology. Also **training and support** may be needed.
15. The term 'urgent care centre' may be better to use than 'minor injury'

3.) Specialist Services

We need to develop new ways to look after patients with the most serious illness and injury, ensuring they receive the best possible care in the shortest time frame. We need to deliver improvements in patient outcomes and ensure timely assessment and treatment to reduce the risk of death and disability.

Many services that provide clinically specialist care experience significant challenges around several areas including workforce. Work is currently going on to help ensure that these services are strong and sustainable for the future. To produce better outcomes for patients and to support these challenged services, we know we have to make better use of the resources we do have. We could do this by bringing these clinical teams and their specialist equipment together over fewer sites to create centres of excellence.

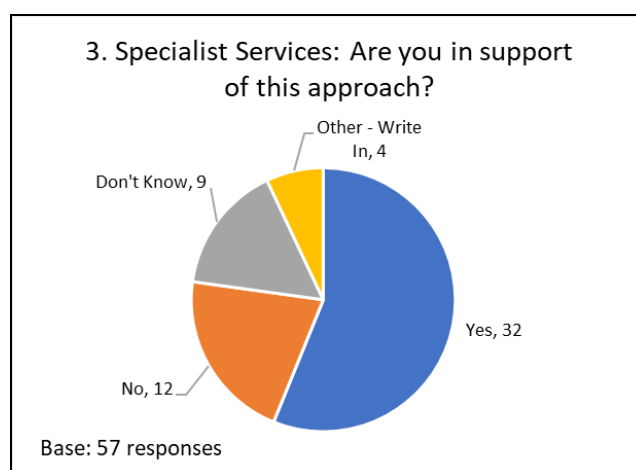
Quantitative results from online survey

There were 13 focus groups held about Specialist Services, which engaged with approximately 123 people.

There were 57 responses to the online survey and answered whether or not they agreed with the priority.

There was a slight majority who supported the approach described above.

Those who responded 'Other - please write in' were mostly concerned with the locality of services and specialist equipment, and the access difficulty this may add, particularly for patients travelling to appointments.



Detailed results of the engagement:

1. What do you think of this idea?

It was only the focus groups that were asked this specific question, so responses come from 13 of the groups, three from Worcestershire and ten from Herefordshire and they are mix of patient liaison groups, hospice groups and specialist conditions support groups for types of long term conditions and cancers.

Overall, the majority of respondents were ok with having centres of excellence and were very happy to be treated by a qualified specialist, however there was much concern about travel and where these centres of excellence would be located.

"In theory a good idea but access and transport issues are a major barrier to patients when the treatment is out of area."

Concerns were:

- Time spent travelling when you are ill, particularly if you suffer from long term conditions such as MS
- Locations of these centres being chosen on merit rather than history, the ability to change/expand service as conditions and their treatment become more common over time
- Looking at where is easier to travel i.e. from Hereford to Birmingham is easier than Hereford to Coventry in terms of the transport links and roads.

There were also concerns around how people's postcodes affected the level of treatment, i.e. live in Hereford with a Worcestershire postcode, and those living over the border in Wales but receive treatment in England.

"Some comments were expressed about problems with people coming to the hospital from just over the border in Wales - Welsh ambulance, but nightmare to coordinate as some will do it, some won't."

Respondents also wanted to know what impact this would have on patients being able to see the same Doctor or specialists.

2. Do you have other ideas or thoughts about how we can address this issue?

Again, travel for patients was a large concern, the impact of having to travel much further to see specialists. There were similar levels of support for encouraging specialists to visit localities i.e. one person traveling further away so many patients can meet at local centre.

"Equipment should come to local locations rather than patients travelling to centres, and surgeon/clinicians come to these facilities e.g. Worcester head and neck clinic held at Hereford once a week."

"Centres of excellence are great, but 50 patients travel to see one doctor or nurse. How about one doctor or nurse going to local hospitals."

Following that there were some ideas about what is needed to improve conditions for staff, in order to recruit and retain more staff in the NHS. Some comments were about staff being overworked, over-managed and bullied in certain locations; other options were about providing opportunities for career development, recruit people with a view to train them up, ongoing training, supervision and support

"Provide better targeted training for the staff of the future. Free courses in healthcare to attract new students. Pair up schools and colleges with universities to provide the right training and range of courses."

"The specialist workforce needs to be continuously learning, developing new skills, using clinical audit and measuring their practice against the best. To do this they need to have access to resources (time and money). By providing these resources we can attract the best staff and thereby provide the best care. Having experienced excellent care provided in a specialist unit with knowledgeable, motivated and staff with delegated clinical decision-making responsibility made a lasting impression."

There were also similar proportions of respondents who felt unable to offer any ideas about how to address these issues.

There was some concern about how care could and would be managed across two sites i.e. centre of excellence then community care for recovery, with a strong view that follow ups/after care should be local. This included the idea of better working with Voluntary and Community Organisations, which can help with transport issues as well as care in the community.

"All agreed that post-operative support needs to be at a local level, not at centre of excellence. This raises the issue of which clinician is responsible for the patient's care. Would this be the surgeon at the centre of excellence or a local consultant or other professional leading on after-care. Ownership of services provided across two sites (tertiary & secondary).

“Agreement that after-care and support did not necessarily have to be consultant led. It could be a specialist cancer nurse who took this role.”

“Community transport is really good - will take you to hospital appointments and wait for you (If you receive benefits, you can claim some expenses towards this). Some charities have voluntary drivers. Community and voluntary organisations need to be promoted and advertised more. NHS should work closer with community/voluntary orgs that help their services a lot.”

“Use mentors/volunteers to do home visits. Mobile carers. Check rest of patient’s everyday life - support networks, financial situations - to ensure that they are coping with all aspects or if they need other support services.”

There were some suggestions as to how to provide better information to patients to help them to be more informed, manage expectations and be able to help themselves.

“Be honest with service users and carers on provision and availability involve them more, provide more information.”

“Train expert patients as they know how to live with conditions better than doctors.”

There was some concern around the disproportionate affect this may have on elderly people and those who are disadvantaged in the community.

3. What do you think digital technology can do to support this work?

There was felt to be huge benefits in being able to access and share patient records/results with different professionals, hospitals and teams, reducing the duplication and risks of not having the right information.

“Patient held records and real-time digital records so that care can be organised anywhere in the UK. Provide easily accessible information. Give fast access to patient records for health professionals throughout the NHS.”

“Speed up unnecessary paperwork, send reminders to patients so they are less likely to miss an appointment, pass information around those who need to know have full knowledge of the patient so can make a better assessment of their needs towards a better outcome.”

“Use digital technology to record patient information once for the use of all relevant medical professionals. Recent experience at Worcester Royal was that many different medical professionals asked the same or similar questions many times over, recording the answers on sheets of paper. This must be a waste of time. Passing information between services, professionals and different centres appears to be haphazard and slow. Why can’t they all access the relevant data on-one with sensible safeguards to protect confidentiality? Sharing of X-ray and scan results between hospitals seems to be difficult too sometimes resulting in the same tests being done twice at different centres, why is this?”

The use of video conferencing for medical care was mixed, in that some felt it would be very useful and save people time waiting etc, but that this would not be suitable for all, for various reasons such as age and connectivity.

“You can offer support to people through digital platforms. Experts could video call patients that they needed to check in with, would be quicker than an appointment.”

“Skype for routine appointments to avoid travel or sitting in queues.”

“Skype appointments/ telephone calls can be useful, but many patients are already isolated due to their health conditions and there are definite benefits to them seeing someone face-to-face.”

It was felt that there needed to be improvements in the NHS IT system in order to facilitate any increase in use of digital technology.

There were some specific uses that could be trialled to help with specialist services such as:

“Clear directions downloaded onto a mobile phone and a parking disc that can be printed for that session.”

“E-learning, simulation etc.”

“Video could be used to provide information to patients about their condition or treatment plans. This could be offered in addition to other types of information, such as written, and not necessarily instead of face-to-face consultations.”

“In terms of a model I would argue for very well-equipped satellites/access centres where all but the most advanced diagnostics can be done by technicians. Each site would be supported by an on-site consultant who rotates with other members of the central team and acts as a communication channel (up and down) between life at the coal face amongst general and para medical practitioners and the ivory tower of interdisciplinary consultants at the Centre. Digital technologies can then be redesigned to optimise the performance for the many not the few.”

Recommendations:

1. **Centres of Excellence** were felt to be ok, however there was concern with the **locations** of these centres and the knock-on effect of **travel**, especially on patients. It was felt patient having to travel much further for treatment was negative and added extra stress to the situation, particularly those who are very ill or have long term conditions such as MS.
2. **How these centres would be chosen** was queried, i.e. preference that locations were chosen on merit rather than history; and realistic travel planning i.e. not restrained by the STP e.g. if it is easier to travel to Birmingham from Hereford than it is to get to Coventry.
3. Some thought needs to be given to **people living on the borders** of counties, such as the Herefordshire/Worcestershire border and those on the English/Welsh border. Making sure that there is a consistent approach to how those are dealt with, and what level of service people should expect.
4. The potential for **specialists to do ‘day visits’ to hubs** was suggested, as this would impact on the numbers of people having to travel as far.
5. It was felt consideration was needed into how patients would be managed outside of these centres of excellence, i.e. after-care and follow-ups. It was felt that this needed to happen at a local level, but the **care across these two sites** needed to be seamless.
6. In order to **recruit and retain staff**, respondents felt that conditions needed improving particularly around not being overworked and levels of bullying, levels of supervision and support and on-going training. There should be options for career development and alternatively recruit people with a view to train them up, as this may prove less costly and be more attractive.
7. More **information** to patients in terms of what to expect and how to help themselves, use of ‘Expert Patients’.

8. Make sure that those who are **older** and/or **disadvantaged** are not unduly affected by any changes.
9. **Improvements in digital technology** was felt to be a huge improvement if **information and patient records and results** could be shared more efficiently and effectively across locations and teams. However, with any digital technology this **would not suit all**, potentially at risk are **older people** or those **without good connectivity**. The **capacity of the current NHS IT system** was questioned whether it could cope with such improvements. Although it was felt that digital technology could potentially help around:
 - Video conferencing/appointments
 - Directions, parking and information about the centre you are visiting available in a app
 - Videos for patients to provide them with information about their condition or treatment plan
 - Use for e-learning/simulations for ongoing personal development for staff.

4.) Prevention and Self-Care

In 2016 local people told us that information about how to keep healthy, or how to manage long term conditions, proved difficult to access, contradictory and sometimes confusing. They told us that they wanted to access this information through trusted sources and people - like GP's, nurses or other health care professionals. They also told us that some people need encouragement to help them access groups or make changes to the way they live their lives.

Since 2016, we have been working to help people manage more aspects of their long-term conditions themselves, and to support communities to live healthier and active lives. We now have social prescribing schemes in some areas to encourage patients to access non-medical treatments which are often helpful.

Whilst this is helping, demand for NHS services continues to grow - often for avoidable illnesses caused by such things as smoking, poor diet, obesity or alcohol or drug use. The plan is to address some of this through smoking cessation support for some groups of people, and through such things as Diabetes Prevention Programmes.

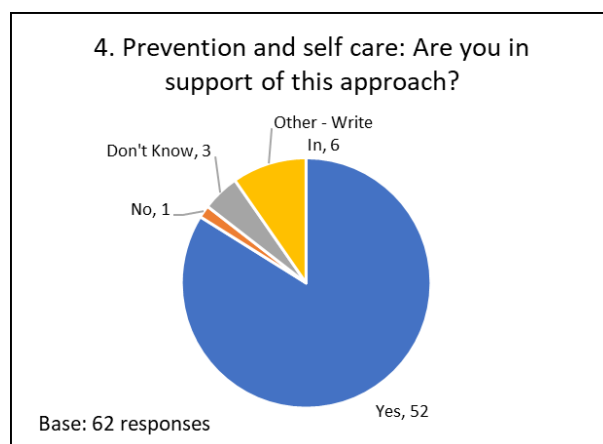
Quantitative results from online survey

There were 21 focus groups held about Prevention and self-care, which engaged with approximately 177 people.

There were 62 responses to the online survey and answered whether or not they agreed with the priority.

There was a clear majority who supported the approach described above.

Those who responded 'Other - please write in' were split between support and not, some thought it was a good idea, but the challenge is getting people to access these types of support. Others felt that there were other clusters of population that needed help more for conditions that are not self-inflicted such as dementia, mental health, etc.



Detailed results of the engagement:

1. How can we encourage people to engage with support programmes?

A lot of the comments were around **support groups**, making them **more attractive** to people with like-minded people, making them **local** and at **times of day** that suit those who may be working. There was also a need for **good advertising** that they are there and the possibility of using a '**mentor**' type role to go along with people the first few times as it can be daunting going to new groups.

"Run them out of normal working hours."

"Transport / local to communities / free classes / info?."

"Have many groups for different people, so one group for women over 40, one for under 40, mixed groups for those who'd prefer that. I've got fibromyalgia and going to the support group was painful. Much older ladies going on and on about how they couldn't change anything to make them better. They needed their own group. I am active and healthy and for me my

condition is a mystery. I want a group with like-minded people. And I'm sure everyone accessing a support group wants to feel unity."

"Support people to actually attend for the first time. It can be difficult to go somewhere new on your own."

Following that, respondents felt that the **messages of healthy lifestyles** needed to be continually shared across various channels. There was a mix of views as to whether these messages should be **hard hitting** or more a **'nudging rather than nagging'** style.

"Focussed into messages via systemic approach of key priorities with repetition and variety of styles."

"Give more profile to programmes such as diabetes prevention, mobility and obesity on TV advertising campaigns. Consider which images are used to advertise programmes - don't put people off e.g. older people using mobility classes might discourage those who are younger. More local events to highlight opportunities locally. GP surgeries could host these."

One idea that was proposed by a number of respondents was the use of **'success stories'** either by those people becoming mentors or visiting schools/support groups to talk about how it is in real life.

"By publicising success stories, of people who have engaged with social prescribing and have benefitted, A public campaign on TV media, etc to explain what it is and why it works."

"Peer support experiences from people who have already undergone similar experiences and support groups."

"Maybe a mentoring scheme via past users of the support programme."

Young people were often mentioned, in terms of getting the messages instilled in people early in life.

"School programmes to educate from an early age - better engagement with YP on Health messages."

Respondents acknowledged that it was difficult as you **cannot make people change**, they must want to change and will do so in their own time. However, it was felt that there needed to be a culture change in **Doctors to get people to tackle lifestyle issues** with patients more directly.

Language was a barrier for one group of Syrian refugee women as their English language skills were not yet good enough to engage with any support groups, mother tongue support would be welcome and is needed.

2. How can we support people to make better lifestyle choices and better manage the conditions they do have?

Respondents gave a very broad view of how to support people, as this topic covered quite a wide range of conditions. Education is key, again tackling issues with children in schools and parents at home to instil healthy lifestyle messages early. Clear consistent messages, advertised nationally were also felt to be useful, sometimes linked in with TV shows. Engagement with schools to get healthy messages out there.

"Knowledge of what a good lifestyle choice is."

“Education and information on the benefits for them personally might help. They've got to be convinced that it's in their best interests.”

Better written information available, easy to understand, in different languages if needed. Having these available in different locations and given to patients at different times. If people are given a long-term condition diagnosis, they are not able to take in too much information at once.

“Consistent information and messages. People are bombarded with conflicting advice about how we should manage our health, for example diet and exercise and what is good for you and what helps.”

“Making sure that information is out there so that people know about what is available such as expert patient program is often too late when we hear about it and there is no space left on the courses.”

“When people receive information is a key issue, sometimes we are not ready to hear it at the point of being told we have a problem, so information needs to be given at multiple times along a patient's journey.”

There was a clear role for GPs and other health care professionals to tackle the issues directly, giving enough time to get to the bottom of the issue, i.e. what are the barriers to people changing, what support do they have around them etc. However, it was acknowledged that the time available for appointments prevented this type of discussion/intervention taking place. There were some views that these lifestyle changes needed to be explored first before medication was prescribed but support for the patient and professional was needed for this to happen. Trying a holistic approach rather than just medical.

“Provide access to information and assistance in change. Listen to patients. When told “I can't cope” don't dismiss it. Don't keep talking about healthy eating when told “I can't cook”. Ask questions because patients don't know what help is available.”

“GPs need to be more upfront about speaking to people about sensitive things, like weight or smoking, this is limited at the moment by short appointments”

“Be straight with people and ask the professionals to be honest and straightforward too. Professionals should be prepared to stop dishing out pills willy nilly when they are covering up lifestyle choices. Encourage a healthy diet. Offer lonely people social outlets so that they do not need to seek out professionals for company and sympathy.”

Regular, consistent support and/or support groups/open clinics were identified as potentially being useful. Having the same person check up on you and praise you for achievements was felt to be effective. Like peer mentoring - having that understanding support around you, would be effective.

“Group member with experience of mental health services - need better post hospital support, person felt they needed weekly support but were offered monthly support.”

“Provide regular, consistent support. Set up support groups - encouragement from others in a similar situation. Peer support (mentoring scheme).”

“Information about the benefits, addressing barriers to people making changes and helping them to problem solve around these '1 step at a time' approach, recognition that change is not easy and not judging people when they struggle. Peer mentors.”

“Using tech, providing supportive phone/text encouragement.”

“Regular interested contact/praise etc.”

Ongoing checks for long-term health conditions need to be reinstated, pharmacists, or specialist nurses were felt to be best placed to do this.

“Group members with diabetes - offered a yearly check-up/blood test. Would welcome more regular contact/support - e.g. telephone call.”

“Fund e.g. pharmacies and walk-in centres to provide e.g. Blood pressure checks, other screening services and use social prescribing e.g. Singing/dance/tai chi /walking groups.”

“Even the nurse doing my annual checks tells me if I want a professional opinion on my worsening angina, I have to request a GP appointment rather than her doing it as a matter of routine!”

There was also a view that nationally there should be some changes, such as tax on unhealthy food, national healthy lifestyle campaigns, changes in legislation where necessary e.g. increase smoking age.

3. What needs to happen for people to make better lifestyle choices while they are well?

There were very similar responses to those above. Education; clear, simple messages and information. Use a holistic approach to treat patients, offering support groups and encourage self-help with patients taking responsibility for their own health.

Some of the more specific changes mentioned in answering this question were making healthy lifestyle options cheaper, such as food, exercise and activity; making use of national campaigns, celebrity endorsements and focusing on the positives.

“Carrot incentives (feels like all the effort goes into people who cannot be bothered to look after themselves - feels like they get rewarded) e.g. cheaper fresh fruit and veg, promote cheap or free ways to keep active, improve walking and cycling routes to make it possible for people to do these things (roads feel too dangerous).”

“Encourage people to buy healthy foods by not charging too high prices.”

“National help with back to basics re how to cook, shop well.”

“Education during school years. Better food labelling! Not serving food with chips, bread and rice on the same plate! A program of moving towards cold pressed oils rather than inflammatory refined fats.”

“Promote screening by celebrity endorsement, publicity and social media.”

However, there were also the more hard-hitting suggestions, higher taxes on unhealthy food, restrictions on alcohol and tobacco.

Offering more support groups, particularly around mental health and self-esteem, such as ‘food for mood’; engaging with workplaces and having more healthy community groups/champions were also ideas that were supported. There was a suggestion to do more low-level screening to highlight people who may be at risk of unhealthy lifestyles.

“More involvement of workplaces - work practice can cause a lot of stress and illness.”

“NHS putting on more courses to support good mental health e.g. mood master and food for mood. Need more of this not just one off.”

“Positive role models in the community championing the idea i.e. local sports clubs etc.”

“Encourage community groups to start exercise classes/weight loss programmes.”

“Screen people for healthy lifestyle indicators at blood donation point.”

“Low key screening, e.g. multiple-choice online questionnaire.”

4. What could local people do or contribute to improve their own health and that of others in their community?

There were a few key themes that came out of the responses, like the other questions; around setting up/joining support groups; becoming peer supporters, champions or mentors and how community groups could help. There were several similar suggestions about how community groups could help in terms of walking groups, exercise classes, supporting allotments, holding workshops and cookery classes. People expressed a need that professionals may need to support some of these groups.

“Organising open days, holding groups that prevent anything, from social isolation to exercise to prevent falls.”

“Some sort of bartering system i.e. I will train/run with you for an hour, what can you do to support me? or a catalogue of support: people offering the healthy bits of their lifestyle to others for free or nominal cost.”

“Start local walking/running/cycling groups that are free to join and attend. Local shops need to make the healthier options cheaper. People who grow their own veg and have surplus should share it round their community.”

There was talk of being a ‘good neighbour’ or friend that looks out for other people, particularly if they are unwell, or inviting them for a walk or to join an exercise class with you.

“Offering help with certain tasks (e.g. gardening, cooking, housework) as a means of improving their own and the health of others, as part of an education program, course, or less formal means.”

“Keep an eye on local older people.”

There were views that this should not be left to communities to deal with, and that it is very much everyone’s individual responsibility to take care of themselves.

“Don’t assume there is a community, public health needs to be active in these areas.”

There was felt to be a general need to educate and encourage a healthy lifestyle but no specific methods of how this should be done.

There should be a focus on mental health and how this can impact more widely on a person.

“Stress, depression, anxiety stop people coming out of their houses to join in. Mental Health may be a barrier.”

There were some cultural/generational barriers identified, particularly in the Asian community and how they are not aware of some of the unhealthy lifestyle choices they may

be making in terms of cooking and exercising and were resistant to change, relying on family member to try to educate and change behaviours.

“Main concern is middle and older generation. Other family members encourage older people to attend events with them. Need motivation to go out. Culture change. Stay in house is normal, didn’t have culture of walking in the park or exercising. Younger generation have big role in encouraging older generation to join in.”

5. What do you think digital technology can do to support this work?

Mixed views about digital technology, with equal numbers who felt they didn’t know if it could, those who felt that it wouldn’t help and those who had some innovative ideas about how it could.

Types of healthy lifestyle apps, message reminders, were thought to be useful; particularly if they could be used to monitor yourself at home and results be checked over by a doctor. Anonymous messaging for support, or emails/forums for advice were also felt to be useful.

“Free to access programmes and apps. - like couch to 5k running etc.”

“Promotion of healthy lifestyle apps via Text/email.”

“GP surgeries to give you some equipment e.g. blood pressure machine, heart monitor etc. Then you send them the results. They check up on you regularly.”

“GP surgery offer ongoing health advice prompts/texts e.g. “Have you had your five a day?” “Have you moved 250 steps this hour? Apps where there is a community/league with others = competitive.”

Respondents felt it would be useful for sharing information instantly, sharing trusted information and helping to educate around this theme of healthy lifestyles. It also had the potential to link people up locally either with others with similar experiences or particularly community groups that would be of assistance.

“Coordinate and streamline processes for patient - one stop info centres and records.”

“E-referral from clinicians/social workers to local social prescribing providers. “

“Online availability of local group details for help with talking about particular issues, destressing, where to turn to.”

It was very clear that the use of technology would not be suitable for all, such as areas of the county not connected well with the internet and the older generation, but for the younger generation and potentially men then it might help access.

“If men had to use technology to address their health, this will help. Give a man a gizmo and they will monitor themselves. But depends on what you mean by digital. It could mean texting to remind to drink some water, how many steps today?”

Recommendations:

1. Respondents felt that **making support groups more attractive and accessible** would help people to attend these, along with **good advertising** of when and where they are. It was felt that a ‘mentor’ type role might be needed for some as it may be daunting for some to attend particularly that first session.

2. Respondents viewed **success stories** as being potentially very powerful, either in a role as mentor or simply going out and teaching others (schools/support groups) about how it is in real life.
3. **Messages** of healthy lifestyles needed to be **continually and consistently shared across various media channels**, however there were contradictory views about whether these should be hard hitting or a 'nudging rather than nagging' style. **Better written information**, leaflets were felt to be useful so that they could be re-visited in the patient's own time, when they are ready to take in more information.
4. **Education** in general but particularly **young people** via schools and parents was mentioned frequently.
5. There was some acknowledgement that **people needed to want to change** and that you couldn't make them.
6. It was felt that **doctors needed to be more direct with patients** in dealing with their lifestyle issues and consequences. Although the **time given at doctor's appointments** was felt to be a barrier to this.
7. **Regular, consistent support** was felt to be needed, particularly if it was the same person, and there was praise for achievements. **Regular on-going checks for long-term conditions** was also felt to be reinstated more, although it was proposed that nurses/pharmacists could do this, not only a doctor. **Low-level screening** was felt to be a potential way to prevent some of these issues by picking people up earlier.
8. **Language and to some degree culture**, was seen as a barrier in some communities, such as Syrian, Arabic and Asian.
9. Respondents felt there was scope **nationally** to be able to help in terms of healthy lifestyle campaigns, taxes on unhealthy foods and changes in legislation.
10. **Locally** there were some suggestions around the ability to set up support groups, have local champions/peer supporters. Hosting local walking groups, exercise classes, supporting allotments and holding workshops were all suggestions about how local communities could help but felt that they should not be doing all the work and **support from professionals** was needed.
11. Respondents felt there was generally a need for **people to take responsibility for themselves**, however there was scope for a '**good neighbour**' type scheme to look after those more vulnerable in the community.
12. **Mental health** prevention was an important area.
13. **Digital technology**, although **not suitable for all**, could be of use in terms of:
 - Healthy lifestyle apps with message reminders such as 'have you eaten your 5 a day',
 - Apps that could link with the doctor to monitor yourself at home and 'send' over your results to be checked by a doctor.
 - Anonymous messaging for support.
 - Online forums for advice.
 - Sharing trusted information instantly.
 - Linking people up to local community/support groups.
 - Engaging with men i.e. new gizmo to try out to monitor themselves.

5.) Health Inequalities

Overall, health outcomes in Herefordshire and Worcestershire are good but we face some real health inequality challenges. For example, there are large numbers of older people living in poor health meaning there is a gap between life expectancy and healthy life expectancy, and there are some condition specific premature mortality concerns around certain illnesses including some cancers and heart disease. We also know there is a gap in mortality rates between advantaged and disadvantaged communities - especially in Worcestershire - and some outcomes for children and young people are not what we would want them to be - for example, in terms of school readiness, obesity and homelessness.

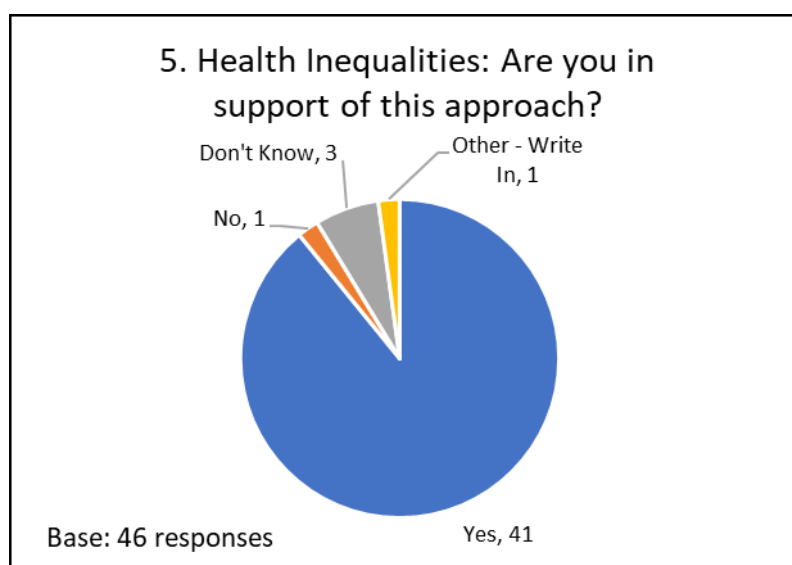
We need to address health inequalities and the fact that some communities are at higher risk of poor health.

Quantitative results from online survey

There were 12 focus groups held about Health Inequalities, which engaged with approximately 164 people.

There were 46 responses to the online survey, who all answered whether or not they agreed with the priority.

The majority supported this approach.



Detailed results of the consultation:

1. What actions do you believe will help to address these issues?

The responses to this question were extremely broad and there were very few 'themes' that stood out. Some potential actions that were mentioned a few times were **targeted advice and resources**.

"Input of cash/resources into disadvantaged areas."

"Target advertising at the poorer communities about whatever health issues they are more likely to have."

"Better access to services for all especially where rural transport is an issue."

Education, particularly in schools was the second most commonly raised issue, along with working with parents to teach younger children about healthy lifestyles, and early intervention at that age group to pick up issues early. It was also felt that schools should offer more sports/PE and free school meals.

Followed by **working with the local community and sharing local knowledge**.

“Think about who within communities can communicate with people - laundrette, police station. People who visit places e.g. shop which may be their only contact with others. Information and understanding of issues in places people may visit. Identifying where people go e.g. Supermarket or community café. Staff and volunteers to have awareness and training to help identify who might need help and support.”

“Listening to deprived communities and funding the services and activities that they would like “

There were a few comments about Hereford Medical Group and other GP surgeries in Colwall, where respondents experienced some difficulty accessing GPs. Including difficulties, seeing the same GP, getting through on the phone to make an appointment and having to visit other GP surgeries. It was felt having a walk-in GP service would be useful for most people and especially those who led more chaotic lives making it difficult for them to access a specific appointment time.

There were a similar number of responses that felt individuals needed to be more accommodating and responsible themselves.

Tackling some of the environmental factors that affect health was felt to be an area that needed action, although it acknowledged that this was wider than just health.

“Addressing the disparities between health and lifestyle and home. Heating poverty? Food Poverty?”

“I do not think the NHS is responsible for the fact there are these communities, however, educate parents to provide healthy, home cooked meals. The provision of nursery places, before and after school clubs and free school meals plus more emphasis on sports at school but these are not in the remit of the NHS.”

All other suggestions were only made by one or two respondents.

2.What do you think needs to be offered locally to improve the health of disadvantaged communities?

Similar to the responses above, there were very many different suggestions as to what can help improve the health of disadvantaged communities. The most common response was **to have services in those areas** and try to improve environmental circumstances so that there are **no disadvantaged areas**.

“An end to austerity! Disadvantaged communities need services, funding, support and aspiration to counteract their disadvantages. Decent wages, a functional social security system and affordable housing.”

“Local GPs staff to always contact the Council / local Councillors whenever health problems are due to inadequate living conditions (e.g. mould spores, un-heated dwellings etc).”

There was felt a need to have **parenting classes/support** within communities, to help instil healthy lifestyles into young children.

“Parents should have classes every year about childcare for that age.”

“Parenting classes - not offered but mandatory, not everyone is a natural parent and some really struggle but feel the pressure to be perfect.”

Other suggestions were support groups, health seminars and information and free sports/exercise facilities.

“First diagnosed with lung condition - thought there would be an expert at the GP surgery, but there wasn’t. Someone mentioned Pulmonary Rehab - started 2 years ago. Invited to start Breathe Easy (Malvern) - these sessions are well attended, but they are trying to stop these sessions, the instructor says it may not survive as they are wanting to save money, but the costs are minimal and the benefits are huge as without it, people would go backwards. It is used by a lot of people (nearly all men) and there isn’t anything else for them. If you get people in a group doing exercise specifically for them, the social benefits are huge (mood lifts, don’t need to see GP as much and lots of other benefits).”

There were some mentions of specific **types of medical staff** that currently or previously checked on vulnerable groups of people, however the current service is not as good as it could be, such as over 75’s Health Visitor, Community Matrons, Community Development Workers.

3. What do you think digital technology can do to support this work?

There were a lot of respondents who felt digital technology wouldn’t support this work, almost as many who didn’t know and the same number who felt it wouldn’t be suitable for all to use.

For those that did feel it could support this work, there were two areas; better communication and quickly sharing records were the most advantageous. Better communication covered areas such as advice, information, healthy lifestyle messages. Whilst sharing of information meant patient records being used by all medical staff involved.

“In some ways it can help patients access services that otherwise may be difficult especially if whilst the long-term plan emphasises local services it seems that many specialist services (e.g. cancer and stroke) will be concentrated in centres of excellence and therefore more difficult to access.”

“Advice on Facebook and Twitter.”

“Help get the message out to help improve their health.”

“An integrated computer system in use by health, community and social care would help.”

“Better access to notes. Better knowledge of pathology to upcoming patients”.

“Speed things up and inform.”

There was some useful suggestions where technology could be useful, such as videos for patients to demonstrate exercises, appointment reminders and use of the online prescription service.

Technology was felt to be able to help those with hearing problems and learning disabilities.

“Careline - can’t really hear them on the phone, can’t hear the phone ring, can only use the house phone, can’t use mobile. Signal problems with mobiles makes it even harder to hear. Careline do a test, they phone back, but if you can’t hear it, it’s no good. Careline would be good if they found other ways to communicate (e.g. vibration, text messages).”

“Get a lot of problems with doctors - not being able to make appointments due to difficulty with hearing people on the phone and problems with telephone appointments (can’t hear doctor/ they mumble) - they are not allowed to speak to a third person. To make an

appointment with Hereford Medical Group you must ring up to make an appointment, they have to ring you back - if you can't hear nothing gets done - so adjustments to overcome these problems would be welcome. “

“Some people with learning needs can find technology useful - don't have to speak to anyone in person or over the phone.”

Recommendations:

This was a broad theme and respondents views reflected that, meaning that there were not many unanimous recommendations.

1. There was some support for **targeted resource and advice in disadvantaged areas**.
2. **Education**, particularly in schools and support for parents to teach young children about healthy lifestyles. Schools were also felt to be a good place to increase levels of activity through more physical education and healthy eating with free school meals.
3. **Working with local communities**, both to identify those at risk and needing help and to put support in; having local support groups.
4. **Improving access to a GP**, this was particularly around being able to make an appointment as phone waiting times were felt to be too long, the ability to see the same GP; and it was felt that a walk-in GP service would be particularly useful for people who led more chaotic lives.
5. There was a view that the **wider environmental factors that affect health**, such as wage levels, housing condition, and cost of living needed improving, however it was acknowledged that this was wider than health and probably needed tackling on a national level.
6. **More access to free sports**.
7. **More on the ground staff**, Doctors, over 75's Health Visitor, Community Matrons, Community Development Workers.
8. Technology could be used, particularly for **sharing information and easier communication**; a few ideas to use technology for videos to support patients with condition, appointment reminders, and the online prescription service.
9. Technology could be particularly useful for those with **hearing loss and learning disabilities**.

6.) Mental Health Care for Young People

Mental health problems often develop early and half of all mental health problems are established by the age of 14 years, with three quarters established by 24 years of age. Prompt access to support enables children and young people to maximise their prospects for a healthy and happy life.

Over the next 5 years the NHS wants to look at how what it could do around offering community mental health crisis services to meet the needs of our children and young people and providing Mental Health Support Teams in schools and colleges, to build on the support already available. Work will also take place to look at the structure of mental health services and how it supports young people aged 18-25 years to understand how it could become more joined up across health, care, education and the voluntary sector.

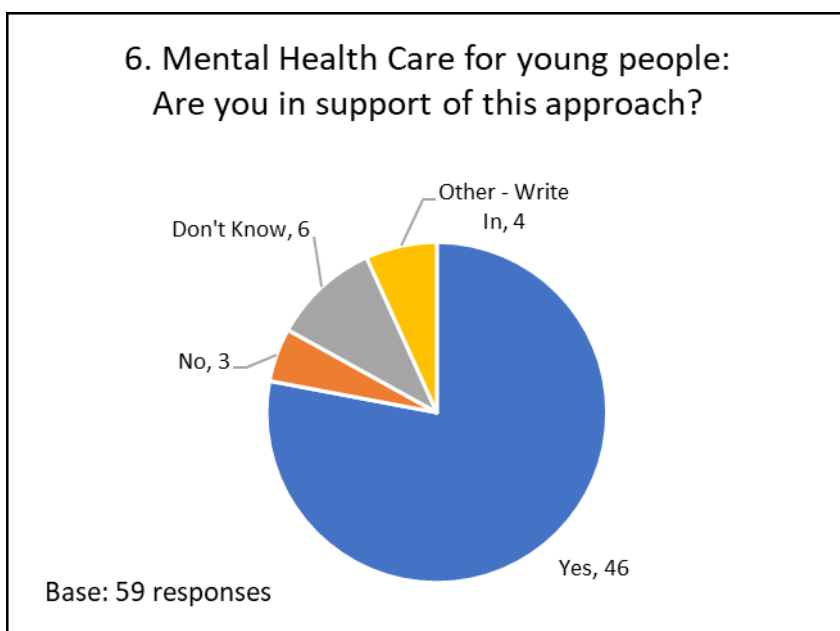
Quantitative results from online survey

There were 11 focus groups held about mental health care for young people, which engaged with approximately 174 people.

There were 59 responses to the online survey, who all answered whether or not they agreed with the priority.

The majority supported this approach.

Of the four who answered 'Other - write in', two added information. One in support of having trained counsellors in each school and other who felt five years was too long for a time frame to wait for improvements.



Detailed results of the engagement:

1. What do you think we need to consider when thinking about community crisis services for children and young people?

Waiting times for accessing services was the most frequently mentioned issue by respondents, along with being able to access services immediately, and not having to wait for weeks/months for a service and having an accessible service.

“The support needs to be flexible and available to the young person when they need it. They shouldn't have to wait months to see a professional or access support as during this time issues can escalate and actually require more intervention which increases delivery costs.”

Other suggestions were education about mental health in schools and colleges. More resources should be available in schools to be able to deal with issues when they arise. Better working between education and health was felt to be required.

Support for low level mental health problems would be useful to prevent problems getting out of control.

It was felt that family therapy was needed or at least support for the whole family approach. Support received should be tailored to individual needs.

“There needs to be a wider range of options available e.g. 1-2-1, groups, counselling, helplines so that a wider range of young people feel able to access support.”

“Help that caters for your needs, rather than read from a textbook.”

There was felt to be a general lack of awareness of what services are available, and that the capacity of current staff meant that services were not accessible/available, services also needed to be available 24 hours a day, 7 days a week.

Respondents felt that the young people needed a ‘safe place’ in order to ask for help.

“Friendly non-clinical environment.”

“An objective secure place like school or in a counselling room.”

There were some concerns about the age range of services particularly for those younger age groups, under 16 and under 18 were mentioned.

Targeted intervention and more resources were also requested by a few respondents.

Specific comments were made about the current crisis team, with difficulties being able to call them directly, them no longer providing outreach at certain services such as SHYPP (young peoples supported housing). Also how young people physically get support in A&E in times of crisis as Ambulances and SHYPP were no longer able to assist with this.

Respondents identified that services/support were needed for self-harm and suicide particularly.

2. What would make a good mental health support service in schools and colleges?

Having specific individuals/ roles situated in schools in suitable locations that were accessible to young people at all times was very important.

More training and support for staff to identify and deal with issues as they arise, along with clear pathways for referral and expectations about service and waiting times.

For young people themselves, bullying was identified as a major issue and cause of mental health problems, with tougher consequences needed for those doing it. Also, anonymity and confidentiality were important to young people, being able to quietly access help without peers being able to see/know what they were doing. Making sure they were listened to and believed was important to young people.

De-stigmatizing mental health through education was seen by respondents as a vital role to prevent mental health issues in the future and make it ok for people to ask for help.

Respondents felt a general need to build up resilience and develop better coping mechanisms in general.

Peer support or champions were felt to be a useful tool. As well as there being more support for low level mental health issues and more capacity in specialist services.

Support for parents/families dealing with their children’s mental health.

Services that were young people friendly.

Schools in general putting less pressure on young people and employing alternative approaches to tackle times of high stress such as exam time. Suggestions were use of animals, green woodworking and creative arts.

Respondents felt there were opportunities for outside agencies to be able to come into schools and talk with young people and support the staff in dealing with mental health issues.

Particular groups at risk were the LGBT community, particularly children who are trying to identify who they are and where they belong. Also, those with Autism and Anxiety.

“Before my daughter came out, she was very anxious and didn’t know who to talk to and she got in a real state. There was no one at school, no local information available. She lacked confidence and became anxious and started to have panic attacks because there was no support available and no one to talk to. Didn’t know where to get help. Nothing at school. Usually something available at schools for the 16 plus age group but not younger and my daughter was 13 when she needed support.”

3. When thinking of mental health services for young people aged 18-25, what changes are needed locally?

The key factor respondents identified was more resource needed. Shorter waiting times for services, services for those not at crisis point to prevent them from getting to crisis. Specifically, targeted support for this age group and many more services providing the same service for patients up to age 25 years.

The transition from Child and Adolescent Mental Health support to adult mental health support was not viewed as being very good. The transition is not smooth and patients often have to go back to being on a waiting list.

Easier access to services, including referral processes like self-referral, location of services and times that young people are available.

The availability of counselling services was not felt to be very good from respondents although many felt it should be, as talking to someone was felt to be important. The potential of using peer support was also thought to be important.

“Trained youth support workers in 24/7 late night cafe places listening ears, support from young people.”

Clearer expectations of service provision, process and pathways, which are communicated and shared widely. Better working with communities and community groups, support groups for those leaving school as this is quite a significant transition. Working with schools in general to educate about mental health, remove stigma and building resilience.

“Once out of school age, young people may feel abandoned so a continued support group, maybe like the AA groups.”

A walk-in service could be useful and joined up teams/services aimed at this age group were other suggestions.

4. What do you think digital technology can do to support this work?

Human interaction was the single most favoured request, although digital technology could be seen to help, counselling and talking to someone was best done face to face. The risks associated with Skype and connectivity/buffering only added to anxiety.

There was also a strong view that digital technology and social media adds to or is a cause of some mental health issues, therefore relying on it to solve these issues was not realistic. Although there is potential for social media campaigns and YouTube videos, celebrity endorsements to help reduce the stigma of mental health issues.

Although many respondents felt there were opportunities to use digital technology. Sharing information and records about patients, signposting to services, being able to access support 24 hours a day, 7 days a week was felt to be very useful. Respondents also felt that sometimes it was easier to write down feelings rather than talking about them, so chat rooms and texting facilities were supported.

There were several apps mentioned that were felt to help; Calm harm, BESTIE (developed in Worcestershire but not yet in use), Kooth, headspace, Knothole and others aimed at meditation, anxiety, colouring, distraction.

Improving access to professionals was one option where respondents felt digital technology could be used. Although particularly with young people there was concern about confidentiality.

“Maybe access to a chat with trained professional so they feel listened to when they feel low.”

“Have counsellor/ therapist/support worker profiles available to see online.”

Recommendations:

1. **Waiting times** was the main issue being raised, support not being available at the times needed, including low level support as well as crisis points.
2. The general **accessibility** of current services was not felt to be good enough and services are required **24 hours a day and 7 days a week**. More resources are required, and better publicising of what services were available, and how to access them. Walk in services were felt to be useful with the ability to self-refer for support.
3. **Working with schools and colleges:** education to help reduce stigma of mental health, learning coping mechanisms and building resilience. Ensuring staff are trained to identify those who need help and ensure that they have the resources needed to support those in need by having accessible ‘**well-being practitioners**’ who are readily accessible. Having safe places where young people could access support anonymously and confidentially.
4. Make use of **peer support** roles.
5. **Tackle bullying** - this was seen by young people as a major cause of mental health problems and was rarely dealt with effectively.
6. **More support for families**, and family therapies to help the whole environment surrounding the young person.
7. **Individually designed services**- what may help one young person may not be suitable for another.
8. **A better transition** from child and young person’s mental health service to the adult mental health services was needed, but also all services should be providing the same service for all those aged up to 25 years old.
9. **Human interaction**, talking therapies and counselling were all felt to be needed but inaccessible.

10. Groups that were felt to **need support** were those **under 18 years** old, those who were likely to **self-harm and attempt suicide**, those from the **LGBT** community, those with **Autism** and those suffering from anxiety.
11. **Digital technology** could be used - with caution as it was at times seen as a **cause of mental ill health**, however it could be used to better share information, connect patients with specialists, **signpost to services and self-help with apps**. It was felt to be useful in providing support/advice 24 hours a day, 7 days a week.

7.) Learning Disability and Autism Services

Since the development of the Sustainability and Transformation Plan in 2016, much work has gone on to improve how services work together, and how they understand and respond to the needs of people with learning disabilities. Going forward, this will need to include an understanding of the particular needs of people with autism. This work is often about making reasonable adjustments in health services to support those with a learning disability or autism - for example by including flags in patient records to ensure staff know and respond accordingly.

Over the coming years we need to work towards achieving timely diagnostic assessments for children and young people with suspected autism. We also need to look at how we can enable more people to receive care closer to home through multidisciplinary services and crisis care, which could reduce preventable admissions. It is also recognised that people with a learning disability or autism are likely to experience poorer physical health and outcomes, making treatment of the whole person important.

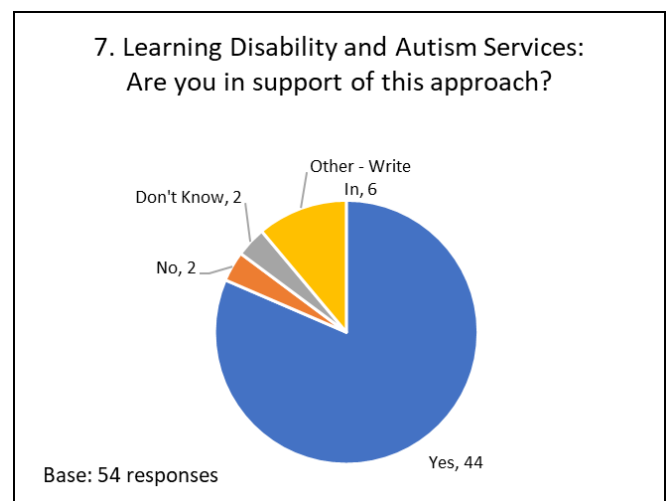
Quantitative results from online survey - Percentages

There were 9 focus groups held about Learning disability and Autism Services, which engaged with approximately 60 people.

There were 54 responses to the online survey, who all answered whether or not they agreed with the priority.

The majority supported this approach.

Of the six who answered 'Other - write in', four agreed but didn't feel they had the right knowledge to fully respond, another agreed but wanted more resource with it. And another did not feel the approach was clear enough for them to agree nor disagree.



Detailed results of the consultation:

1. What other reasonable adjustments could be made by health providers to support people with a learning disability and/or autism?

There were two priorities that came out clearly; the need for early diagnosis and reduce the waiting times to get one and that all staff be trained to recognise hidden disabilities and act accordingly.

There were specific things that could be done to aid people with learning disabilities or autism when attending a GP surgery:

- Easy read appointment reminders/information booklets.
- A quieter environment so it is less busy, or a separate waiting area, shorter waiting times,
- Longer appointments to allow time for better communication and making sure the patient has time to understand and ask questions, better use of Health Action Plans.
- Not assuming people can read and better use of pictures and symbols.

- Patients with learning disabilities and/or autism may need support from someone to get to an appointment and during it, transport and finding your way around the surgery or hospital were a concern. The patient should always be addressed directly during appointments rather than just communicating with carer.

It was felt that there should be better general awareness from all staff and members of the public about hidden disabilities and some of the adjustments they require.

There was a need for a multi-agency approach in dealing with people with learning disabilities or autism.

More support for teachers in schools, and more support for parents.

2. What would make a good diagnostic service and process for people with autism?

Overwhelmingly the main response was for a quicker, simpler referral process for diagnosis. This was for parents to refer via a GP, but also for schools and nurseries to be able to refer.

“A better referral process for schools/parents to access.”

“Getting parents to look out for a few indicators and then booking appointments with someone who could assess their child.”

“It needs to be made a faster pathway and ensure parents are kept involved/updated throughout. It is also essential that all providers involved talk to each other and not leave it for parents to chase.”

“Make it easy for nurseries and schools to refer parents with children who they believe are in need of intervention.”

There was a need for qualified staff to enable these assessments to happen, those with specialist knowledge, understand and experience to enable them to accommodate the various needs. A neutral, safe place could be used as an assessment centre or alternatively visiting a child in their home, nursery/childminder or school setting was also helpful in the diagnostic process.

“Well trained staff who understand people with learning disabilities or those who may have an autism diagnosis. Staff who can communicate with people with learning disabilities and autism Those staff who give time to understand the person and treat them holistically. people with learning disabilities /autism cannot always show /tell where pain is. Treat the patient with respect -get to know them.”

“The involvement of professionals who are experienced and trained in interacting with people with autism. Clear, concise communication. Calm, non-threatening environment. Space to calm down if feeling stressed, threatened etc.”

Listening to parents more was highlighted by respondents, as well as there being more support available for parents and families; especially after the initial diagnosis.

Access to local assessments and support was felt to be important. A multi-agency approach was identified as a benefit.

“Multi-agency approach. Speak to those working with the individual.”

3. What would make a good community and crisis care service and so prevent admissions to hospital?

Views about this were quite broad as to what would make good care. The most commonly mentioned suggestion was that staff should be specifically trained in disabilities therefore would understand and assess the situation better.

“Making sure that they have had training about understanding learning disabilities.”

“Specialist trained staff and enough of them to provide a good service to users and their families.”

Following that, there was a need identified for medical professionals needed to be able to visit people in their own homes.

“A multi-disciplinary team, trained to work with people with learning disability and autism, possessing the appropriate skills. The team should be prepared to work in the Community and in the patient's home.”

“I think it comes down to employing more people so that someone is available 24/7 when a crisis occurs. Treatment could be carried out in the home of the patient.”

“More on call professionals available to assess person before they end up at A&E.”

In general, respondents felt there needed to be more resources, more support in the community and services available before crisis points are reached. This also included a 24-hour service, either as an actual service, like a walk-in centre, or a 24-hour advice phone line or 24 hour messaging service. It more support was put in at home then the patient would not end up at A&E.

Being listened to more was identified both for the patient and/or the carers.

“Listen to people and their families.”

“To actually listen to people better the first time and to explain things properly.”

4. What could services change or do to better treat the whole person, not just the presenting learning disability and/or autism?

This was quite a broad theme; however, a better understanding of learning disability and autism was felt to be beneficial so professionals could treat and understand the patient better.

“A better understanding of varying conditions so appropriate understanding and advice can be given.”

“Better training and awareness of autism and how it effects the whole person.”

“Ensure that staff in generic services have a working knowledge of learning disability and of autism.”

There needs to be better communication, to listen to and treat the patient as an individual.

Respondents also felt that this area need more resources, use more holistic approaches for the individual, joined up services and listening to parents/carers/family members.

More time with a GP to be able to discuss healthy lifestyles would be appreciated, especially if they told patients the benefits. Healthy lifestyle support groups/workshops were welcomed where participants can learn about healthy eating, cooking and shopping, learning these tasks together. Provide easy read versions of leaflets and recipe cards.

“Easy Read information about how to eat healthily. Easy read recipes. Ideas about things you can swap to make your food healthier. Groups to go to about healthy living. Could include cooking demonstrations and exercise taster sessions. Regular sessions so you can see how you are getting on and share ideas and support each other. You Tube demonstrations about exercise and cooking.”

General information about hygiene and what people can do to help it. Seeking medical help as soon as you need it not to let it linger and worsen, tackling personal issues with the help of Doctors.

“Having more of an understanding about how illness spreads and hygiene. Films, for example on YouTube giving simple messages about personal care, such as handwashing and cleaning your teeth.”

“Have sessions that are male or female only to discuss specific issues around health and ask questions.”

“Support staff need to notice if people are not well and make sure they see a GP to nip things in the bud so they don’t get really ill.”

“Make sure people go to the GP and that illnesses do not get really bad so that people need to go to hospital e.g. constipation, chest infections and urine infections. “

5. What do you think digital technology can do to support this work?

This question was only asked and answered via eight focus groups across Herefordshire and Worcestershire, so numbers of comments are very low. However, there seems to be general support for accessing doctors’ appointments via a video link such as Skype or Facetime, or by phone.

There was general support for apps and smart assistants as these are considered useful reminders and tools. Videos on YouTube were also seen as a useful resource showing step by step instructions e.g. recipes.

“Get ‘Alexa’ or mobile phones to remind you to take medication regularly or reminders about health appointment.”

“An app could offer de-escalation tips, role plays or any virtual or written support/advice/info?”

Using a Fitbit and challenging friends was a way to encourage more exercise, and other technology to help to do exercise at home for those who do not like to go out.

It was acknowledged that the use of digital technology would not be suitable for everyone with learning disabilities or autism, however having simpler to use phones and tablets would help.

Recommendations:

1. **The need for early diagnosis.** This needs to be a quick, simple process started as soon as concerns are raised. A key part of this would be listening to parents/family.
2. There should be a **basic level of understanding by all medical staff** to recognise hidden disabilities and act accordingly. Also, a need for more specialist knowledge for medical staff who could deal with assessment/diagnosis process.

3. Reasonable adjustments within GP surgeries:

- a. **Easy read appointment reminders**/information booklets
 - b. **A quieter environment** so it is less busy, or a separate waiting area, shorter waiting times
 - c. **Longer appointments** to allow time for better communication and making sure the patient has time to understand and ask questions, better use of Health Action Plans,
 - d. Not assuming people can read and better **use of picture and symbols**.
 - e. Patients with Learning disabilities and/or autism may need **support from someone to get to an appointment and during it**, transport and finding your way around the surgery or hospital were a concern.
 - f. The **patient should always be addressed directly** during appointments rather than just communicating with carer.
4. A need for **GPs to be able to visit patients in their own homes**, as a way of preventing them from reaching crisis point.
 5. Better **general awareness/understanding** about learning disabilities and autism across the general population.
 6. **Multi-agency approaches**, although the detail of what exactly was not spelled out in this process.
 7. **More support for teachers in schools**, particularly in recognising conditions and the referral process.
 8. **More support for parents/families**, particularly during the diagnosis process and straight after.
 9. **Having a safe, calm, neutral place for assessments** was felt to be useful, as well as observations in 'normal' settings such as schools, nurseries, childminders and home.
 10. **Services available need to be 24-hours a day, 7 days a week**, which includes doctors' appointments, walk-in, phone lines and messaging services.
 11. **Better communication and listening to patients, by staff**. Communicating in a way that they understand and make sure they do understand before they leave. Better use of health action plans, information so that people can look these up later when they can take the time to understand/remind themselves. Skype appointments were a possibility.
 12. **Communicating directly about healthy lifestyles**, what to do and how. Support groups, YouTube videos, apps/smart assistants, easy read leaflets, Fitbit challenges were all ideas about how to encourage people with learning disabilities and autism to remain healthy.

8.) Adult Mental Health Services

Over the next five years, investment in mental health services will grow, which needs to support the work of frontline services for common disorders, severe mental health problems and emergency support. We will also be looking to better organise services generally so that they are more joined up with local physical health care provision. We know this is important because it provides a better patient and carer experience but also because people with mental illness are at higher risk of poor physical health. It is therefore essential that we look at ways of working that treat the whole person, not just the presenting illness.

Over the coming years, work will be undertaken to look at how we can provide access to mental health crisis support in the community. We will also alternative forms of provision for those in crisis, which might include safe havens or crisis cafes for instance.

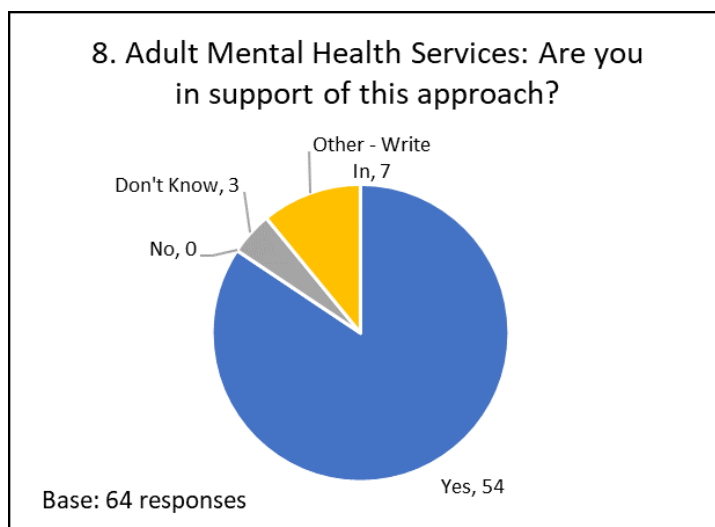
Quantitative results from online survey - Percentages

There were 11 focus groups held about adult mental health services, which engaged with approximately 84 people.

There were 64 responses to the online survey, who all answered whether or not they agreed with the priority.

The majority supported this approach, and there were no respondents who did not support the approach.

Of the seven who answered 'Other - write in', there was general support, but with some concerns over funding, for crisis cafes, community services not being free and more services being available.



Detailed results of the engagement:

1. What do you think makes good mental health crisis care?

There was a clear message about a service that was accessible, available immediately and 24 hours a day 7 days a week. Making a service that was available with a reduction on waiting times to receive that service. Ideally the respondents wanted it to be local.

Respondents felt that more resources in terms of staff is needed.

'A place of safety' was identified - often as a drop in for evening or weekend, somewhere patients could turn to when they needed support.

"24hr facility for people to walk into when in crisis - place of safety overnight, it always seems worse on your own at night."

"Crisis care now - people are dealt with by a clinician and deal with the problem, but people want a safe haven, not necessarily an acute unit. They don't want to go to Stonebow inpatient mental health unit, they want to cope away from places like this, places that are more homely. Need things that are available at the weekend (crisis seems to come at the weekend)."

“Fast access to the right people in a safe environment.”

It was felt that better joined up working would make better crisis care, particularly those working on the front line together, NHS 111, ambulance, police and mental health teams, as well as long term care when faced with a crisis or trying to prevent one.

“Clear information so patients, police, social care & others who need to know can understand and support people to use the service.”

“To work holistically with the patient. To identify which service is most appropriate to the individual patient, i.e. a key social worker experienced with the needs of older people and who is able to work closely with a health visitor - both of whom can link into multi-specialist support services, e.g. physio, falls management, oncology etc. You have mentioned into your intro above that often mental health problems lead to physical conditions. Yes, that's correct but such an assumption should not be at the cost of forgetting that many physical problems which are not addressed in a supportive environment will undoubtedly lead to depression and despair.”

Respondents felt there was a general need for more services put in place where people could access to prevent them from getting to a ‘crisis’ stage, support for low level mental health issues and early intervention.

It was also recognised that there needed to be support for the family of those suffering from a mental health crisis, it is often family dealing with it but they don’t know where to turn for help.

“Where carer and patient can both access support. We must consider that mental illness not only affects the patient but the carer also. Work needs to be done with both, especially the carer so they don't end up suffering too.”

Having a better trained workforce was needed, including training in some of the softer skills such as listening, communication, non-judgemental attitude, relaxed, empathy and a good understanding of what patients are going through.

Knowing who to contact and getting through to someone face to face for an assessment was felt to be important as is continuity and consistency of care.

There were also queries as to how a ‘crisis’ is defined and by whom.

2. What alternative forms of provision would best work for Herefordshire and Worcestershire?

There were quite broad responses to this question, with lots of different suggestions. Most common suggestions were around having a ‘safe place’ or a drop in and having access to services before and at the point of crisis.

“Yes, I have enjoyed visiting the new lightpoint cafe on Broad St in Hereford. But my crisis is always late Friday and over the weekend. A place where I could go to keep me safe is really needed.”

“If safe havens are created, they need to be properly funded and staffed, they need to be genuinely safe and be able to signpost you in the best direction to get the help you need.”

“Open clinics to encourage people to support each other and avoid crisis.”

“Drop in centre’s where someone could go for advice support and for check-ups.”

Face to face support and support groups that were local would help, and treatments within the community.

“Small intervention units closer to the patient’s home and community.”

“Regular drop in sessions for people to get low level support in their communities.”

Having staff better trained in mental health issues.

Respondents felt that it was useful to have crisis cafes, but also to have services that were there to support enduring mental health conditions.

“Support psychologically for long term conditions.”

“Long term support for people with on-going needs that currently fall outside your support (care leavers, ex-offenders) is needed. Their life needs support to manage their independence.”

3. What could mental health services change or do to better treat the whole person, not just the presenting illness?

The key area of change is respondents would like to see is better joined up working, integration of different services and teams, making the care more seamless.

“Having a multi-disciplinary team that can support access to longer term support that might be needed whether it’s housing, social care or employment support.”

“Link acute mental health services to other acute services. Allow fluid timely access of mental health professional to acute patients experiencing in-patient stays for physical conditions.”

“Ensure the various professionals are working together, e.g. Community Psychiatric Nurse, GP, psychiatrist, psychiatric pharmacologist.”

Following that there was felt a need for both ‘whole person’ care so more than just mental health - their whole body and health and holistic care that looked at the whole situation and environment for that person and the effect that might be having on the person.

Better training for staff, particularly around physical health so that they can understand how physical health affects mental health and vice versa. Also, better listening skills.

More talking therapies are needed, as well as additional funding to pay for alternative therapies rather than a medical intervention.

4. What do you think digital technology can do to support this work?

Human interaction was felt to be vitally important when supporting adults with mental health issues, however it was seen useful if technology would allow better sharing and access to personal records across teams and agencies.

There was some support for an online support offer and signposting of services which is available 24 hours a day 7 days a week.

“Video consultations might help with earlier access to treatment and reduce anxiety in patients who find going out or unfamiliar settings difficult.”

Otherwise respondent did not feel there was much more of a role for digital technology.

Recommendations:

1. **How and who defines a 'crisis'.**?
2. Provision of an **accessible service available 24 hours a day**. Immediate service at times of crisis and reasonable waiting times otherwise.
3. **A place of safety** that they could access any time was needed.
4. **More staff** in general was felt to be needed in order to help access.
5. Better **joined up working**, integration with services was also wanted.
6. A better **trained workforce who understand mental health issues**, had knowledge of how physical health impacted on mental health and had a better set of 'softer skills' such as listening.
7. More **low-level intervention** to stop people from reaching crisis point.
8. When a person with a mental health condition presented to a medical care professional it was felt better to treat the whole person in terms of physical and mental health, and a **holistic approach** looking at their whole situation and environment.
9. **Support services for the family** of the patient who are dealing with the effects of living with someone with mental health issues.
10. **Knowing where to go for help**, who and how to contact them was needed, i.e. phone number to call at the time of a crisis.
11. **Face to face support** was felt to be vital to this service.
12. **More talking therapies** and alternative to medication was felt to be needed.
13. Digital technology was felt to only be useful in this field in the area of **sharing information across teams and agencies, access online support 24 hours a day 7 days a week** and signposting where to get help and available services.

Appendix 1

The following tables list the community groups visited and the focus groups organised across Herefordshire and Worcestershire between March 15th and June 3rd 2019.

Out of Hospital local Care 314 people.		
Group	Number of people	Location
Malvern	8	Malvern
Ledbury over 65's	20	Ledbury
Norfolk House (Stonewater Housing) Leominster - Residents meeting	18	Leominster
Simply Limitless, Kidderminster - Older People	8	Kidderminster
Herefordshire Carers Support Group	8	Herefordshire
Evesham and District Mental Health Support Service	3	Evesham
Wychavon Focus Group	3	Pershore
Worcester Hive	2	Worcester
Wye Valley Trust Patient Experience Forum	14	Hereford
Bromsgrove focus group	4	Bromsgrove
Sight Concern Redditch	14	Redditch
Sight Concern Malvern	12	Malvern
Kidderminster	9	Kidderminster
MS Society - WF (Wyre Forest) Group, Kidderminster	13	Kidderminster
Redditch Focus Group	3	Redditch
Redditch Older People's Forum	18	Redditch
Redditch Carers Group	6	Redditch
Keenage Club, Age UK, Worcester	8	Worcester
Hereford Library Stand	50	Herefordshire
University of Worcester - Health and Social Care students	50	Worcester
Sight Concern	12	Bromsgrove
St Michaels Hospice - Living Well Group	18	Herefordshire
Arkwright court, Leominster - Stonewater Housing	11	Herefordshire
Headway	2	Herefordshire

Emergency Services 179 people.		
Group	Number of people	Location
Simply Limitless, Kidderminster - Older People	8	Kidderminster
Hot Food Kitchen (St Martins Church)	23	Herefordshire
Herefordshire Headway	9	Herefordshire
Wychavon Focus Group	3	Pershore
Wye Valley Trust Patient Experience Forum	14	Hereford
Bromsgrove Focus Group	4	Bromsgrove
Kidderminster	9	Worcestershire
Redditch Carers Group	6	Redditch

University of Worcester - Health and Social Care students	50	Worcester
St Michaels Hospice - Patient & Carer	22	Herefordshire
St Michael's Hospice - Living Well Group	18	Herefordshire
Arkwright Court, Leominster - Stonewater Housing	11	Herefordshire
Headway	2	Herefordshire

Specialist Services 123 people.

Group	Number of people	Location
Herefordshire Headway	9	Herefordshire
Venture	Not recorded	Herefordshire
HCS Support Group	8	Herefordshire
The Swallows Head and Neck Cancer Support Group	12	Worcestershire
Wye Valley Trust Patient Experience Forum	14	Hereford
MS Society - WF (Wyre Forest) Group, Kidderminster	13	Kidderminster
Simply Limitless	3	Kidderminster
St Michaels Hospice Patient & Carer group	22	Herefordshire
St Michaels Hospice - Living Well Group	18	Herefordshire
Arkwright Court, Leominster - Stonewater Housing	11	Herefordshire
Headway (One stroke survivor and carer wife)	2	Herefordshire
Kidderminster Prostate Cancer Support Group	11	Kidderminster

Prevention & Self-Care 181 people.

Group	Number of people	Location
Herefordshire Carers Support Group	8	Herefordshire
Talent match	6	Herefordshire
Vennture	Not recorded	Herefordshire
Mental Health Forum	10	Herefordshire
Ledbury over 65's	8	Herefordshire
SHYPP Leominster	6	Herefordshire
Herefordshire Headway	9	Herefordshire
Ross on Wye GP practice patient participation groups 65+	15	Herefordshire
Evesham and District Mental Health Support Service	3	Evesham
Wychavon Focus Group	3	Pershore
Simply Limitless - Older People	5	Kidderminster
Kidderminster Focus Group	9	Worcestershire
Muslim Women's Association	8	Worcester
Redditch Focus Group	3	Redditch
Sight Concern Malvern	12	Malvern

University of Worcester - Health and Social Care students	50	Worcester
Syrian Refugee Women - Kidderminster	6	Worcestershire
Hereford Library Stand	Not recorded	Herefordshire
St Michaels Hospice - Living Well Group	18	Herefordshire
Headway - one stroke survivor & carer	2	Herefordshire

Health Inequalities 164 People.

Group	Number of people	Location
Deaf Direct Group	10	Herefordshire
Herefordshire Headway	2	Herefordshire
Herefordshire Carers Support group	8	Herefordshire
Redditch Focus Group	3	Redditch
Simply Limitless	5	Kidderminster
Redditch Mental Health Group	14	Redditch
Hot Food Provider - Baptist Church	19	Herefordshire
University of Worcester - Physiotherapy and Occupational Therapy Students	50	Worcester
St Michaels Hospice - Patient & Carer	22	Herefordshire
St Michaels Hospice - Living Well Group	18	Herefordshire
Arkwright Court, Leominster - Stonewater Housing	11	Herefordshire
Headway	2	Herefordshire

Adult Mental Health 84 people.

Group	Number of people	Location
Carers in Mind	6	Herefordshire
Vennture	Not recorded	Herefordshire
Herefordshire Carers Support Group	8	Herefordshire
Herefordshire Headway	9	Herefordshire
Worcester Hive	2	Worcester
Wye Valley Trust Patient Experience Forum	14	Hereford
Community Connectors, Tolly Community Centre	9	Worcester
LGBTQ+ group, The Hive	14	Worcester
Redditch Carers Group	6	Redditch
Redditch Mental Health Group	14	Redditch
Headway	2	Herefordshire

Learning Disability and Autism Services 72 people.

Group	Number of people	Location
Speakeasy NOW Health Checkers team	9	Worcestershire
Speakeasy NOW forum	12	Worcestershire

Severn Source	5	Worcestershire
Starlight Expression Self Advocacy Group - Bromsgrove	8	Worcestershire
Comet Group Malvern - Self Advocacy group for people with LD	9	Worcestershire
Headway	2	Herefordshire
Where next work council - Redditch	8	Worcestershire
ECHO Rep group	7	Herefordshire
Speakers Corner	12	Droitwich

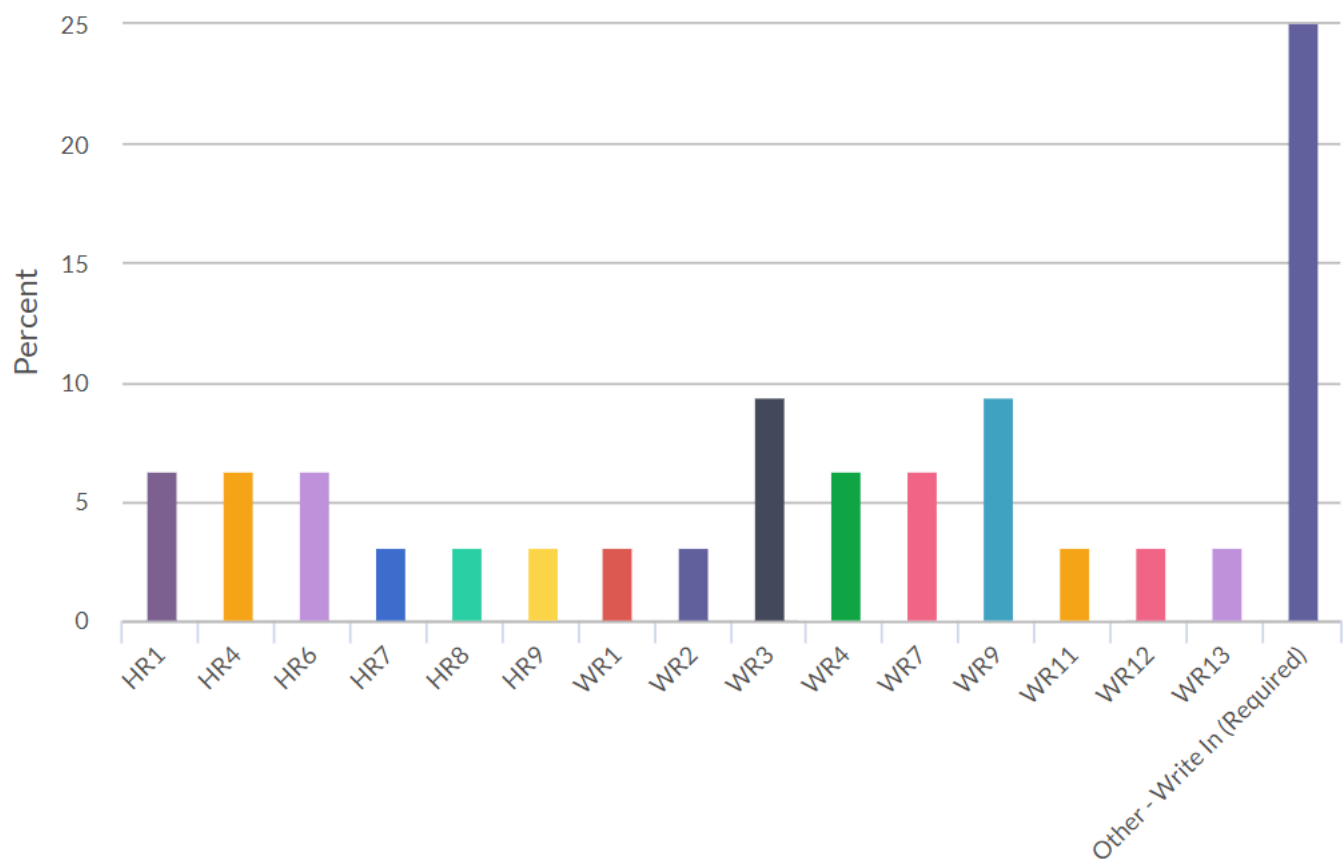
Children & Young People's Mental Health 174 people.

Group	Number of people	Location
Malvern	8	Worcestershire
SHYPP - Leominster Foyer	6	Leominster
Talent match	5	Hereford
Venture	Not recorded	Hereford
School and college staff leading on MH Schools MH forum	75	Herefordshire
Wellbeing Ambassadors - CLD	4	Herefordshire
Wye Valley Trust Patient Experience Forum	14	Hereford
LGBTQ+ group, The Hive	14	Worcestershire
Hereford Library Stand	Not recorded	Herefordshire
Headway	2	Herefordshire

Appendix 2

Postcode breakdown from online survey responses.

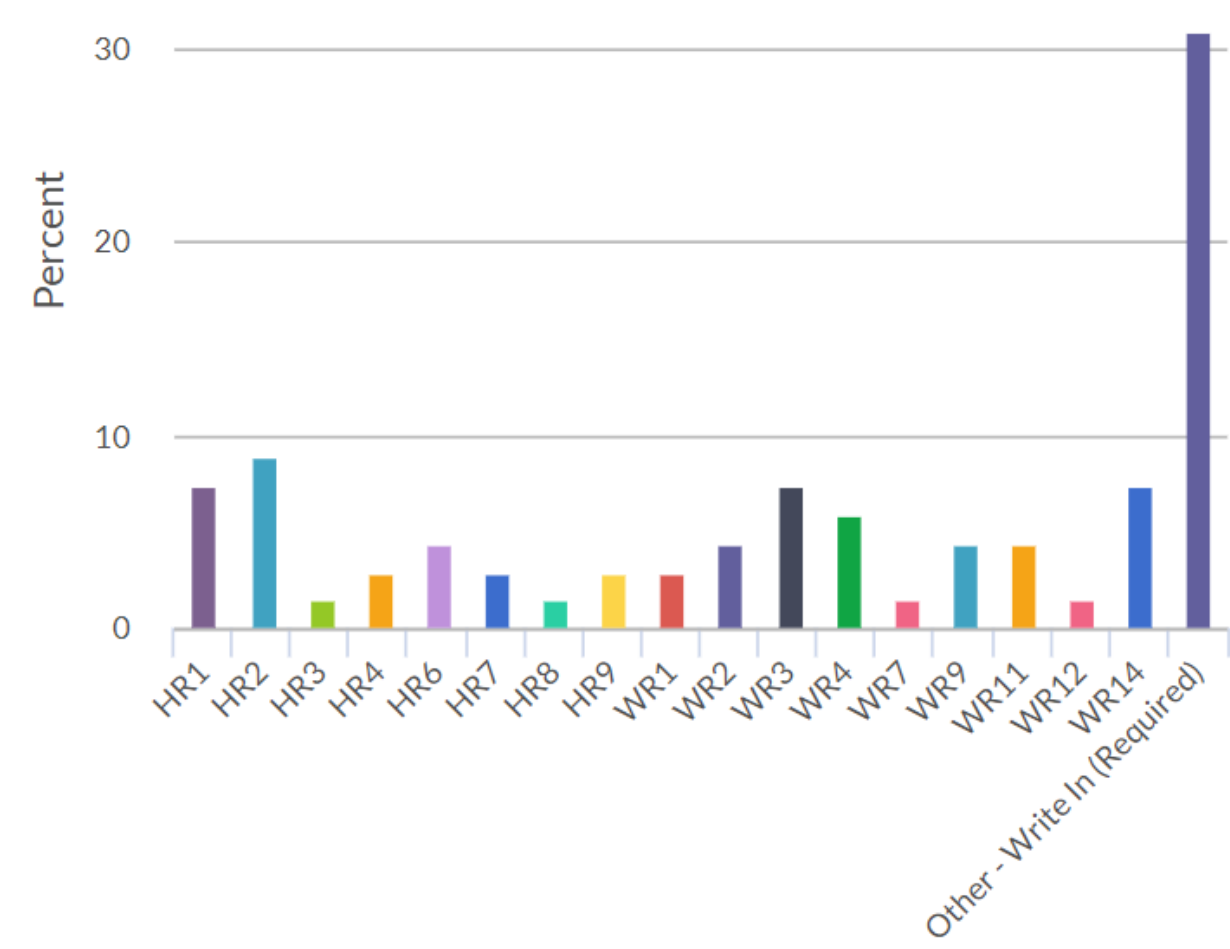
Out of hospital local care - 60 online responses



Other - write in

Other - Write In (Required)	Count
B60	4
B48	1
B98	1
DY10 4RU	1
N459yb	1
Totals	8

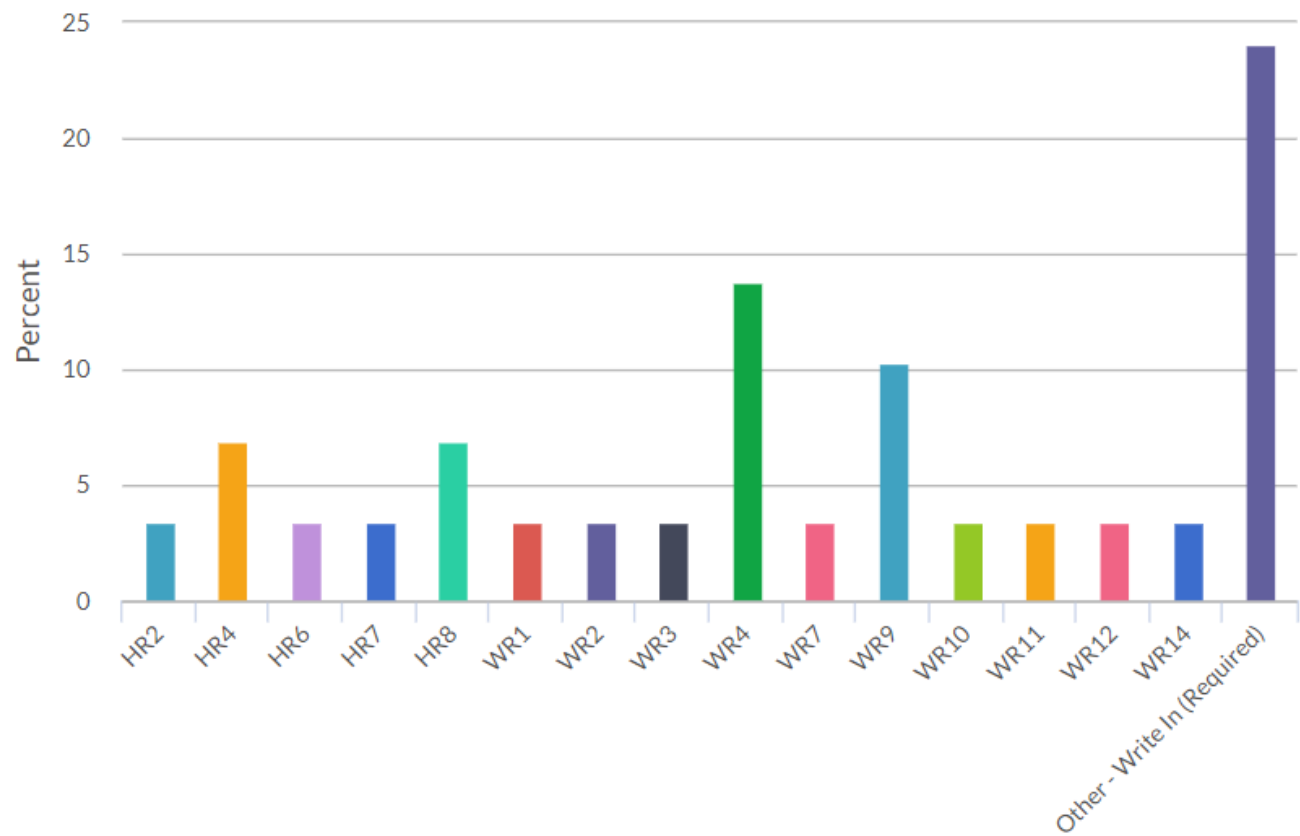
Emergency services - 126 online responses



Other - write in

Other - Write In (Required)	Count
B60	4
B97	3
B98	3
B48	2
DY11	2
3ly	1
B45	1
B48	1
B61	1
DY10	1
DY11	1
DY12	1
Totals	21

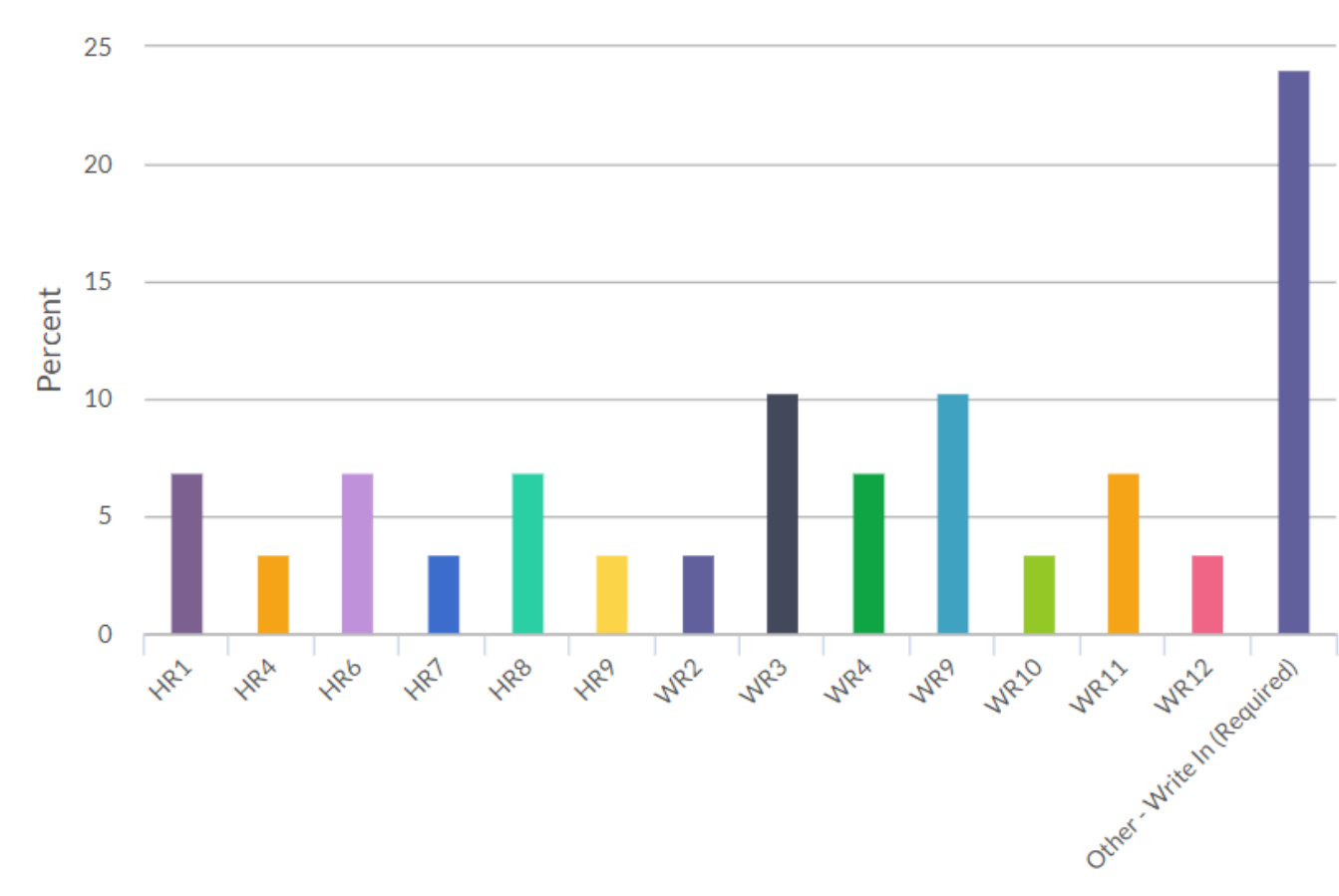
Specialist services - 57 online responses



Other - write in

Other - Write In (Required)	Count
B60	4
DY10	1
GL20	1
N45	1
Totals	7

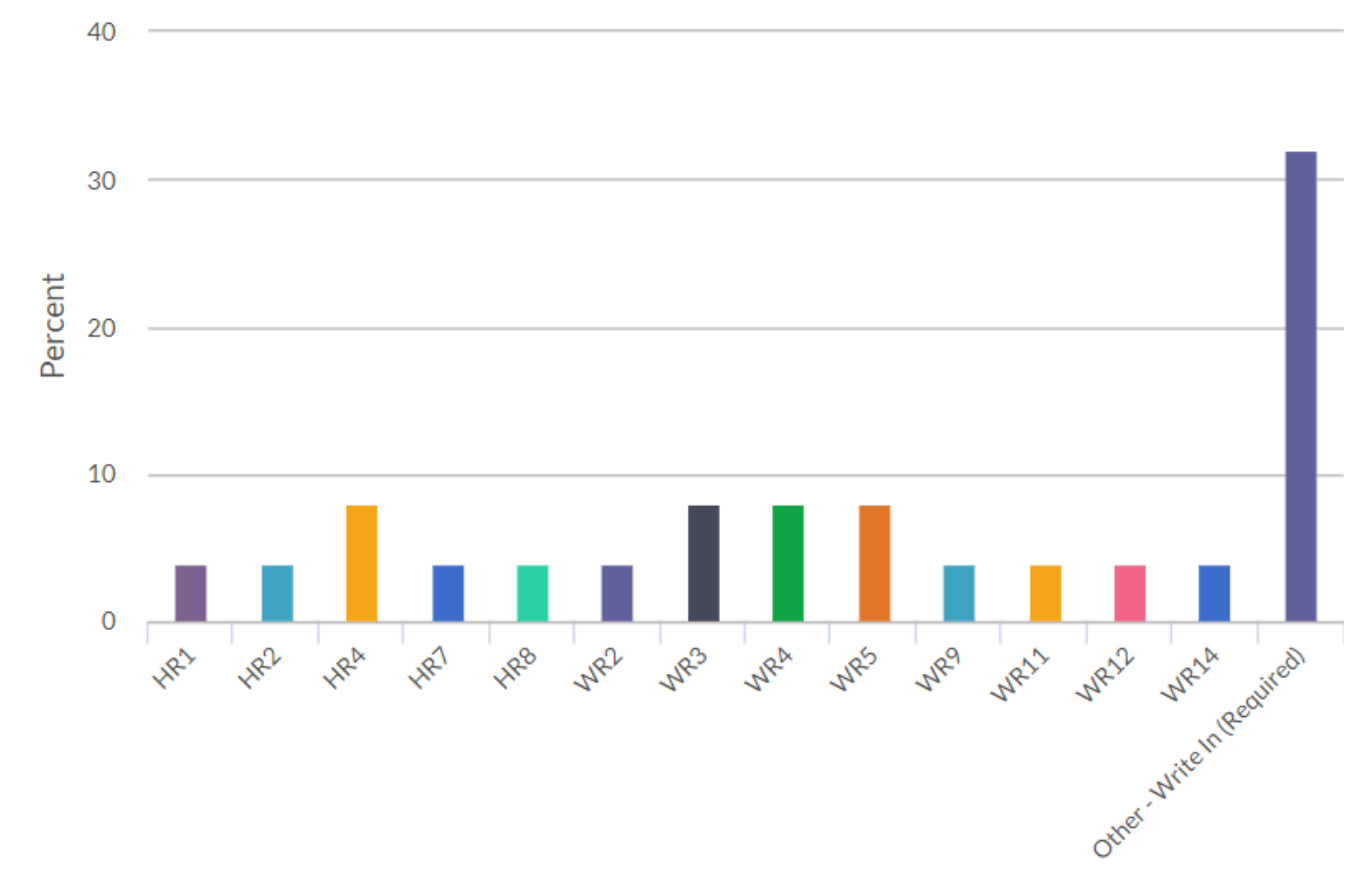
Prevention & self-care - 62 online responses



Other - write in

Other - Write In (Required)	Count
B60	2
B45	1
B98	1
DY10	1
DY11	1
Dy12	1
Totals	7

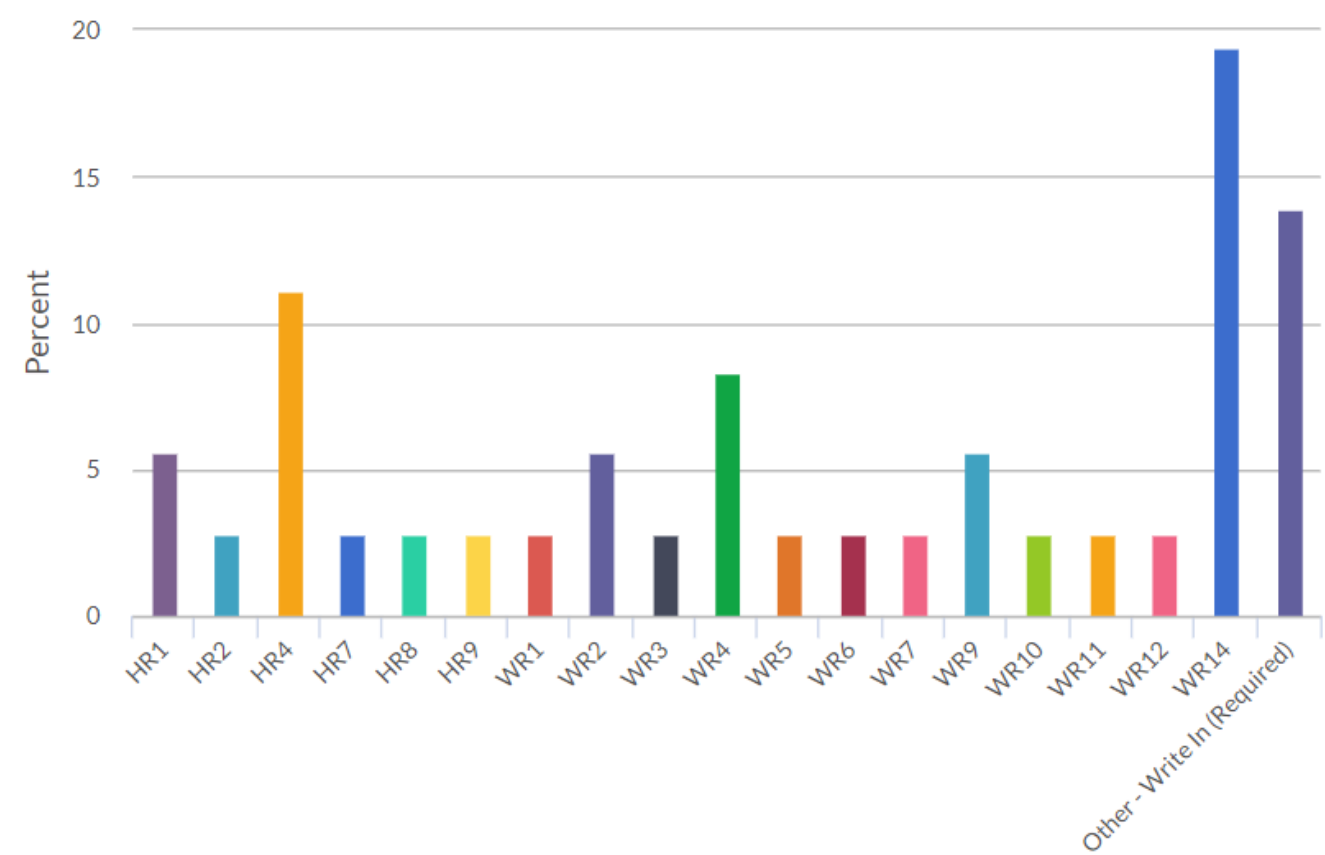
Health inequalities - 46 Online responses



Other - write in

Other - Write In (Required)	Count
B60	3
B45	1
B48	1
DY10	1
DY11	1
DY12	1
Totals	8

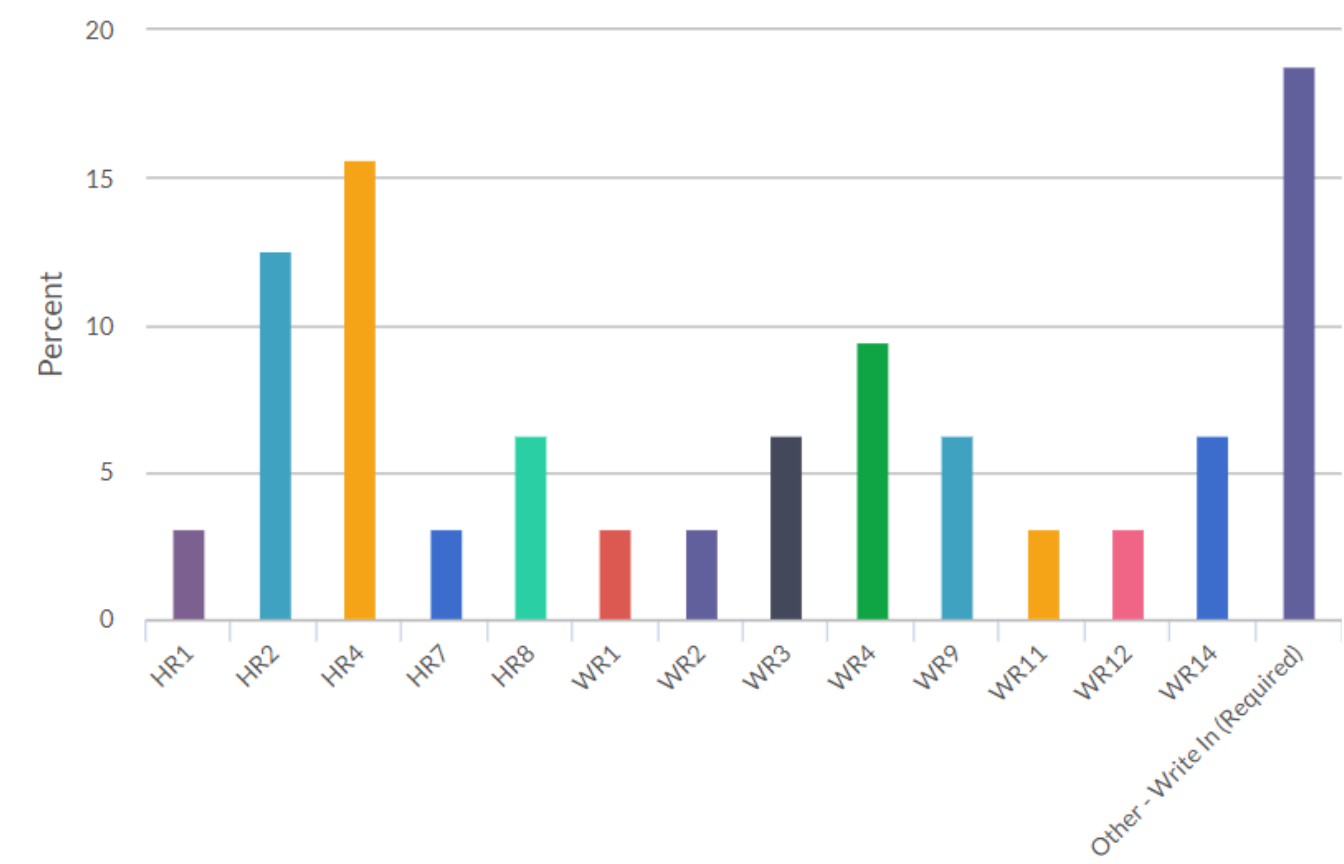
Mental health care for children & young people - 59 online responses



Other - write in

Other - Write In (Required)	Count
3ly	1
B60	1
B98	1
DY10	1
DY11	1
Totals	5

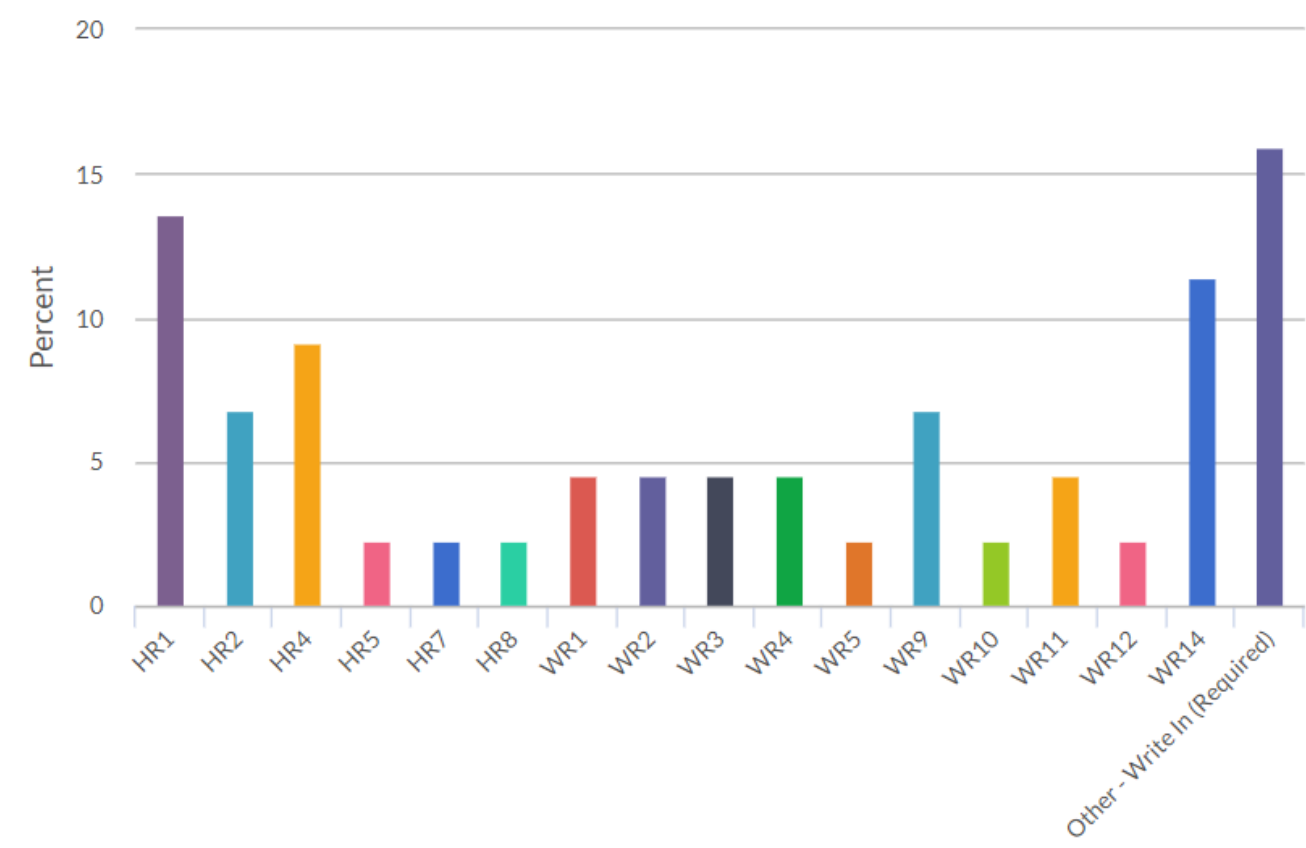
Learning disability and autism services - 54 online responses



Other - write in

Other - Write In (Required)	Count
B60	4
B97	2
Totals	6

Mental health care for adults - online responses



Other - write in

Other - Write In (Required)	Count
B45	1
B48	1
B60	1
B97	1
B98	1
DY10	1
DY11	1
Totals	7

Appendix 3

Existing Healthwatch Engagement Reports

In planning the NHS Long-Term Plan engagement project with Herefordshire and Worcestershire STP, we decided to focus on areas where more information was needed in our engagement and draw on previous recent engagement work where relevant. The following outlines some key findings from the public, which Healthwatch Herefordshire and Worcestershire have gathered over the last eighteen months in previous work.

Healthwatch Herefordshire

Dementia (Publication April 2019)

The engagement took place with 152 people across many settings including dementia specific support or community groups, health care professionals working with people living with dementia, general community groups, public events and learning disability groups.

The findings are grouped into the following headings:

- Generic feedback on the dementia pathway
- Support following a diagnosis
- Respite
- Carers
- Social Care
- Care in hospital

People wanted:

- A single point of contact throughout their dementia journey
- Varied methods of trusted information for families/carers in a variety of formats.
- A campaign to highlight the benefits of an early diagnosis and advice on what steps people could take to aid prevention of dementia onset.
- Easy and accessible information on planning for RESPECT (Advance care planning), Lasting Power of Attorney, social care funding, continuing healthcare.
- Expanding on dementia friendly communities' movement. Focusing on everyday places in our community such as hairdressers, shops, banks etc.
- Increase in the Dutch Meeting Centre model like Leominster & Ross on Wye into areas such as Bromyard, Ledbury & Hereford.
- Support with form filling and provision of education sessions for carers about dementia.
- Thinking about respite in alternative non-traditional ways for carers.

Homefirst and Hospital @ Home (Publication June 2019)

31 people from across Herefordshire agreed to complete a survey either on the telephone or by a home visit. The services received by them were as follows:

- Hospital @ Home 7 people
- Home First 18 people
- Both services 6 people

Most customers were happy with the services they received from both Home First and Hospital @ Home and the staff providing services. 74% said they had achieved their goals. Over 70% of people gave examples of positive experiences and just under 20% of people gave examples of areas of their treatment that they were unhappy with and how services could be improved.

The key recommendations were:

- Information to be given to patients and carers about the integrated service, at multiple different points on the journey.
- Encourage carer involvement to work on a short term reablement solution.
- Consider the ending of the service and exit onwards. Such as use of talk community and social prescribing to encourage community activation. And outline self-care to continue and maintain independence, e.g. physio exercises.
- Encourage use of the goal sheet with hospital @ home patients
- Help to navigate the system on people's behalf. E.g. coordinating with GP if new medications aren't on a care plan.
- Integrated discharge team improvements in timely co-ordination with family members and transport from secondary care and discharge prescription medication.
- Hospital discharge function clearly linked to continuation of home first including the continuation, start, stop or restart of the package.
- Routinely give out information to patients and service users to feedback improvements which can be fed into staff development.

Outpatients (Publication June 2019)

In March 2019 Healthwatch visited 8 clinics over a two-week period at Hereford County Hospital and surveyed 165 patients.

The clinics visited were:

- Radiology, fracture clinic and trauma and orthopaedics.
- Ophthalmology.
- Ear, nose and throat.
- Urology and Rheumatology.

Key themes were:

- Text reminders were helpful.
- Signage improvements could be made in some clinics to point out reception areas and check in procedure for clinics.
- Mixed feedback on waiting times for appointments. Delays at x-ray.
- Improvements to cleanliness in radiology.
- Positive feedback about staff attitude, friendliness and helpfulness.
- Patients like to know what delays are likely to be.
- Mixed views about electronic check in.
- Some clinics could send out information ahead of the appointments to highlight what to expect.
- More space in waiting rooms for wheelchairs.
- Examples of staff going beyond to help patients.
- Better coordination with GP needed.

Complex and multiple conditions (Publication October 2018)

We engaged with a variety of community groups and organisations that have attendees with multiple/complex conditions to gather people's experiences of health and social care services.

We also carried out a survey online. 66 people have contributed to this project at a focus group or through completing a survey.

Our findings are:

Medication

- We recommend greater promotion of medicine reviews at pharmacies.
- Health professionals should provide patients with trusted websites to use to avoid patients looking at websites that may provide them with inaccurate information.

Inter-agency coordination and communication

- Departments and organisations to communicate more efficiently, especially with mental health services. Primary Care Home1 Co-location of services to make this a priority in the model and demonstrate how it is effective.
- Seeing mental and physical health as the same thing as opposed to treating in isolation - taking a holistic approach to care.
- Health/hospital passports (document detailing a patient's important information; requirements around care, their health needs, communication and any reasonable adjustments which may be required) - a consistent approach to patient passports in order to reduce patients having to explain their full story at appointments. This could also be used to list multiple conditions to encourage health professionals to use a more holistic approach in their treatment.
- When someone's care is reviewed, professionals to encourage a more holistic approach.

Customer service

- Health professionals to be reminded about the importance of communicating with patients in a kind and considerate manner. Where we have heard about positive experiences, good communication has been part of the reason, however where communication has not happened so well, it has had a negative impact on the patient (A training resource or top tips to engage with patients may be a useful reminder).

Unpaid Carers

- To resource and support the running of organised carers' groups, as an example of valuing carers.
- Consistency across the county so that all services actively promote the rights of carers and the support they can receive. For example, reasonable adjustments can be made to help them in their caring role when accessing a GP surgery and this should be the same in all surgeries.

2gether Triangle of Care (coordination between patient, carer and health professional)

- Ensure that this process happens with all patients during their care planning process and is explained and demonstrated to patients and carers.

Respite Care

- Improved access to respite beds in the county / alternative approaches to be considered for patients who don't necessarily need a hospital bed or need respite for a week (e.g. some patients/carers would benefit from a day service).

Managing your condition

- Implement a 'listening service' which will help people feel supported, especially around the point of diagnosis. Potentially expert patients could be utilised to talk through what it means to live with a condition and when people might need further information or support.

Living with and beyond cancer (Publication April 2019)

In December 2018 & April 2019 Wye Valley Trust and Macmillan jointly hosted a focus groups in Hereford with Healthwatch, for people who have or have had cancer and family and friends to share their experiences and views on cancer care.

We gathered the views of 19 carers and patients who have experience of cancer. We asked them:

'What should good cancer support look like for patients and their families?'

Below are the themes:

- Aftercare support centre - support groups, counselling, nutrition, and access to diagnostics specific to cancer history.
- Integration - Joining up of services beyond Discharge.
- A named person or GP to go to - for support information on medical or emotional issues.
- Family Aftercare - Partners, Close friends, Parents, Children.
- Training of district nurses. E.g. provision of treatment close to home for the night-time.
- Use of telemedicine
- Holistic needs assessment looking at the whole person - helping to find way through what's on offer including psychological.
- Better education of GP's on metastatic diagnosis or a Macmillan Renton Unit service for Post treatment follow up which can be accessed ongoing.
- Discharge planning across borders.
- Cancer nurses at every GP surgery.
- Confidence in unpaid family carers - Training course for carers.
- Access to cancer specific professionals - to avoid GP's.
- Buddy scheme.
- Time - an afternoon became a day, why? What's the blockage? Has impact on family and leads to low tolerance.
- Reduce time spent on the cancer unit when you don't have much time left to live. Need better systems.
- Reduce isolation. Some people have no family and friends' network to help them through cancer.
- Social prescribing - extension to community.
- Good signposting for next steps - and additional communication for family members.
- Fear of recurrence.
- Support to continue working.
- Listening and psychological skills training for patients/carers to help support one another. Peer support.
- Post treatment side effects support. Late effects clinic

- Community support for carers and patients.
- Key point of contact. Cancer Nurse Specialist (CNS) or other key person.
- One record for a patient which includes everything.
- Isolation due to lack of transport.
- Access to the same GP.
- Signposting. GP doesn't know information to signpost. Would like information on signposting.
- Men screening. E.g. proper MOT whilst under care for anything. Making every contact count as men do not readily seek out medical advice. Diagnostic pub - meet in public house to discuss issues 1
- Early prevention & detection.
- Transport - Expansion and coordination needed for increasing community voluntary transport.

Healthwatch Worcestershire

Children and young people's mental health report (Publication March 2019)

Between September 2018 and January 2019, we engaged with 233 people about mental health and emotional wellbeing support for children and young people.

We have:

Gathered feedback from parents and carers about their experiences of accessing mental health support for their children:

- 102 parents and carers completed our survey
- 24 parents and carers spoke with us as part of our engagement

Gathered feedback from children and young people about mental health and emotional wellbeing and accessing support:

- 70 young people completed our survey
- 37 young people took part in group discussions as part of our College engagement

The feedback led to the following recommendations:

Commissioners to

1. Ensure clear information is available for parents and carers and young people about:
 - Understanding children and young people's mental health and emotional wellbeing.
 - Different types of support available for mental health and emotional wellbeing in Worcestershire including: CAMHS, Kooth, Reach4Wellbeing, Healthy Minds, local voluntary groups and organisations support and private counselling.
 - Explanation of different levels of support available and when each may be most appropriate.
 - Criteria and referral process to access different types of support.
2. Ensure there is information available for parents and carers about support available for them, including local support groups and organisations.
3. Consider how this information can be more widely promoted to parents, carers and young people, including:
 - Most appropriate online platform - e.g. Worcestershire County Council Website, NHS website

- Schools and Colleges
- Social media
- GP practices and other health and community settings

4. Promote and encourage the implementation of Emotional Wellbeing Toolkit in Schools and Colleges across Worcestershire. Ensuring:

- Parents, carers, children and young people are aware who they can contact or speak to about any concerns or issues regarding emotional wellbeing or mental health.
- Staff within schools and colleges have a good understanding of support available, how to access support and advice available from CAMHS CAST.
- Promotion within schools and colleges about the importance of mental health and speaking to someone about concerns, as part of Personal Social Health and Economic (PHSE) lessons and wider school ethos and approach.

5. Consider the possibility of a point of contact or information helpline for parents, accessible by phone and email, to enable them to find out about most appropriate support and discuss the referral process. Similar to the CAMHS CAST service available for professionals.

Access to appropriate support

6. Commissioners to carry out mapping of available support and counselling to ensure that all children and young people across Worcestershire can access appropriate one-to-one support if required.

7. Commissioners to promote and encourage implementation of guidance in Emotional Wellbeing Toolkit for all schools and colleges to provide or commission counselling for students.

8. Worcestershire Health and Care Trust to ensure that all children and young people who are referred to CAMHS but not offered treatment are informed of alternative support available to them.

9. Commissioners to monitor if those referred to CAMHS but not offered treatment are informed of alternative support available to them.

Waiting times for CAMHS

10. Worcestershire Health and Care Trust to provide reassurance of the process to assess risk to children and young people in relation to not offering treatment following referral or delay to start of treatment.

11. Commissioners and Worcestershire Health and Care Trust to provide information about actions taken to reduce waiting times following Summit.

12. Commissioners to provide ongoing key performance indicators, including waiting times for CAMHS for publication in the public domain, to enable monitoring and review.

Satisfaction with CAMHS service

13. Commissioners and Worcestershire Health and Care Trust to carry out evaluation and monitoring of CAMHS service to provide reassurance that quality standards are being met in relation to - o Understanding individual needs of child / young person

- Involving children, young people and parents and carers in decision making

- Effective communication between CAMHS and schools
- Overall effectiveness of treatment

Outpatients visits

Healthwatch Worcestershire completed 25 visits to the fracture clinics across the three hospital sites between 5th March 2019 - 9th April 2019.

- 13 visits to the Worcestershire Royal Hospital.
- 7 to the Alexandra Hospital.
- 5 to the Kidderminster Hospital & Treatment Centre.

Publication due July 2019.

Mental Health Home Treatment Plan (Publication March 2019)

The new Home Treatment Service (HTS) had been running for 16 months when this project began. In total 22 interviews were arranged and 18 completed.

Recommendations

Service User - Crisis and Care Planning

- Worcestershire Health and Care Trust identify ways to better involve service users in the co-design of their Care Plan
- Worcestershire Health and Care Trust considers the following service user suggestions regarding improving patient experience of the Home Treatment Service:
 1. More frequent visits
 2. Visited more consistently by familiar Home Treatment Service team members
 3. Spending more time with the service user
 4. More medical/psychological input
- Worcestershire Health and Care Trust considers the use of a recorded Discharge Summary within the Care Plan to be shared with the service user for future reference as an aid to the transition between services

Information and Support

- Worcestershire Health and Care Trust should aim to achieve 100% awareness amongst service users of how to make a complaint
- Worcestershire Health and Care Trust considers the following service user suggestions for service improvement:
 1. More staff/resources/funding to enable its expansion
 2. Changing it specifically to address individually voiced criticism
 3. Improve consistency of Home Treatment Service team members attending each service user
 4. Enable a familiar staff member to stay with service user after the transfer on from the Home Treatment Service
 5. Reverting to the previous model or finding a third alternative
 6. Making home visits available day and night
 7. Discretion with identity badges when visiting service users within sight of neighbours
 8. Becoming more accessible to ex Forces personnel

- Worcestershire Health and Care Trust ensure all service users are fully informed in an accessible format about prescribed medication and its potential side effects

Carers - Care Planning

- Worcestershire Health and Care Trust systematically capture the contact details of all carers (regardless of whether they identify as carers) supporting patients engaged with the Home Treatment Service
- Worcestershire Health and Care Trust ensure all carers are meaningfully involved in the planning of the Home Care Plan and fully understand any expectations required of them where applicable
- Worcestershire Health and Care Trust should aim to achieve 100% awareness amongst carers of how to make a complaint and of the Patient Advice and Liaison Service

Information and Support

- Worcestershire Health and Care Trust routinely provide **all** carers with information about Worcestershire Association of Carers, the Carers Assessment and Jigsaw support group
- Worcestershire Health and Care Trust ensure **all** carers are aware of the complaints process and the Patient Advice and Liaison Service

Autism spectrum conditions (Publication March 2018)

Gathering feedback from people with Autism Spectrum Conditions:

- 34 people completed our survey
- 15 young people completed Easy Read surveys
- 29 people took part in group and individuals discussions as part of our engagement

Gathering feedback from Carers of people with Autism Spectrum Condition:

- 101 Carers completed our survey
- 40 Carers took part in group and individual discussions as part of our engagement

Access to Health Services

People told us about the difficulties they can experience when visiting the doctors and hospitals. They gave us lots of examples of things that would help them when making appointments, waiting to be seen and communicating with Doctors and Nurses. We have made suggestions for GP practices and hospitals about ways they can make adjustments for patients with Autism, including a flagging system to make sure they know who might need extra support.

Awareness of Autism Spectrum Conditions

Our findings show that there is variation in the awareness and understanding of Autism across health services in Worcestershire. There is a need to increase awareness by encouraging and promoting training and identifying Autism Champions.

Information

Feedback suggests that there is a need for comprehensive and up to date information about services and support available for people with Autism Spectrum Conditions and their carers. This needs to be available in a central location and promoted in a variety of ways including online and via social media. People also told us they would like more information to help them understand Autism Spectrum Conditions and strategies for support.

Support

On the whole people did not feel they receive the support they need in relation to their Autism Spectrum Condition or their caring role. A need for more appropriate mental health support was identified. People valued support they received from support and social groups and feel there is a need to increase access to these across Worcestershire.

Diagnosis

Feedback suggests that in some cases children, young people and adults have experienced long waits for an Autism Spectrum Condition diagnosis. Many felt they did not receive enough information about the process for diagnosis, understanding the diagnosis or support available following diagnosis.

Acknowledgements

Healthwatch Herefordshire and Worcestershire would like to thank all the community organisations, groups and members of the public who took part in this engagement exercise.

We would also like to thank Max Bassett Research for data analysis services provided.

We thank Healthwatch England for guidance and advice.



Contact us

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Meeting:	Adults and wellbeing scrutiny committee
Meeting date:	Friday 18 October 2019
Title of report:	Work programme 2019-2020
Report by:	Democratic services officer

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose and summary

To consider the committee's work programme for 2019-20 and to note the responses of NHS Herefordshire Clinical Commissioning Group to the committee's recommendations on 'The future of the Herefordshire and Worcestershire NHS Clinical Commissioning Groups (CCG) consultation' as considered at the last meeting (minute 7 of 2019-20 refers).

Recommendation(s)

That:

- (a) the committee reviews the work programme (appendix 1) and determines any additional items of business or topics for inclusion in the work programme;
- (b) the statutory scrutiny officer be authorised, following consultation with the chairperson and vice-chairperson, to add items to the work programme where it is necessary to ensure their timely consideration where there is no scheduled meeting to approve their inclusion;
- (c) the responses of NHS Herefordshire Clinical Commissioning Group to the committee's recommendations on 'The future of the Herefordshire and Worcestershire NHS Clinical Commissioning Groups (CCG) consultation' (appendix 2) be noted; and
- (d) an additional meeting be scheduled on Monday 16 December 2019.

Alternative options

1. It is for the committee to determine its work programme to reflect the priorities facing Herefordshire. The committee needs to be selective and ensure that the work programme is focused, realistic and deliverable within existing resources.

Key considerations

Work programme

2. The work programme needs to focus on the key issues of concern and be manageable. It must also be ready to accommodate urgent items or matters that have been called-in.
3. The updated work programme is attached at appendix 1. Consideration should be given to the type of scrutiny to apply to work programme items, such as undertaking pre-decision scrutiny, performance review, and policy review and development.
4. The work programme will remain under regular review during the year to allow the committee to respond to particular circumstances.
5. Should committee members become aware of additional issues for scrutiny during the year they are invited to discuss the matter with the chairperson and the statutory scrutiny officer.
6. It is recommended that the statutory scrutiny officer be authorised, following consultation with the chairperson and vice-chairperson, to add items to the work programme where it is necessary to ensure their timely consideration where there is no scheduled meeting to approve their inclusion.

Constitutional Matters

Task and Finish Groups

7. A scrutiny committee may appoint a task and finish group for any scrutiny activity within the committee's agreed work programme. A committee may determine to undertake a task and finish activity itself as a spotlight review where such an activity may be undertaken in a single session; the procedure rules relating to task and finish groups will apply in these circumstances.
8. The relevant scrutiny committee will approve the scope of the activity to be undertaken, the membership, chairperson, timeframe, desired outcomes and what will not be included in the work. A task and finish group will be composed of a least two members of the committee, other councillors (nominees to be sought from group leaders with un-affiliated members also invited to express their interest in sitting on the group) and may include, as appropriate, co-opted people with specialist knowledge or expertise to support the task. The committee will appoint the chairperson of a task and finish group.
9. The committee is asked to determine matters relating to the convening of a task and finish group including the scope of the review to be undertaken, the chairperson, membership, timeframe, desired outcomes, what will not be included in the review and whether to co-opt any non-voting members to the group.

Co-option

10. A scrutiny committee may co-opt a maximum of two non-voting people as and when

required, for example for a particular meeting or to join a task and finish group. Any such co-optees will be agreed by the committee having reference to the agreed work programme and / or task and finish group membership.

11. The committee is asked to consider whether it wishes to exercise this power in respect of any matters in the work programme.

Forward plan

12. The constitution states that scrutiny committees should consider the forward plan as the chief source of information regarding forthcoming key decisions. Forthcoming decisions can be viewed under the forthcoming decisions link on the council's website:

<http://councillors.herefordshire.gov.uk/mgdelegateddecisions.aspx?XXR=0&DAYS=28&RP=0&K=0&DM=0&HD=0&DS=1&META=mgdelegateddecisions&V=0>

Schedule of committee recommendations and responses

13. At the last committee meeting (24 June 2019), the committee considered an item on 'The future of the Herefordshire and Worcestershire NHS Clinical Commissioning Groups (CCG) consultation', the minutes are accessible through the link below:

<http://councillors.herefordshire.gov.uk/mgAi.aspx?ID=53194>

14. The responses of NHS Herefordshire Clinical Commissioning Group to the committee's recommendations are attached (appendix 2).
15. Related items have been added to the updated work programme (appendix 1).

Suggestions for scrutiny from members of the public

16. Suggestions for scrutiny are invited from members of the public through the council's website, accessible through the link below:

www.herefordshire.gov.uk/getinvolved

17. Since the last meeting, a member of the public has requested that NHS Continuing Healthcare (CHC) be discussed. This topic was considered by the committee at the 20 September 2018 meeting, with NHS Clinical Commissioning Group requested to report on progress made against their action plan recommendations in six months' time, the minutes are accessible through the link below:

<http://councillors.herefordshire.gov.uk/mgAi.aspx?ID=50321>

18. This item is identified in the work programme for 2019-20 (appendix 1).

Meeting dates for 2019-20

19. The following meeting dates for 2019-20 have been scheduled:

Monday 18 November 2019, 10.30 am

Monday 13 January 2020, 2.30 pm

Monday 2 March 2020, 2.30 pm

Monday 11 May 2020, 2.30 pm

20. To ensure that the committee has a sufficient number of meetings to consider items on the work programme, it is suggested that an additional meeting be scheduled on Monday 16 December 2019 at 9.30 am.

Scrutiny briefings

21. In addition to formal committee meetings, the views of the committee are sought on potential informal briefings for committee members. Potential topics suggested by the chairperson include: a 'voice of the service user' session; changes to mental health provision; and insight briefings from service providers.

Community impact

22. In accordance with the adopted code of corporate governance, Herefordshire Council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development, and review. Topics selected for scrutiny should have regard to what matters to residents.

Equality duty

23. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:
- A public authority must, in the exercise of its functions, have due regard to the need to -
- (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
 - (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
 - (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
24. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. All Herefordshire Council members are trained and aware of their Public Sector Equality Duty and equality considerations are taken into account when serving on committees.

Resource implications

25. The costs of the work of the committee will have to be met within existing resources. It should be noted the costs of running scrutiny will be subject to an assessment to support appropriate processes.

Legal implications

26. The remit of the scrutiny committee is set out in part 3 section 4 of the constitution and the role of the scrutiny committee is set out in paragraph 2.6.5 of the constitution.
27. The council is required to deliver a scrutiny function.

Risk management

28.

Risk / opportunity

Mitigation

There is a reputational risk to the council if the scrutiny function does not operate effectively.

The arrangements for the development of the work programme should help mitigate this risk.

Consultees

29. A work programming session involving scrutiny committee members was held in June 2019. The work programme is reviewed at every committee meeting and during business planning meetings between the chairperson, vice-chairperson and statutory scrutiny officer.

Appendices

Appendix 1 Updated work programme for 2019-20

Appendix 2 Schedule of committee recommendations and responses for 2019-20

Background papers

None identified.

Meeting dates and items 2019-20

Friday 18 October 2019, 2:00 PM

Item	Description	Form of scrutiny
One Herefordshire and integration briefing	To provide an updated overview of the Sustainability and Transformation Programme (STP), One Herefordshire and integration agenda for health and social care.	Policy review and development

Monday 18 November 2019, 10:30 AM

Item	Description	Form of scrutiny
Budget and Medium Term Financial Strategy (MTFS)	To seek the views of the adults and wellbeing scrutiny committee on the budget proposals for 2020-21, as they relate its remit.	Pre-decision scrutiny / Policy review and development

Monday 16 December 2019, 9:30 AM

Item	Description	Form of scrutiny
Community services redesign	To receive an update on community services transformation and the impact on current provision of minor injuries units and community hospital bed provision.	Policy review and development
Continuing Health Care (CHC)	Update on progress since the adults and wellbeing scrutiny committee held on 20 September 2018.	Performance review
Integrated discharge care pathway, including Delayed Transfers of Care (DToC)	Arising from a suggestion by the audit and governance committee (23 January 2019) in relation to Delayed Transfers of Care, the adults and wellbeing scrutiny committee (29 January 2019) agreed to consider this item for its work programme in 2019-20.	Performance review

Adults and wellbeing scrutiny committee, work programme

Monday 13 January 2020, 2:30 PM		
Item	Description	Form of scrutiny
Update on the 2020-21 budget	Further to the item to be considered on 18 November 2019, to consider the budget 2020-21 following consultation and the local government settlement.	Pre-decision scrutiny
Accommodation needs assessment and market position statement	Arising from a suggestion by the audit and governance committee in relation to care home ratings (23 January 2019), the adults and wellbeing scrutiny committee (29 January 2019) agreed to consider this item for its work programme in 2019-20.	Policy review and development

Monday 02 March 2020, 2:30 PM		
Item	Description	Form of scrutiny
Domestic abuse strategy 2019-2022 update	Update on the strategy considered by the adults and wellbeing scrutiny committee on 29 January 2019.	Performance review
Funding and implementation plans for the proposed new Clinical Commissioning Group (CCG) footprint	The adults and wellbeing scrutiny committee (24 June 2019) resolved that the CCG be invited back to outline their detailed funding and implementation plans for the proposed new CCG footprint.	Policy review and development
Talk community hubs	Arising from a suggestion by the general scrutiny committee (6 March 2019), the adults and wellbeing scrutiny committee agreed to consider this item for its work programme in 2019-20.	Performance review
Digital market position and enabling technology strategy	To consider the market position, strategy, and future commissioning plans.	Policy review and development

Adults and wellbeing scrutiny committee, work programme

Monday 11 May 2020, 2:30 PM		
Item	Description	Form of scrutiny
Clinical Commissioning Group benchmarking and performance / delivery data	The adults and wellbeing scrutiny committee (24 June 2019) resolved that benchmarking and performance / delivery data be brought back to the committee.	Performance review
Dementia strategy and progress with the action plan	Update on progress since the launch of the strategy.	Performance review
Sexual health service	Arising from a suggestion from Healthwatch Herefordshire, the adults and wellbeing scrutiny committee (24 June 2019) agreed to consider this item for its work programme in 2019-20.	Performance review

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Potential items 2020-21

Item	Description	Form of scrutiny
Suicide prevention strategy and progress with the action plan	Update on progress since the launch of the strategy.	Performance review

**Adults and wellbeing scrutiny committee, schedule of
committee recommendations and responses**

Appendix 2

24 June 2019		
Item	Recommendations	Responses
The future of the Herefordshire and Worcestershire NHS Clinical Commissioning Groups (CCG) consultation	The committee would like to see benchmarking and performance/delivery data (as set out in the Draft Operational Plan 2019/20) brought back to this committee in 12 months' time; exploring current and future commissioning outcomes, including tracking of the amount and spend in each of the four CCG footprint areas.	NHS Herefordshire CCG agrees this recommendation.
	The committee recommends that the CCG are invited back in April 2020 to outline their detailed funding and implementation plans for the proposed new CCG footprint.	NHS Herefordshire CCG agrees this recommendation.
	The committee would like to see built in to the new arrangements the commitment to keep a Herefordshire office presence in the new future single footprint area.	NHS Herefordshire CCG agrees this recommendation.
	The committee welcomes and would expect to see Herefordshire place based clinical and lay representation at the appropriate level within the new CCG administration.	NHS Herefordshire CCG agrees this recommendation.
	The committee recommends that when there are significant variations of service delivery, including significant financial changes, the appropriate scrutiny committee is consulted and given adequate time to review these changes.	NHS Herefordshire CCG agrees this recommendation.

