Calderdale and Greater Huddersfield Hospital and Care Closer to Home

Summary of findings from all engagement and pre-engagement public, patients, carers and staff

March 2013 – December 2015
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Executive Summary

This report pulls together all the engagement activity we have delivered from the period March 2013 to December 2015. The document follows on from four previous similar reports on children and young people, planned and unplanned care and long term conditions written in February 2013.

The aim of the report is to catalogue our engagement activity, use the information collectively to understand what people are telling us about local NHS services in Calderdale and Greater Huddersfield, and use the key messages to support any future service models for hospital services and care closer to home.

The content of the report highlights the work we have done to engage local people, the themes from that engagement and highlights the equality messages, and any consideration to ensure reasonable adjustments and considerations are given to ensure our diverse population receive appropriate services in the future.

The appendices provide more detail on individual pieces of work, with some accounting for more than one piece of work on a particular topic or service area. It is the detail from each of these pieces that has collectively ensured we have some key themes, and it is the willingness of local people to provide their views that have ensured we are able to further understand what people want us to do to ensure local services are timely, appropriate and of high quality. Local people told us they want to see:

- As many services as possible should be close to home in local settings such as a GP practice with improved waiting and appointment times
- Services that are coordinated and wrap around all the persons needs involving a range of partners and agencies
- The right staff. With the right skills that are caring and competent and treat people with dignity and respect
- Services that are properly planned and that are appropriately staffed and resourced, have the right equipment and maintain quality
- More information available about health conditions and more communication about what is available to ensure people can make choices and have support to self-manage health care
- Services that everyone can access including clean comfortable buildings aimed at the right target audience, appropriate information and staff that represent the community they serve.
- Any barriers to parking, travel and transport addressed with a clear plan which takes account of diversity and locality
- Improved communication between all agencies involved in a persons care and treatment including better communication with young people
- Services that are responsive and flexible - particularly in an urgent care situation
- Reduce delays in getting the care and treatment required and improving waiting times
- Technology that people can use to reduce travel times and unnecessary journeys – particularly for young people
- Support for mental health across all services
The report provides more detail to each of these key themes and further highlights the need to continually communicate, involve and engage people at each stage of service development. We would like to thank everyone who has taken the time to get involved and provide such valuable insight into local services.

Section 1: Introduction

1.1 Purpose of the Report
The purpose of this report is to present the findings from all engagement activity which has taken place over the past two years from March 2013 to July 2015 and the recent pre-engagement stage of Right Care, Right Time, Right Place which took place from July 2015 to August 2015 which includes; Hospital services and Care Closer to Home for Calderdale and Greater Huddersfield. The report captures intelligence collected from all our engagement and will enable commissioners to:

- Consider the views of patients as part of service redesign; and
- Ensure that the feedback is considered in the development of any future options to change the way a current service is provided or delivered.
- Highlight equality issues and the impact on protected groups
- Highlight patient and public priorities and ensure these priorities are in line with current thinking and ensure commissioners can consider all public views in readiness for formal consultation.

1.2 Background
Right Care, Right Time, Right Place is a programme of work that will transform hospital services. This programme runs alongside two ‘Care Closer to Home’ programmes, one in Calderdale and one in Greater Huddersfield. Throughout all these programmes of work we have continued to engage staff, patients, carers, members of the public and key stakeholders to ensure any views on proposed developments and improvements have been gathered and listened to.

From the conversations we have already had, we know people want to have services based locally, be cared for closer to home and to receive more support and education to look after themselves better, for longer. We are making those changes and although progress is slow, it is progress and has the potential to be very successful.

For more than a year we have been improving the quality and range of health care services we provide closer to your homes. By doing this, we are confident that we can reduce the need for people to travel to hospital for routine care. For example, we have introduced new technology which is already reducing the number of routine and outpatient hospital visits for people with certain types of respiratory (breathing) diseases. We have changed the way care is provided in care homes to reduce the number of times older people have to be admitted to hospital as an emergency.

However, we have to set our aspirations in context. Finances within health are in a precarious state and there isn’t a large pot of money to pay for everything we may want to do. There are also significant issues around the availability of staff in key clinical specialties.
The Hospital Trust (CHFT) are required to develop a Strategic plan to demonstrate financial sustainability to the regulator. At the time of writing, commissioners have an indicative timeline from CHFT that suggests that this work will be complete by the end of 2015. It’s true to say CHFT did express a preference for a single site for A&E and for that site to be Huddersfield, but there are increasing quality and financial challenges that mean the full range of proposals for change have to be looked at again. No decisions have been made about the future of local hospital services and it’s important to emphasise that point.

Throughout all of this process we have continued to talk to people, gather views and engage on specific service areas. This report combines all our engagement activity so we can truly understand what people have been telling us over the last two years.

1.3 Our responsibilities
Engaging people is not just about fulfilling a statutory duty or ticking boxes; it is about understanding and valuing the benefits of listening to patients and the public in the commissioning process.

Patient and public engagement can be defined as the active participation of patients, including children, service users, carers, community representatives and the wider public in the development of health services and as partners in their own health care. Involving people gives local people a say in how services are planned, commissioned, delivered and reviewed. It is important to recognise who to involve through engagement activity. Individuals and groups play different roles and there needs to be engagement opportunities for both.

Each CCG has a ‘Public and Patient Engagement and Experience Strategy’ which underpins the principles by which the engagement and consultation operate and highlights the commitment to good practice in delivery. Engaging people who use health and social care services, and other stakeholders in planning services is vital to ensure services meet the needs of local communities. It is also a legal requirement that patients and the public are not only consulted about any proposed changes to services, but have been actively involved in developing the proposals.

1.4 Legal requirements
There are a number of statutory requirements relating to engagement that must be taken into account.

1.4.1 Health and Social Care Act 2012
The Health and Social Care Act 2012 sets out responsibilities for NHS commissioners. This includes the statutory requirement for CCGs to involve and consult patients and the public, replacing Section 242 of the NHS Act 2006.

Specifically, CCGs must involve and consult patients and the public in:
- their planning of commissioning arrangements
- the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
- decisions affecting the operation of the commissioning arrangements
The Act also updates Section 244 of the NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

1.4.2 The Equality Act 2010
The Equality Act 2010 unifies and extends previous disparate equality legislation. Nine characteristics are protected by the Act: age; disability; gender re-assignment; marriage and civil partnership; Pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

Section 149 of the Equality Act 2010 states that a public authority must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance ‘Equality of Opportunity’, and c) foster good relations. To help support organisations to meet these duties a set of principles have been detailed in case law. These are called the Brown Principles;

- The organisation must be aware of their duty.
- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken. Due regard involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.

This formal consultation will fulfil part of our consideration of our legal duty.

An Equality Impact Assessment (EQIA) will need to be undertaken on any proposals for changes to services that are developed through the programme, in order to understand any potential impact on protected groups and ensure equality of opportunity. Engagement must span all protected groups and other groups and care should be taken to ensure that seldom-heard interests are engaged with and supported to participate, where necessary. The data from the engagement will be combined with other data and research to develop the EQIA.

1.4.3 The NHS Constitution
The NHS Constitution came into force in January 2010, setting out a number of rights for patients which are protected by law. This includes the following right at Section 2a: “You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”

1.5 Secretary of State’s key tests
All our service change proposals are expected to comply with the Department of Health’s four tests for service change. These are:

1) Strong public and patient engagement;
2) Consistency with current and prospective need for patient choice;
3) A clear clinical evidence base; and
4) Support from proposals from clinical commissioners

For significant service changes, NHS England operates an assurance process whereby they provide support and guidance to commissioners so that they can demonstrate compliance with the four tests and other best practice checks. The assurance process concludes with an assurance checkpoint at which time NHS England provide a recommendation regarding whether the tests have been met.

1.6 Other considerations
There is another major transformation taking place in the adjoining Mid Yorkshire health and social care economy, which will have direct implications for the work taking place in Calderdale and Huddersfield. There is considerable commonality in the drivers for change and issues being addressed so it is important that messages around these are consistent across the region.
Section 2: Findings from the engagement process

2.1 Engagement process and use of existing data
Healthwatch Kirklees have worked in conjunction with Yorkshire and Humber Commissioning Support (Y&HCS) and the CCGs to produce this composite report.

Healthwatch Kirklees were asked to complete a review of all engagement evidence held and collected between March 2013 and August 2015. This meant reading around 70 documents, including final reports, meeting notes, survey results and annual summaries, that told the story of patient and professional experience of receiving and delivering different health care services. Some were produced by the CCGs, others came from the Calderdale and Huddersfield NHS Foundation Trust, The Patients Association, Patient Opinion and several others.

Some of the documents outlined engagement work about specific services, like the Child Development Service, Musculoskeletal Services and the Anti-coagulation Service; other documents summarised what patients had said about a change in the direction of services overall, such as Care Closer to Home, or the South West Yorkshire NHS Partnership Foundation Trust Transformation.

Each document or group of documents related to a particular topic was then summarised, and the key themes and details were written up in to an ‘evidence summary’. Each of these evidence summaries can be found in this document (5.2.1 – 5.2…) Healthwatch Kirklees also summarised all relevant pieces of engagement work that they have completed across the same time period, including an outpatient survey, a hospital visit report and a focused report on hospital care for people with HIV.

Some of the work that was sent to Healthwatch Kirklees by Y&HCS had already been thematically analysed, and in those cases, Healthwatch Kirklees simply copied the themes from the final document and summarised the evidence according to those themes.

After summarising all of the documents, Healthwatch Kirklees reviewed the key themes from those documents and created lists of top themes in the engagement from Calderdale, from Greater Huddersfield, and from both areas combined. To establish an order of priority for the themes, Healthwatch Kirklees looked at how many pieces of work that theme had been mentioned in, how many people had taken part in the engagement activity that mentioned the theme, and how much discussion there had been around that theme by the people who had been involved in that engagement.

Healthwatch Kirklees are wholly responsible for the results and thematic analysis outlined in the engagement work that they completed that is summarised in this document. Any documents that have been sent through by Y&HCS have been summarised by Healthwatch Kirklees and included in the thematic analysis, but have not been independently verified.
2.2 Findings from the engagement process

2.2.1 Main themes
Below there are 3 separate lists of key themes with evidence matrices taken from engagement in Calderdale, Greater Huddersfield, and both areas together. The key themes are listed in order of priority.

**Calderdale**
1. Giving clear information to the patient about their health conditions and the plan for their care
2. Delivering more services closer to home
3. Delivering flexible services that offer the right care at the right time in the right place
4. Delivering health services through caring and competent staff and volunteers
5. Putting the patient at the centre of their care
6. Improving communication about patients both within and between primary, secondary, community and voluntary sector, and social care
7. Providing seamless, holistic care that links all aspects of care together and wraps around all of a person’s needs
8. Improving use of technology to communicate with patients and carers and other health services
9. Increasing public awareness of health conditions and how to minimise the risk of developing them
10. Working with community and voluntary sector partners to deliver health care in the community
11. Enabling people to care for themselves and seek help when they have concerns
12. Ensuring that hospital discharge is well planned and timely
13. Making sure all changes to services are properly planned and resourced and do not lead to problems accessing services
## 2.2.2 Summary of Evidence Matrix – Calderdale

<table>
<thead>
<tr>
<th>Theme</th>
<th>Call to Action</th>
<th>Care Closer to Home December 14</th>
<th>Care Closer to Home VCS April 15</th>
<th>Care Closer to Home March</th>
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<th>Cardiovascular Disease</th>
<th>Health Forum</th>
<th>Musculoskeletal Services</th>
<th>Respiratory Services</th>
<th>Self-care</th>
<th>Single Care Plan – Young</th>
<th>Unplanned care</th>
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<td>Delivering flexible services that offer the right care at the right time in the right place</td>
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<td>Increasing public awareness of health conditions and how to minimise the risk of developing them</td>
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<td>April 15</td>
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<td>Cardiovascular Disease</td>
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<td>Enabling people to care for themselves and seek help when they have concerns</td>
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<td>Ensuring that hospital discharge is well planned and timely</td>
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- √√ - strong evidence
- √ - some evidence
- Blank – little or no evidence
2.2.3 Greater Huddersfield

1. Giving clear information to the patient about their health conditions and the plan for their care
2. Delivering health services through caring and competent staff
3. Providing seamless, holistic care that links all aspects of care together and wraps around all of a person’s needs
4. Improving communication about patients both within and between primary, secondary, community and voluntary sector, and social care
5. Putting the patient at the centre of their care
6. Delivering more services closer to home
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9. Delivering flexible services that offer the right care at the right time in the right place
10. Involving carers and family in care planning
11. Respecting patient dignity when delivering care
12. Ensuring that all services are fully accessible for all people, including those with specific access needs
13. Minimising barriers to health care caused by travel times and costs
14. Ensuring that there are no concerns about quality of care
15. Improving use of technology to communicate with patients and carers and other health services
16. Increasing public awareness of health conditions and how to minimise the risk of developing them
17. Delays in receiving care are unacceptable
18. Working with community and voluntary sector partners to deliver health care in the community
## 2.2.4 Summary of Evidence Matrix – Greater Huddersfield

<table>
<thead>
<tr>
<th>Theme</th>
<th>Anti-coagulation service</th>
<th>Call to Action</th>
<th>Care Closer to Home February 15</th>
<th>Diabetes – Ashbrow &amp; Greenhead</th>
<th>Golcar Clinic</th>
<th>Huddersfield Royal Infirmary</th>
<th>Medical Assessment Area HWK Visit</th>
<th>Musculoskeletal Service</th>
<th>PRGN – Community Services</th>
<th>PRGN – GP</th>
<th>PRGN – Using technology</th>
<th>PRGN – Vulnerable adults &amp; Over 75s</th>
<th>PRGN – Young People</th>
<th>Princess Royal</th>
<th>Single Care Plan – Young People</th>
<th>Confine</th>
<th>Hospital Discharge Integrated Care</th>
<th>Multiple and Complex Needs</th>
<th>Outpatient survey</th>
<th>Section 136 of MHA 1983</th>
<th>Deaf and Hard of Hearing</th>
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<tr>
<td>Giving clear information to the patient about their health conditions and the plan for their care</td>
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<td>Delivering health services through caring and competent staff</td>
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</table>

- ✓ - strong evidence
- ✓ - some evidence
- (blank) – little or no evidence
<p>| Theme                                                                 | Anti-coagulation service | Children/Young People Wellbeing | Call to Action | Care Closer to Home July 2014 | Care Closer to Home February 15 | Diabetes – Ashbrow &amp; Greenhead | Golcar Clinic | Huddersfield Royal Infirmary | Medical Assessment Area HWK Visit | Musculoskeletal Service | PRGN - Community Services | PRGN - GP | PRGN – Using technology | PRGN – Vulnerable adults &amp; Over 75s | Princess Royal | Single Care Plan – Young People | Continence | Hospital Discharge | Integrated Care | Multiple and Complex Needs | Outpatient survey | Section 136 of MHA 1983 | Deaf and Hard of Hearing |
|----------------------------------------------------------------------|--------------------------|--------------------------------|----------------|-------------------------------|---------------------------------|--------------------------------|----------------|-----------------------------|---------------------------------|---------------------------|-----------------------------|----------|--------------------------|---------------------------------|----------------|-----------------------------|------------|-----------------|----------------|-----------------------------|-----------------|-----------------------------|
| secondary, community and voluntary sector, and social care           |                          |                                |                |                               |                                 |                                |                |                             |                                 |                          |                            |          |                          |                                 |                |                             |            |                 |                |                             |                 |                             |
| Putting the patient at the centre of their care                      | ✓                        | ✓                             | ✓/✓           |                               |                                 |                                |                |                             |                                 |                          |                            |          |                          |                                 |                |                             |            |                 |                |                             |                 |                             |
| Delivering more services closer to home                              | ✓                        |                           ✓/✓ | ✓             | ✓/✓                           | ✓                               |                               | ✓/✓           |                            |                                 |                          |                            |          |                          |                                 |                |                             |            |                 |                |                             |                 |                             |
| Enabling people to care for themselves and seek help when they have concerns | ✓/✓                      | ✓                             | ✓             | ✓/✓                           | ✓/✓                             | ✓/✓                           | ✓             |                            |                                 |                          |                            |          |                          |                                 |                |                             |            |                 |                |                             |                 |                             |
| Ensuring that hospital discharge is well planned and timely          | ✓/✓                      |                                  | ✓             |                               |                                 |                                |                |                             |                                 |                          |                            |          |                          |                                 |                |                             |            |                 |                |                             |                 |                             |
| Delivering flexible services that offer the right care at the right time in the right place | ✓/✓                      |                                  |               |                               |                                 |                                |                |                             |                                 |                          |                            |          |                          |                                 |                |                             |            |                 |                |                             |                 |                             |</p>
<table>
<thead>
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<th>Children Young People Wellbeing</th>
<th>Call to Action</th>
<th>Care Closer to Home July 14</th>
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<th>Outpatient survey</th>
<th>Section 136 of MHA 1983</th>
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| Theme                                                                 | Anti-coagulation service | Call to Action | Care Closer to Home July 2014 | Care Closer to Home February 15 | Diabetes – Ashbrow & Greenhead | Golcar Clinic | Huddersfield Royal Infirmary | Medical Assessment Area HWK Visit | Musculoskeletal Service | PRGN – Community Services | PRGN – Using technology | PRGN – Vulnerable adults & Over 75s | PRGN – Young People | PRGN – Single Care Plan | PRGN – Continence | Princess Royal | Hospital Discharge | Integrated Care | Multiple and Complex Needs | Outpatient survey | Section 136 of MHA 1983 | Deaf and Hard of Hearing |
|----------------------------------------------------------------------|--------------------------|----------------|-------------------------------|---------------------------------|---------------------------------|----------------|-----------------------------|---------------------------------|--------------------------|-------------------------|--------------------------|-----------------------------|--------------------------|-------------------|-----------------|-----------------|-----------------|------------------|----------------|--------------------|
| and other health services                                           |                          |                |                               |                                 |                                 |                |                             |                                 |                          |                         |                          |                             |                          |                   |                 |                 |                 |                  |                |                     |                    |
| Increasing public awareness of health conditions and how to minimise the risk of developing them | ✓                        | ✓              | ✓                             |                                 |                                 |                |                             |                                 |                          |                         |                          |                             |                          |                   |                 |                 |                 |                  |                |                     |                    |
| Delays in receiving care are unacceptable                           | ✓                        | ✓              | ✓                             |                                 |                                 |                |                             |                                 |                          |                         |                          |                             |                          |                   |                 |                 |                 |                  |                |                     |                    |
| Working with community and voluntary sector partners to deliver health care in the community | √√                      | ✓              |                             |                                 |                                 |                |                             |                                 |                          |                         |                          |                             |                          |                   |                 |                 |                 |                  |                |                     |                    |
2.2.5 Calderdale and Greater Huddersfield
1. Providing seamless, holistic care that links all aspects of care together and wraps around all of a person’s needs
2. Delivering health services through caring and competent staff
3. Making sure all changes to services are properly planned and resourced and do not lead to problems accessing services
4. Giving clear information to the patient about their health conditions and the plan for their care
5. Putting the patient at the centre of their care
6. Ensuring that all services are fully accessible for all people, including those with specific access needs
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11. Respecting patient dignity when delivering care
12. Enabling people to care for themselves and seek help when they have concerns
13. Ensuring that there are no concerns about quality of care
14. Delays in care are unacceptable
## 2.2.6 Summary of Evidence Matrix – Calderdale and Greater Huddersfield

<table>
<thead>
<tr>
<th>Theme</th>
<th>Autistic Spectrum Conditions</th>
<th>Cancer</th>
<th>Child Development Service</th>
<th>Community Matron</th>
<th>Diabetes</th>
<th>HIV</th>
<th>SWYT Transformation</th>
<th>Urgent and Emergency Care</th>
<th>Urgent Care and A&amp;E</th>
<th>Urgent Dental Care</th>
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<tbody>
<tr>
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<td>of care together and wraps around all of a person’s needs</td>
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2.3 Detailed summary of main themes

2.3.1 Calderdale

Giving clear information to the patient about their health conditions and the plan for their care
Clinicians should be open and honest with patients about their condition and their treatment and care options, in order to enable them to make informed choices about what is best for them, and be fully involved in care planning. This includes information about the expected outcome of care, how it could impact their life, medication that is needed, and what other supporting services are available, including support groups and helplines/ websites. This can aid people to manage their own health care better.

In some cases, there are supportive services that are not specifically linked to the person’s condition, e.g. counselling, where an awareness that these are available would be useful to the patient.

The information should be provided in a way that is clear and easy for the patient to understand and can be accessed in different ways, including speaking to the clinician, looking online and reading a leaflet, and you should be able to access this information at any time.

Delivering more services closer to home
People really like to use health services that are local to them; in some cases people are willing to forfeit specialist care to access a service closer to home. They see GP practices and community buildings as convenient locations at which to receive community healthcare services, because getting to them reduces travel times and costs. They would like to see more services being delivered in this way including outpatient appointments which would typically take place at the hospital. This could be achieved through expansion of GP surgeries, or local care hubs created by GPs working together across a defined area, with consultants coming out of hospitals to deliver outpatient clinics where possible.

There should be greater investment in this to prevent overburdening of GPs as the key provider ‘close to home’, with consideration given to how the expansion of GP responsibilities and services might impact a patient’s ability to access a regular GP appointment. Practice nursing staff or community nurses could offer some more generic care and testing, reducing the burden on specialist staff.

Users of respiratory services speak very highly of the community respiratory nurses, by comparison to their experiences of the hospital, which shows the effectiveness of care closer to home.

Delivering flexible services that offer the right care at the right time in the right place
There are many potential barriers to accessing health services, but many of these can be addressed by offering more flexibility in the way that services are delivered, for example, working people struggle to attend day time appointments, so providing evening and weekend appointments enables them to access services.

Appointments should be easy to arrange, available at a variety of times across 7 days, 52 weeks per year, and you should be able to choose what is most convenient for you.
They should be available quickly in response to your need at the time without any long wait to get the support or assistance you need. Some community services should be available 24/7 so people can access them when there is an urgent need.

There needs to be some variety in the way that you can book appointments and access services, like drop-in centres, telephone appointments and online booking.

Services should be responsive to the needs of the person, and adapt to meet them rather than this resulting in a need for reassessment. A change in approach should mean that someone is quickly able to access services, out of hours if necessary, rather than go through a re-referral process.

**Delivering health services through caring and competent staff and volunteers**

Staff delivering health care services should be helpful and empathetic, knowledgeable and skilled, flexible and pro-active and have a positive attitude to caring. They should be aware of a variety of care options and local services.

Good interpersonal interaction between patients and clinicians is essential to delivering good quality care, so it’s crucial that all staff can listen and respond appropriately, as well as deliver care. They should have an understanding of how different cultures and experiences influence the way people interact with services which can lead to barriers, and remain open-minded and non-judgemental.

Staff should have a level of competence that means they are trusted by the patients, and should be offered training and education that allows them to achieve that competence. When people are urgently unwell, they typically prefer to see a doctor rather than a nurse to be assessed, and ideally that would be a doctor familiar to them.

Some patients feel that their practical understanding of managing a health condition could be very useful to other people in the same position, so would be willing and able to be upskilled to deliver peer support.

**Putting the patient at the centre of their care**

People do not want to be defined by the conditions they have, and they wish that health services didn’t treat them in that way. They want their needs to be at the centre of their care, rather than their conditions or diagnoses. There should not be a “one-size-fits-all” model of care; the care model needs to account for people's individual needs and diversities.

Services should fully involve them in the assessment of their needs, the planning of their care and the reviews of it so that they feel listened to, know that their care plan meets their needs and understand their options. Then it's important that the service that is provided actually meets their needs and fits with their care plan.

When people feel that they need a service they have used before, they should be able to re-contact the service and self-refer, even if that’s just for advice.
Improving communication about patients both within and between primary, secondary, community and voluntary sector, and social care

Information about a patient needs to be accessible to all providers involved in their care, so that the patient doesn’t have to tell their story time and time again to various professionals. Without clear communication and referral pathways between providers and services, patients can have a ‘pillar to post’ experience.

Gathering an understanding of the patient’s story through sharing a record of the patient’s care should improve the consistency of service provision, and the level of understanding that different clinicians have of the health care of each patient. It could make the discharge process safer and simplify referral processes.

To improve communication between different services and different sections of the NHS requires a change in culture to see more services working together to care for a whole patient, rather than working in their area of specialism, and this would require serious planning and effort.

Providing seamless, holistic care that links all aspects of care together and wraps around all of a person’s needs

People expressed frustration that different parts of their care don't run smoothly together, instead they face gaps between services and a lack of clarity on which services to access to get the care they need.

Patients ask that services work together so that their care is seamless, and they don’t see the joins. Care pathways should encompass all of the care needs of the patient, not just their condition, and should support patients at all stages in their health care journey, including reviews, follow-up and ongoing support. They should offer an appropriate level of care for that person's needs. This means people are less likely to access multiple services whilst trying to establish which one they need, and there will be less duplication of testing or assessing when using different services.

Developing multi-agency partnerships and integrated care programmes should reduce the impact of gaps between services, but it's crucial that these span beyond secondary care services, and include GPs and social care providers. Examples of these could be a Single Point of Access, for people to contact for information and triaging; co-location of services in a single building or unit leading to integrated workforces; care coordinators who oversee the care for an individual with ongoing needs to ensure all parts of the system understand the care needs of that person; a Single Care Plan that would outline all care needs.

People like to have continuity in their care, which can be assured through staff that are familiar with their health issue so that they can receive consistency in their treatment across all services.

Improving use of technology to communicate with patients and carers and other health services

Utilising developments in technology can overcome barriers to healthcare; for example long travel times and expensive travel cost can be limited by delivering telehealth consultations. Many services acknowledge that there are ways they could better use technology to interact with patients.
Unified systems for recording patient information and sharing it with other providers could lead to efficiencies, and be used to monitor patient care and quality standards.

There are opportunities to provide information and connect people with the same experiences through online “hubs”, so they can self-care and offer support to each other, reducing their need for primary and secondary care services.

**Increasing public awareness of health conditions and how to minimise the risk of developing them**
Patients who experience long-term conditions often feel it is important that the general public have an awareness of those conditions so they can themselves identify whether they might have a long term condition, then get checked, or do something to minimise the risk of developing a condition.

There are some national campaigns to raise awareness, but people think more should be done to change people’s attitudes to reduce the incidence of some of the more preventable long term conditions. This could include screening programmes, offering accessible information through the media or local clinicians, such as a GP, or educational programmes for young people.

In Calderdale, there are high quality public health initiatives like the Upbeat programme and Smoking cessation support which help with self-management of health conditions.

**Working with community and voluntary sector partners to deliver health care in the community**
The voluntary and community sector can aid community services in many different ways; they can work flexibly, utilise their knowledge of networks and communities and use their local intelligence and their community estates and assets. Investment in this area would be welcomed by the sector.

Often they can effectively deliver support services, such as support groups and information sessions, and can be particularly involved in preventative and self-care programmes.

**Ensuring that hospital discharge is well planned and timely**
It’s necessary to ensure that discharge of patients happens at a time and in a way that ensures patient safety. Before discharge takes place, there needs to be some assurance that an appropriate level of care is in place at home or in a care home, either through community services or with the support of family.

The planning and coordination of discharge needs improvement overall.

**Making sure all changes to services are properly planned and resourced and do not lead to problems accessing services**
People are concerned that the amalgamation of services could lead to further reductions in the services capacity. Services should be properly planned and any change properly resourced, so there is no commitment made to alter services when this can’t actually be achieved. People expressed particular concerns about over stretching GPs with supported self-care and more care delivered closer to home.
Enabling people to care for themselves and seek help when they have concerns
Wherever possible, health services should be supporting people to take responsibility for managing their care; focusing on the strengths of the patient and their potential to be involved in their care helps them to maintain their independence and minimise their reliance on health care services. When planning to self-care, it’s important to consider all the barriers to doing this and how these could be overcome, for example, through better access to necessary medications.

Delivering services that support people with long term conditions when patients initially have concerns about changes in their health can help to prevent a crisis; and subsequent hospital admissions. Additionally, identifying health conditions sooner can minimise their long term impact.

Self-care can be enabled through education and information, self-care training courses, peer support, regular check-ups and preventative programmes, such as weight loss support.

2.3.2 Greater Huddersfield

Giving clear information to the patient about their health conditions and the plan for their care
Clinicians should be open and honest with patients about their condition and their treatment and care options, in order to enable them to make informed choices about what is best for them, and be fully involved in care planning. This includes information about the expected outcome of care, how it could impact their life, medication that is needed, and what other supporting services are available, including support groups and helplines/websites. This can aid people to manage their own health care better.

Information should be provided in a way that is clear and easy for the patient to understand and that can be accessed in different ways, including speaking to the clinician, looking online and reading a leaflet, and the ability to access this information at any time, so patients can always get an answer if they are unsure about what to do.

It’s important to make sure that people understand why they are attending appointments and understand what they are for, so all care received feels valuable.

Delivering health services through caring and competent staff
Staff delivering health care services should be helpful and empathetic, knowledgeable and skilled, flexible and pro-active and have a positive attitude to caring. They should be aware of a variety of care options and local services.

Good interpersonal interaction between patients and clinicians is essential to delivering good quality care, so it’s crucial that all staff can listen and respond appropriately, as well as deliver care. They should have an understanding of how different cultures and experiences influence the way people interact with services which can lead to barriers, and remain open-minded and non-judgemental. It may be useful to have a workforce that is representative of the population, so there can be a full understanding of barriers faced by people with specific disabilities or backgrounds.
Staff should have a level of competence that means they are trusted by the patients, and should be offered training and education that allows them to achieve that competence. It's important to have consistency in the staff who deliver services, so people can feel familiar with the person caring for them.

Providing seamless, holistic care that links all aspects of care together and wraps around all of a person's needs
People expressed frustration that different parts of their care don't run smoothly together, instead they face gaps between services and a lack of clarity on which services to access to get the care they need.

Patients ask that services work together so that their care is seamless, and they don't see the joins. Care pathways should encompass all of the care needs of the patient, not just their condition, and should support patients at all stages in their health care journey, including reviews, follow-up and ongoing support. They should offer an appropriate level of care for that person's needs. This means people are less likely to access multiple services whilst trying to establish which one they need, and there will be less duplication of testing or assessing when using different services.

Developing multi-agency partnerships and integrated care programmes should reduce the impact of gaps between services, but it's crucial that these span beyond secondary care services, and include GPs and social care providers. Examples of these could be a Single Point of Access, for people to contact for information and triaging; co-location of services in a single building or unit leading to integrated workforces; care coordinators who oversee the care for an individual with ongoing needs to ensure all parts of the system understand the care needs of that person; a Single Care Plan that would outline all care needs.

Improving communication about patients both within and between primary, secondary, community and voluntary sector, and social care
Information about a patient needs to be accessible to all providers involved in their care, so that the patient doesn't have to tell their story time and time again to various professionals. Without clear communication and referral pathways between providers and services, patients can have a “pillar to post” experience.

This record of a patient’s story should be kept up to date, rather than being stagnant information, and should be stored or transferred in a safe way. Patients would like to have a say in the information held on their medical record and be one of the stakeholders with access to this, as with the Single Care Plan proposed for young people. This should improve the consistency of service provision, and the level of understanding that different clinicians have of the health care of each patient.

To improve communication between different services and different sections of the NHS requires a change in culture to see more services working together to care for a whole patient, rather than working in their area of specialism, and this would require serious planning and effort.
Putting the patient at the centre of their care
People do not want to be defined by the conditions they have, and they wish that health services didn’t treat them in that way. They want their needs to be at the centre of their care, rather than their conditions or diagnoses.

Services should fully involve them in the assessment of their needs, the planning of their care and the reviews of it so that they feel listened to, know that their care plan meets their needs and understand their options. It’s important for clinicians to respect the difference between an assessed clinical need and the practical needs of that person and incorporate that in to the planning; services should be delivered in a way that is convenient to the person rather than convenient to the provider. Some people choose to access complimentary therapies, support services and peer support, and this should be incorporated in to the planning.

Focusing on providing a service centred on the patient should reduce the number of patients who feel marginalised, as access to services will be worked through with them rather than allocated, and will meet any specialist needs that they have.

When people feel that they need a service they have used before, they should be able to re-contact the service and self-refer, even if that’s just for advice.

Delivering more services closer to home
People really like to use health services that are local to them; in some cases people are willing to forfeit specialist care to access a service closer to home. They see GP practices and community buildings as convenient locations at which to receive community healthcare services, because getting to them reduces travel times and costs. They would like to see more services being delivered in this way, including outpatient appointments which would typically take place at the hospital. This could be achieved through expansion of GP surgeries, or local care hubs created by GPs working together across a defined area, with consultants coming out of hospitals to deliver outpatient clinics where possible.

There should be greater investment in this to prevent overburdening of GPs as the key provider “close to home”, with consideration given to how the expansion of GP responsibilities and services might impact a patient’s ability to access a regular GP appointment. Increasing the use of pharmacies for medication reviews, could be one way to reduce demand on GP services.

Patients have expressed a real frustration that they are fearful of losing their local services, either at the hospital or following the closure of local healthcare clinics.

Enabling people to care for themselves and seek help when they have concerns
Wherever possible, health services should be supporting people to take responsibility for managing their care; focusing on the strengths of the patient and their potential to be involved in their own care helps them to maintain their independence and minimise their reliance on health care services.

Delivering services that support people with long term conditions when patients initially have concerns about changes in their health, helps to prevent crises and subsequent hospital admissions. Additionally, identifying health conditions sooner can minimise their long term impact.
Self-care can be enabled through education and information, self-care training courses (e.g. the DESMOND course for diabetes), peer support, regular check-ups and preventative programmes, such as weight loss support. Patients felt that an interactive, regularly updated care plan promotes independence, and limits reliance on other services to help with care.

**Ensuring that hospital discharge is well planned and timely**

It's necessary to ensure that discharge of patients happens at a time and in a way that ensures patient safety. Before discharge takes place, there needs to be some assurance that an appropriate level of care is in place at home or in a care home, either through community services or with the support of the patient's family, friends or relatives. This means that it’s necessary for the hospital to properly coordinate with family, community services or a care home to make sure handover is smooth and to provide the information that enables this to happen.

The planning and coordination of discharge needs improvement overall.

**Delivering flexible services that offer the right care at the right time in the right place**

There are many potential barriers to accessing health services, but many of these can be addressed by offering more flexibility in the way that services are delivered, for example, working people struggle to attend day time appointments, so providing evening and weekend appointments enables them to access services.

Appointments should be easy to arrange, in convenient locations, available at a variety of times across 7 days, 52 weeks per year. They should be available quickly in response to patients need at the time, without any long wait to get the support or assistance patients need.

There needs to be some variety in the way that you can book appointments and access services, like drop-in centres, telephone appointments and online booking. For people who need regular appointments for testing, there should be options available for how patients interact with the service, and an exploration of whether testing can be done at home.

Delivering a flexible service is very important to those who may have more chaotic lifestyles, and additional needs, such as those with substance misuse issues or caring responsibilities, who face additional barriers in accessing health services.

**Involving carers and family in care planning**

Respect parents and carers and their views in the development of care plans, as they are crucially important in delivering care plans and can have significant influence on their feasibility.

Make sure substantial support is in place for carers so they can fulfil their caring role, and can navigate the system easily.

**Respecting patient dignity when delivering care**

All care should be provided in a respectful way that allows the patient to have as much dignity as is possible. The physical care environment needs to be designed in a way
that enhances the patient’s feelings of privacy, and staff interaction with patients should make them feel respected.

Some of the most vulnerable patients are those who feel their views don’t count because they are not treated with respect by professionals, such as those people with multiple and complex needs, like homelessness or substance misuse issues.

**Ensuring that all services are fully accessible for all people, including those with specific access needs**

Health services should be easy for patients to access, both physically, and in a way that meets specific needs. People are very concerned about any changes that would see services moving further away.

If a patient has a disability, the service should still be delivered in a way and location that meets their needs; this could relate to physical access for people in wheelchairs, or making sure that there are multiple ways of letting people know that the patient is being called in to an appointment, for people who have sensory impairments adjustments need to be made.

**Minimising barriers to health care caused by travel times and costs**

Travelling to a service was highlighted as the biggest barrier faced; lengthy travel times and high travel costs impact people’s ability to get to appointments, as they may not be able to fit the appointment in or they may not be able to afford to get there. This is a particular concern for people who need regular appointments.

Any new services should be easy to access by public transport and provide suitable car parking on site or nearby, including disabled parking.

**Ensuring that there are no concerns about quality of care**

In most engagement, patients and carers praised elements of the care that they had received, but often had feedback about a part of the care that hadn’t met the standard that they were expecting, e.g. people with diabetes were frustrated by inconsistencies in the level of care they received. All services should be aiming to provide a service with excellent care standards, although patients acknowledge this isn’t always feasible.

It’s unclear in some services whether enough has been done to assure the quality of care that people are receiving, for example people detained under Section 136 of the Mental Health Act, who may have been placed in a police cell, but there has been little done to monitor the quality of care they received there.

**Improving use of technology to communicate with patients and carers and other health services**

Utilising developments in technology can overcome barriers to healthcare; for example long travel times and expensive travel cost can be limited by delivering telehealth consultations. Many services acknowledge that there are ways they could better use technology to interact with patients.

Unified systems for recording patient information and sharing it with other providers could lead to efficiencies, and be used to monitor patient care and quality standards.
There are opportunities to provide information and connect people with the same experiences through online “hubs”, so they can self-care and offer support to each other, reducing their need for primary and secondary care services.

**Increasing public awareness of health conditions and how to minimise the risk of developing them**

Patients who experience long-term conditions often feel it is important that the general public have an awareness of different long term conditions in order to identify whether they might have them, get checked, or do something to minimise the risk of developing them.

There are some national campaigns to raise awareness, but people think more should be done to change people’s attitudes to reduce more preventable long term conditions. This could include screening programmes, offering accessible information through the media or local clinicians, such as a GP, or educational programmes for young people.

**Delays in receiving care are unacceptable**

Waiting for care and treatment whilst in a care setting is frustrating for patients using both urgent and planned care services, especially when there is no explanation for the delay. Information should be provided about how long delays will be and why they are occurring. Some specific clinics at Huddersfield Royal Infirmary regularly have delays, which is especially frustrating to patients using those.

**Working with community and voluntary sector partners to deliver health care in the community**

The voluntary and community sector can aid community services in many different ways; they can work flexibly, utilise their knowledge of networks and communities and use their local intelligence and their community estates and assets. Investment in this area would be welcomed by the sector.

Often they can effectively deliver support services, such as support groups and information sessions.

2.3.3 *Calderdale and Greater Huddersfield*

**Providing seamless, holistic care that links all aspects of care together and wraps around all of a person’s needs**

People expressed frustration that different parts of their care don’t run smoothly together, instead they face gaps between services and a lack of clarity on which services to access to get the care they need.

Patients ask that services work together so that their care is seamless, and they don’t see the joins. Care pathways should encompass all of the care needs of the patient, not just their condition, and should support patients at all stages in their health care journey, including reviews, follow-up and ongoing support. They should offer an appropriate level of care for that person’s needs. This means people are less likely to access multiple services whilst trying to establish which one they need, and there will be less duplication of testing or assessing when using different services.

Developing multi-agency partnerships and integrated care programmes should reduce the impact of gaps between services, but it’s crucial that these span beyond secondary
care services, and include GPs and social care providers. Examples of these could be a Single Point of Access, for people contact for information and triaging; co-location of services in a single building or unit leading to integrated workforces; care coordinators who oversee the care for an individual with ongoing needs to ensure all parts of the system understand the care needs of that person; a Single Care Plan that would outline all care needs.

**Delivering health services through caring and competent staff**
Staff delivering health care services should be helpful and empathetic, knowledgeable and skilled, flexible and pro-active and have a positive attitude to caring. They should be aware of a variety of care options and local services.

Good interpersonal interaction between patients and clinicians is essential to delivering good quality care, so it's crucial that all staff can listen and respond appropriately, as well as deliver care. They should have an understanding of how different cultures and experiences influence the way people interact with services which can lead to barriers, and remain open-minded and non-judgemental.

Staff should have a level of competence that means they are trusted by the patients, and should be offered training and education that allows them to achieve that competence. In some cases, patients wanted to be seen specifically by experienced staff for both the assessment of their needs and to deliver the services.

**Making sure all changes to services are properly planned and resourced and do not lead to problems accessing services**
People are concerned that the amalgamation of services could lead to further reductions in the services capacity. They should be properly planned and any changes to a service should be properly resourced. There should be no commitment made to alter services when this can’t actually be achieved.

In some cases, services still need additional resource to meet the demand and to reduce waiting times, but it’s unclear how easy it is to get this, for example increasing specialist nurse provision for diabetes or delivering more urgent care.

**Giving clear information to the patient about their health conditions and the plan for their care**
Clinicians should be open and honest with patients about their condition and their treatment and care options, in order to enable them to make informed choices about what is best for them, and be fully involved in care planning. This includes information about the expected outcome of care, how it could impact their life, medication that is needed, and what other supporting services are available, including support groups and helplines/websites.

Information should be provided in a way that is clear and easy for the patient to understand and that can be accessed in different ways, including speaking to the clinician, looking online and reading a leaflet, and able to access this information at any time. For example, people with diabetes would particularly like a self-care handbook as part of the information they receive.
Putting the patient at the centre of their care
People do not want to be defined by the conditions they have, and they wish that health services didn’t treat them in that way. They want their needs to be at the centre of their care, rather than their conditions or diagnoses.

Services should fully involve them in the assessment of their needs, the planning of their care and the reviews of it so that they feel listened to, know that their care plan meets their needs and understand their options. Then it’s important that the service that is provided actually meets their needs and fits with their care plan.

Ensuring that there are no concerns about quality of care
In most engagement activities, patients and carers praised elements of the care that they had received, but often had feedback about a part of the care that hadn’t met the standard that they were expecting. All services should be aiming to provide a service with excellent care standards, although patients acknowledge this isn’t always feasible.

Some concerns were raised about the quality and the appropriateness of care in both the Urgent Dental Care review and the diabetes engagement, where some patients felt that standards in primary care should be raised.

Delays in care are unacceptable
For services such as the Autistic Spectrum Conditions service and Wheelchair services, patients are experiencing long waits both for assessment and then to receive care. This can lead to additional difficulties in their lives or with their conditions which may be avoidable if they had been able to access services.

Waiting for care and treatment whilst in a care setting is frustrating for patients, especially when there is no explanation for the delay.

Ensuring that all services are fully accessible for all people, including those specific access needs
Health services should be easy for patients to access, both physically, and in a way that meets specific needs. People are very concerned about any changes that would see services moving further away.

If a patient has a disability, the service should still be delivered in a way and location that meets their needs; this could relate to physical access for people in wheelchairs, or making sure that there are multiple ways of letting people know that the patient is being called in to an appointment, for example, people who have sensory impairments may require more visual or auditory methods.

Patients access A&E, sometimes unnecessarily, because it is the most accessible and well known service, in their opinion. Staff also signpost to A&E because they feel it is accessible. Until other services are perceived as being as accessible, or more so, patients will continue to go to A&E. One way to ensure people get the right service when choosing to access A&E is to co-locate primary care services, particularly out-of-hours.

Minimising barriers to health care caused by travel times and costs
Travelling to a service is often the biggest barrier; lengthy travel times and high travel costs impact people’s ability to get to appointments, as they may not be able to fit the
appointment in or they may not be able to afford to get there. This is a particular concern for people who need regular appointments, for example those parents travelling to the Child Development Service.

Any new services should be easy to access by public transport and provide suitable car parking on site or nearby, including disabled parking.

**Involving carers and family in care planning**
Respect parents and carers and their views in the development of care plans, as they are crucially important in their success and will have significant influence on their feasibility.

Make sure substantial support is in place for carers so they can fulfil their caring role, and can navigate the system easily.

**Improving communication about patients both within and between primary, secondary, community and voluntary sector, and social care**
Without clear communication and referral pathways between providers and services, patients can have a “pillar to post” experience.

**Delivering flexible services that offer the right care at the right time in the right place**
There are many potential barriers to accessing health services, but many of these can be addressed by offering more flexibility in the way that services are delivered, for example, working people struggle to attend day time appointments, so providing evening and weekend appointments enables them to access services.

Appointments should be easy to arrange, available at a variety of times across 7 days, 52 weeks per year. They should be available quickly in response to the patients need at the time.

**Respecting patient dignity when delivering care**
All care should be provided in a respectful way that allows the patient to have as much dignity as is possible. The physical care environment needs to be designed in a way that enhances the patient’s feelings of privacy, and staff interaction with patients should make them feel respected. Anything that staff do that implies they have a prejudice towards a patient impacts on that person’s dignity.

**Enabling people to care for themselves and seek help when they have concerns**
Wherever possible, health services should be supporting people to take responsibility for managing their own care; focusing on the strengths of the patient and their potential to be involved in their care helps them to maintain their independence and minimise their reliance on health care services.

Delivering services that support people with long term conditions; when patients initially have concerns about changes in their health, helps to prevent crises and subsequent hospital admissions. Additionally, identifying health conditions sooner can minimise their long term impact.
Self-care can be enabled through education and information, self-care training courses, peer support, regular check-ups and preventative programmes, such as weight loss support.

2.3.4 Equality
As a matter of routine all engagement activity undertaken by NHS Calderdale CCG and NHS Greater Huddersfield CCG is subject to equality monitoring. This helps support and informs decision making by contributing to the development of equality impact assessments, analyses and other service improvement activity.

This is more straightforward when presenting the public with surveys where a form can be appended than when other engagement methodologies are implemented. Where focus groups are undertaken it is often less easy to line up any equality monitoring with feedback given and for drop-ins information may not be related to individuals.

When considering feedback it is important to understand who has given their views and sometimes more importantly, who has not. The equality monitoring is compared to local demographics to understand if a representative sample of the community has been reached. Where specific services are under review the groups targeted will often be those in receipt of the service, such as people with mobility issues when considering wheelchair services.

Equality monitoring is also used to help compare views and outcomes for different groups of people to understand if there are any trends in opinion which need taking into account.

A review of the evidence collated for this report demonstrates that there are some themes that are likely to be particularly resonant with protected groups. These include;

1. Providing seamless, holistic care that links all aspects of care together and wraps around all of a person’s needs
2. Making sure all changes to services are properly planned and resourced and do not lead to problems accessing services
3. Giving clear information to the patient about their health conditions and the plan for their care
4. Putting the patient at the centre of their care
5. Ensuring that all services are fully accessible for all people, including those with specific access needs
6. Minimising barriers to health care caused by travel times and costs
7. Involving carers and family in care planning
8. Improving communication about patients both within and between primary, secondary, community and voluntary sector, and social care
9. Delivering flexible services that offer the right care at the right time in the right place
10. Respecting patient dignity when delivering care
11. Enabling people to care for themselves and seek help when they have concerns

Some protected groups are likely to have differential access, experience and outcomes when they use NHS services, in listening to feedback it is important to try and consider if we can identify any of these potential issues in order to fully understand what the likely impact is and how it can be addressed or minimised.
Given the breadth of engagement activity there is not always a large or diverse enough sample to define any significant trends, but where this is possible this is described in the engagement report. People do mention in their comments and in other engagement activities what the issues are for particular communities and these are collated and fed back to decision makers.

In appendices 4.46 the aspects of equality noted through the review of engagement are detailed. In reviewing this data it becomes clear that issues of a representative sample are often noted. In planning the pre-engagement activity detailed later in this report active efforts were made to reach out to communities who may previously have been under-represented.

2.4 Right Care, Right Time Right Place – Engagement

The engagement process took place between April and July 2014. These were a number of activities taking place throughout this period and the responses we received are as follows:

<table>
<thead>
<tr>
<th>Method</th>
<th>Contact / attendance</th>
<th>Responses received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop in Sessions</td>
<td>202+ attendees</td>
<td>153 responses</td>
</tr>
<tr>
<td>Calderdale and Greater Huddersfield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asset based approach</td>
<td>1,263 contacts</td>
<td>1,244 responses</td>
</tr>
<tr>
<td>Calderdale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asset based approach</td>
<td>477 contacts</td>
<td>57 responses</td>
</tr>
<tr>
<td>Greater Huddersfield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existing networks</td>
<td>18,000+ contacts</td>
<td>215 responses</td>
</tr>
<tr>
<td>Calderdale and Greater Huddersfield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stakeholder activities</td>
<td>20,500 contacts</td>
<td>806 + responses</td>
</tr>
<tr>
<td>Calderdale and Greater Huddersfield</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Figures including + mean we did not always count the numbers attending therefore the target audience was greater than the numbers recorded)

In total we received 2,475 responses with the majority of these responses 85% on the Strategic Outline Case (SOC) and the remaining 15% on the CCGs commissioning intentions. 1,306 equality monitoring forms were completed (this comprises; 1091 from the SOC engagement, 126 from the 5 Year Strategy engagement and 89 form the drop in sessions) and from these we know +we received the majority of our responses from residents in Calderdale who provided 51% of the total responses, Greater Huddersfield 3% and 46% where there was no postcode provided. It is worth noting however that this does not take into account the remaining 891 responses where some may have come from residents in the Greater Huddersfield area.

As well as our planned engagement activities a number of meetings were held with key stakeholders. These contacts have not been counted in the contact or response figures in the table above. However, feedback from these organisations can be found in the findings for both the CCGs and Providers’.

The focus of the Providers’ engagement was to gather views on the ideas set out in the SOC. The full SOC document was made public on the Right Care, Right Time, Right
Place website. The focus of the Commissioners’ engagement was to gather views on the commissioning intentions as part of the five year plan. NHS Calderdale and Greater Huddersfield CCGs each have their own strategy these documents including a questionnaire were circulated to existing networks for comment and views gathered at the local drop in sessions for each CCG.

The engagement process carried out on behalf of the Providers and Commissioners in the response to the case for change jointly produced findings which highlighted some common themes. It is clear that the public see one health system and views relating to primary and secondary care were contained in each of the engagement exercises.

The areas or aspects of care which were highlighted as being of highest importance to the public when redesigning a health care system are as follows (these are not cited in any order of importance):

- People wanted to see more care closer to home and in a variety of community settings
- The public in Calderdale do not want to lose their A&E as part of services changing
- Travel and transport needed further consideration as people could neither afford the time to travel; the cost, or find suitable parking on premises. People want services to be based locally
- Access to services in the community needed to be 24/7 including bank holidays and there was a strong message that GP access in particular needed to be addressed if the system was to change. People also wanted services they could drop in to
- People wanted more focus on prevention and innovative opportunities to keep themselves well or be educated, particularly at a young age
- Appropriate staff are needed in the community and this included more GP’s, district nursing staff and those with a particular focus on a specialism or to meet the needs of diverse communities
- There were concerns that the model looked good on paper but would it work in practice, this included comments relating to capacity to deliver including social care, how information is shared and how services are coordinated
- People did not understand the detail of any of the plans and wanted to understand this further
- People wanted the community to be part of the solution including design, delivery and estates with greater community participation being the key to delivering services for each community
- Mental health services were not working and there was a need to look at services further in both primary and community care
- Hospital services were poor on waiting times and needed to improve in addition there were a number of comments that people are discharged too early
- There needs to be more consideration for vulnerable groups, protected groups, carers and those with a disability
These themes reflect on the whole the things that people have already told us they would like to see in the planning of future health and social care services.

Whilst staff training had been mentioned previously it was not reflected as a priority in these engagement findings although people did want to see the right staff with the right skills in the community model. Education and information was not described as a theme on this occasion although the details regarding ideas for supported self-care included these areas. Technology was cited as telephone access and sharing information in this instance and managing risk and safeguarding were reflected in people’s experiences which varied.

2.5 Right Care, Right Time, Right Place – Stakeholder event - August 2014

A joint stakeholder event for both Calderdale and Huddersfield took place on Tuesday 12th August at the Shay Stadium in Halifax and the event ran from 10:00 -3:00pm, over 120 people attended the event. The purpose of the stakeholder event was to ensure that the process we had followed as part of both the Providers’ and Commissioners’ engagement process had adequately captured the views of all those who wanted to share a view or make a comment.

In addition we wanted to provide feedback on the findings so far so we could gather any final views which could then be considered as part of the engagement process.

Following the Providers’ and Commissioners’ engagement process a joint report of findings was written on the feedback we had received. This report provided analysis on the data gathered and presented the key findings from:

- The commissioning intentions, and
- The Providers Strategic Outline Case

This report of findings formed the basis of the stakeholder event ensuring that we were able to;
- Present the findings from the engagement activity to key stakeholders.
- Provide a further opportunity to provide comment.
- Describe how the information will be used.
- Describe the community model, in hospital model; and
- Present the evaluation criteria

The purpose of the event was to ensure key stakeholders participated in helping to align the findings from the engagement activity with any future models and plans.

The key emerging themes from the Stakeholder Event were similar to those gathered in the report of findings for the Provider and Commissioner engagement process. The stakeholders who attended the event provided a more detailed commentary and this has ensured that we have gathered rich data and very detailed stories, information and feedback. The key emerging themes from the event are:
• Participants were generally in agreement that they want services closer to home, delivered by the right staff in the right setting with transport and estates considered.
• Stakeholders want to see more detail to these plans which they felt were too vague. Stakeholders want to know what it means for them and they want to continue to be engaged in this process.
• Supported self-care and prevention was a key focus to enable these plans to work and this included the right approach, information and communication.
• Stakeholders wanted the model to reflect the diverse population and meet the needs of those who are more vulnerable and require different approaches and support.
• The third sector wanted to play a key role in developing and delivering these services at a local level in a variety of community settings.
• Participants were considered about the financial and work force considerations required by this model and whilst it looked good in principle were unsure if it could be delivered.
• Stakeholders welcomed multi agency working, single care plans and a single point of access which included information sharing, but wanted to see social care as a more central part of the community model.
• The in hospital standards confused people, they wanted to know what this would mean for hospital services and needed more information.
• People agreed with 24/7 access in primary care and saw the GP as central to this model, however access and availability of GPs were a concern.
• Stakeholders want Commissioners to address some of the issues relating to hospital discharge, transport and A and E as part of this model.
Section 3: Findings from the pre-engagement process

3.1 Background
As part of our pre-engagement process we needed to ask more questions on hospital care, what services are best delivered in a hospital setting and what services are better placed in the community. We needed to do more engagement to help us understand:

- Emergency and urgent care
- Hospital services
- Services as part of the Care Closer to home model for Calderdale and Greater Huddersfield, and
- Maternity and paediatrics

From this we wanted to further understand any impacts for service change, including what will work, how far people are prepared to travel to receive different types of service and any planned or unplanned care they may need.

3.2 Engagement and equality process
The target audiences we engaged included public, patients, carers and their representatives and we used a number of mechanisms and key activities to deliver pre-engagement activity.

The pre-engagement was specifically targeted to audiences who could provide us with information that would help us understand a range of views from a number of protected groups and localities.

Pre-engagement builds on our existing engagement activity which is cited in section 2 of this document (page 11-37). We used the information we already had to develop questions we still needed to ask and identified any gaps in our target audience.

Using this approach we were able to focus our engagement on particular audiences. A ‘Communications, Engagement and Equality Plan’ for ‘Hospital and Care Closer to Home’ was written to describe our methods and approaches.

3.3 Methodology
What we did
We engaged with a sample group of people who reflected our local population and who would be directly affected by service change. This included

- Those directly affected by the services identified in phase 2 of ‘Care Closer to Home’ model for Greater Huddersfield.
- Those directly affected by the services identified in phase 1 and 2 of ‘Care Closer to Home’ model for Calderdale.
- People who represent the protected characteristics as set out in the Equality Act to support the development of an equality analysis.
- People from a sample group of local areas who can provide a local perspective to service change.

A list of the groups we engaged can be found in appendix one of the ‘Communications, Engagement and Equality Plan for Hospital and Care Closer to Home’ (see appendix
5.1). It is worth noting that maternity and paediatrics will have a separate plan for engagement which will not be delivered until autumn and this work will be added to this report.

In addition we wanted to ask a sample group of people their views on unplanned and planned care; from previous engagement activity we already know people do not want to lose A&E services, but we also know people prefer to use services closer to home in a number of urgent unplanned situations.

We needed to understand the reasons for this response by asking specific groups to provide more information. In addition we needed to understand in more detail the impact of changing current services so we can consider specific needs further.

For planned care we wanted to engage in a more meaningful conversation. People have not adequately responded to the plans for planned care and we wanted to take into consideration the needs of different groups and so required more information.

By delivering pre-engagement we wanted to further understand if there are particular issues for specific groups of people living in Calderdale and Greater Huddersfield that we may not have considered before we progress to formal consultation.

3.4 Our approach
The method we used for engagement was a structured questionnaire (see appendix 5.2). The questionnaire used ranking to identify preference (1 being the most important or preferred to 10 being the least) the ranking was used to breakdown preferences so we can identify the most important aspect of care in each situation. We recognise that all aspects of care are important and worked with local community assets to identify preferences. As trained individuals supported people to complete the survey either face to face or as part of a focus group (see data capture form appendix 5.3); the rankings were explained.

Focus group activity during pre-engagement was delivered in the style of appreciative inquiry which focuses on enabling people to imagine the desired future state of our health and social care system. Using both these approaches the engagement team;

- Were able to provide further platforms for discussion by supporting third sector partner organisations to host conversations in their local communities or through established networks,
- Directly targeted those groups who we needed specific feedback from,
- Used equality monitoring (see appendix 5.4) and impact assessment tools to identify the effectiveness of activities, potential impact on protected groups and how well they are reaching representative samples of the community;

Using a combination of quantitative and qualitative questions that reflect the broad themes and approaches of the inquiry, the responses were analysed and the findings presented at two local stakeholder events in August, one in Calderdale and one in Greater Huddersfield.
3.5 Findings from the pre-engagement process

Calderdale and Greater Huddersfield
Target audiences were engaged in Calderdale and Greater Huddersfield. For Calderdale we engaged with 14 local groups and in Greater Huddersfield 15 local groups. In Calderdale 13 of these groups hosted a focus group as part of their asset based approach to delivering engagement. In Greater Huddersfield the main method for engagement was survey returns. From those responding to the survey 57% had an ongoing health condition and from the focus groups all represented a protected group to support our understanding of diversity (see appendix 5.5).

In addition we trawled through all the ‘Patient Opinion’ postings and Patient Advice and Liaison Service (PALS) queries received over the past two years. In total we gathered 654 responses, the breakdown is as follows:

- Focus groups – 199 people engaged with some equality information
- 278 survey responses with completed equality monitoring
- 108 ‘Patient Opinion’ postings
- 69 PALS queries

3.5.1. Urgent Care – survey response

_Urgent care was described in the survey as not life threatening, a minor illness such as a suspected broken bone, a cut, suspected sprain, a stomach upset or perhaps a child who has been tired for a few days._

We asked people to tell us using a rating from 1-10 of their preferred contact in an urgent care situation (1 being the preferred contact and 10 being the last preference). From all the responses we received the preferred contact for people in an urgent care situation are rated below. The list is ranked in order of preference with each score representing the weighted average (the lowest score is the highest preference):

1. GP Practice (scored 2.13)
2. Chemist (scored 3.49)
3. Walk in Centre (scored 3.89)
4. Family, friend or self (scored 4.43)

For a number of people responding the main reason for attending A&E (scored 4.67) as a first point of contact was to receive an x-ray. Most stated if they thought they had a suspected broken bone or fracture that they would automatically go to A&E to receive treatment.

We also asked people in an urgent care situation what the most important aspects of care were, people had to rate the question using 1 to 10, (1 being the most important to 10 being the least important). People told us _the most important aspects of care in an urgent carer situation are:_

1. To be seen straight away (scored 2.74)
2. To access a service straight away (scored 3.40)
3. To talk to someone straight away (scored 3.41)
4. I know I will get the treatment I need (scored 3.97)
Urgent Care – focus group response
Those holding focus groups provided extra intelligence on urgent care services; people told us:

- All focus groups cited the GP as the preferred first point of contact but access such as unavailable appointments, opening times and lack of drop in services prevented this being possible for some
- We want to see someone with knowledge and experience
- I want to know I can access a BSL interpreter and I want my records to flag this to staff
- Some people commented they did not like A&E as it was too long to wait to be seen
- Need more trained staff, facilities and equipment at walk in centres to treat people
- A&E was seen as a responsive service that provided what people wanted and could be developed as a ‘one stop shop’, A&E offered the 24/7 access people want

Patient opinion: Fractured femur

I had a fall outside a friends house. I knew that I needed to go get to A&E and managed to get to Huddersfield Royal in her car. I was assessed and a total hip replacement was to be arranged. I was move to a ward and it was decide that my surgery would take place at Calderdale Royal Hospital to which I was moved 4 days later and had surgery the following day. After physio on the ward I was discharged 7 days later. Hand rails, toilet seats and trolley and a key safe were all waiting when I got home. I had 6 weekly visits from the physio at home followed by physio in outpatients. I would be extremely likely to recommend this service.

(posted on patient opinion - 26/9/14)

3.5.2 Emergency care – survey response

*Emergency care was described in the survey as life threatening or serious such as a heart attack, stroke or serious injury where you might also be taken to hospital by an ambulance.*

Some, not all, of the people responding to the survey told us that the options were difficult to rank as all were equally as important in an emergency care situation. However through face to face engagement people told us what the **most important aspects of care in an emergency situation** are (1 being the most important to 9 being the least important):
1. Knowing I can be seen straight away (scored 2.27)
2. Knowing I can get the treatment I need (scored 2.87)
3. Knowing I will see the right health care professional who understands my condition (scored 3.40)
4. To know that I won’t wait too long to be seen (scored 3.69)
5. Being treated by a specialist who regularly deals with life threatening conditions (scored 4.18)

A number of people told us what else we should consider in an emergency care situation, from those responding people told us:

- Wanting the right care where ever that is
- Seeing a professional with special knowledge, skills and equipment to care for me
- Receiving care quickly
- Getting the treatment I need
- Feeling safe
- Having transport that can accommodate my needs – particularly for people with a disability.

**Patient opinion: Cardiology**

My husband had chest pain and we firstly went to A&E. As a nurse myself every single member of the A&E team have the best people skills, with every patient they demonstrate compassion, care and courage and total commitment under extreme circumstances. My husband had had a previous heart attack and was transferred to Calderdale Royal Hospital for further tests. Commissioners in Calderdale and Huddersfield need to feel very assured that their teams are doing an amazing job and provide a gold standard of care.

*(posted on patient opinion - 24/3/15)*

**Emergency Care – focus group response**

Those holding focus groups provided extra intelligence on emergency care services, people told us:

- In an emergency people want the same service at weekends
- Staff who can coordinate care
- A good ambulance service
- Concerns were raised that A&E would close in Calderdale
- Accessible dental suite in Todmorden needs more promotion
- Ambulance response times were reported as poor in the upper Calder Valley
• More training for staff on mental and physical illness
• First responders need to be properly trained and equipped
• For people with a learning disability feeling safe was a high priority
• New residents including migrants were unsure of who to contact in an emergency and did not know what was and wasn’t an emergency
• In an emergency situation most agreed the right type of care was important

3.5.3 Planned Care – survey responses
In the survey planned care was described as hospital services and treatment that are planned. For the majority of patients they would use the hospital in this way to have a planned procedure which could mean a short stay in hospital or day surgery.

We asked people to rank from 1-9 (1 being the most important to 9 being the least important). From the responses we received the most important aspects of care for people who require a planned care procedure are:

1. To be treated by staff who understand my condition (scored 2.67)
2. To know I will get the treatment I need (scored 3.06)
3. To access a service straight away (scored 3.24)
4. For my appointment not to be cancelled or changed at short notice (scored 3.78)
5. To be treated by caring and helpful staff (scored 4.56)

It is worth noting that, services being closer to home were ranked 8 out of the 10 options with a score of 5.55.

In addition people told us what else we should consider when we are planning to provide planned care, from those responding people told us:

• The person treating me to have access to all the information about me they need
• Services to be joined and coordinated
• Services to be provided at local treatment centres such as the GP/drop in sessions
• Good access including follow up appointments, more use of the telephone for contact
• Recovery time to be appropriate with services in place to provide aftercare

Patient opinion: Day surgery

I went in to hospital yesterday for excision of fibroadenoma. I was terrified about this procedure, but all the nurses were lovely with me. The surgeon was great and the anaesthetists were also really reassuring (despite me having a complete melt down in theatre). I would be extremely likely to recommend this service

(posted on patient opinion - 9/10/14)
Planned Care – focus group response
Those holding focus groups provided extra intelligence on planned care services, people told us:

- People want planned procedures that take place when they should, changes and cancellations have a big can effect on people who work, who have planned childcare, people on a low income as they have to travel again.
- Staff have poor knowledge of disabilities, require training
- We need to improve the care we provide to people with autism and dementia
- Call buttons next to the beds need to be within reach
- More disabled equipment is needed to support recovery and independence
- Radio and television charges are too high in the hospital
- Skilled staff and aftercare were more important than location
- Staff needed to be culturally appropriate
- Information provided in a planned care situation needs to be clear so people know what to expect
- Discussions early on about what will follow planned care would be useful so people know what to expect
- A treatment plan which sets out what will happen before admission and translated or interpreted would support people better
- For people with a learning disability having visitors within easy reach was important

3.5.4 Therapies and technology

In the survey we describe this as rehabilitation and therapy that people would receive following a period of illness or injury. A patient may receive rehabilitation or therapy in order to help them recover.

Those responding told us that the preferred locations to receive therapies and services to support rehabilitation would be;

- Local GP Practice
- Local Health Centre
- At home

Each of these locations almost scored equally suggesting the preferred location for therapies is out in the community and closer to peoples home. In addition 71% of those responding also suggested other locations for receiving therapy and rehabilitation services which were community buildings including community centre, church halls, voluntary groups and leisure centres. **84% of people prioritised getting to the location** to receive treatment as the highest consideration alongside 75% who wanted assurance that staff were properly qualified and trained.
Patient opinion: Care received

My stepfather who is now 90 years old has had several visits and appointments for investigation at his hospital. This has involved several departments, his doctors surgery and community outreach. He has received outstanding care and I cannot praise everyone enough. I cannot list the whole of the dates and departments visited, he has had tests for a variety of conditions including neurological, speech therapy, falls service, carpel tunnel. Well done to all concerned.
(posted on patient opinion – 7/4/13 )

People who told us about the use of technology said that:

- 67% would use the mobile phone, 55% would prefer to use a computer or laptop
- 44% would try new technology
- 25% would if supported to use new technology, 23% would not use it or be able to access it

In addition some of the things we need to consider when looking at the use of technology to support healthcare are:

- Poor Wi-Fi connection in a number of local areas
- People still want face to face contact as well as or instead of
- Expensive data usage for some with a mobile phone or no internet
- Lack of equipment or knowledge would need to be supported

Technology and therapies – focus group response

Those holding focus groups provided extra intelligence on urgent care services, people told us:

- Rehabilitation and therapies
  - Want service to include alternative therapies such as reflexology and massage
  - Some rehabilitation services were seen as poor and needed to be improved
• Technology
  o Use text reminders for appointments and for those requiring more support such as people with a learning disability, a phone call would be appreciated
  o Emails can be difficult to read for some, a lot of people can’t use or don’t have access to a computer and need to be considered
  o Training is needed to support the use of technology
  o Language, translation and literacy are a barrier to using technology

3.5.5 Travel and transport:

We asked people how far they would be prepared to travel to receive treatment in an urgent care situation or services for planned care. The responses we received are as follows:

In an urgent care situation those responding told us:

• 41% of people want to travel under 15 minutes,
• 56% of people will travel 15-60 minutes (42% wanting under 30 minutes)

This response coincides with the findings from urgent care that most want to receive a service in a local setting close to home and that the highest priority for urgent care is to be seen and to access a service straight away.

We asked people how far they would be prepared to travel to receive treatment in a planned care situation. The responses we received are as follows:

In a planned care situation those responding told us:

• 32% of those responding wanted to travel under 15 minutes,
• 60% of those responding wanted to travel 15-60 minutes (31% wanting under 30 minutes)

In comparison to urgent care the distance people were prepared to travel has increased for planned care.

In addition those responding told us how they travel. How people travel - on average across all three responses is as follows:

• 80% use a car or taxi – those responding had concerns about cost of parking or journey cost
• 35% use public transport - those responding had concerns about getting to early appointment, services not on bus routes, and the cost and convenience of travel for a long distance
• 20% had supported transport – for this service there were some concerns about access including wheelchair access and journeys on patient transport taking too long.
Travel and transport – focus group response
Those holding focus groups provided extra intelligence on travel and transport care services, people told us:

- I would travel as long as the service is good and I receive the appropriate care
- I will travel as long as I am seen at my appointment time or within 15 minutes of the time given
- Concerns that patient transport does not take wheelchairs other equipment to support independence on arrival at hospital
- Patients also need to get home safely, not just arrive in hospital safely
- A many services as possible should be within a 15 mile radius
- Journey times were exhausting, early collection, long journeys and the same again to return home, a full days travel to have a 10 minute appointment
- Travelling too far can make an illness worse
- People want to understand the risks of longer journeys
- Cost of travel and affordability needs to be considered on an individual basis – solutions to help people in these circumstances need to be put in place
- Parking charges should be exempt for people whose relatives are in hospital for a long period or with a serious condition or require over 2 weeks stay
- Services that can be close to home should be

3.5.6 Maternity and Paediatric

We received 835 responses to our engagement on maternity and paediatric services. The questions we asked were about the maternity services received in both a hospital and community setting. We also asked parents views on paediatric services. In addition we received a response to the engagement from 377 young people and parents just on paediatric services. In total we engaged with 1,212 people.

The key emerging themes from both the maternity and paediatric engagement and the paediatric engagement are as follows:

**Maternity services**

- People want to see staff who are highly skilled, professional, calm, compassionate and confident
- People want staff who are not rushed or stressed so they can give time to each individual
- People want to see the same staff throughout their pregnancy and where possible all the way through birth. This includes more midwife time after birth to support mums transition which would include the health visitor taking over
- People want as many services as possible closer to home and where they are not to have improved waiting and appointment times that fit around the needs of the patient
- Transport And travel are key including getting about in the latter stage of pregnancy and considering people who have other children and also don’t drive. Designated parking spaces with longer waiting allowances for parents
- More information and support before pregnancy to ensure the right choices for birth are made, including support for dads. Most people who had a home birth reported a
good experience but a lot of people did not understand what was on offer and did not feel informed enough about what this would mean

- More awareness and training for staff on the cultural view of home birth and also how to support families including same sex partners, adoptive parents and parents with a disability or long term condition
- Parents want to have good equipment in the right location with access to services if things go wrong – this included home birth transfers and access to consultants whilst in hospital
- The environment for giving birth was also important to people. People want a calm and clean space that is private and comfortable with lots of room and good nourishing food
- People want more support whilst in hospital including help with feeding and not being discharged
- too early
- For families who face complications or loss of a baby they would like separate spaces and entrances

**Paediatric services**

- Most parents want support to self-manage a child’s illness or condition. This was described as advice, information and drop in services or facilities where they can gather advice and guidance
- Parents want services close to home with limited travel time and have described their GP practice as their preferred contact point in an urgent care situation which has the right equipment and staff to deal with a range of urgent care situations
- Parents want access to a paediatrician when they visit hospital and to know their child is being seen by the right healthcare professional
- Parents want separate spaces for children, including child friendly environments with shorter waiting times where children can be seen straight away
- Children and young people want reassuring and understanding staff who communicate well in a non-patronising way, speak different languages and who understand mental health conditions
- Children young people want reduced waiting times in A&E, an environment with child friendly facilities such as toys and Wifi
- Children and young people also prefer the GP as the first point of contact in an urgent care situation and want to be seen straight away in services near to where they live or close to home on good bus routes

**Equality**

**Equality Findings: Maternity and Paediatric Surveys**

835 people completed the survey with most people partially or fully completing the equality monitoring form. To understand the representativeness of the data a comparison was undertaken against the local demographics. Calderdale CCG is co-located with the local authority so the data is compared to the 2011 Census. For
Greater Huddersfield CCG the data (in the most part) comes from the Census 2011 which covers the Kirklees local authority area, some data relates to South Kirklees and this has also been used. This means the data cannot be a direct comparison. Any notable or expected variations will be noted. For some equality groups we do not have local data available for comparison so national data will be referenced.

The two surveys were analysed separately regarding their equality data.

Postcodes
The respondents were from a geographical mix, but more Calderdale postcodes were collected, although 204 people left the question blank. It is important to ensure we garner opinions from across the hospital footprint.

Sex
As expected the majority of returns were from women as the survey targeted users of maternity services as well as paediatric services. 100 men completed the survey; 44 completed the maternity and 56 the paediatric survey. This is a relatively small number and while this could have been predicted we would want to know more about how men feel about potential service changes in the public consultation to ensure all impacts have been considered.

Themes from Maternity Section:

- Fathers / men wanted more information and classes, and to be more involved and feel included in the pregnancy and birth
- Privacy and confidentiality was very important to them
- Fathers / men wanted to be able stay at hospital to help with looking after the baby especially after traumatic births, more privacy and facilities for fathers at the hospital would help them to do this

Themes from Paediatric Section:

In relation to Urgent Care men rated these themes significantly higher than women:

- Knowing my child can be seen straight away by a healthcare professional - men
- Knowing I will see the right health care professional who understands my child’s condition
- Feeling safe

There were no significant trends for women.

Age groups

Respondents' from Maternity Section – Age
The age range reached in relation to the maternity survey 18 -24 is within the expected child-bearing age group. It would have been useful to get some views from younger people who have used maternity services, though from the equality data it is not possible to tell when someone used the service.

Respondents from Paediatric Section – Age
A specially designed survey was created for children and young people to elicit their views on paediatric services; however it is clear that some chose the complete the survey attached to this maternity survey (ages 6 – 60 completed this section). These children’s views will be collated alongside those from the paediatric survey to ensure they are considered in the right place.

**Ethnicity**

The respondents were mostly representative of the local population, with some notable exceptions; the ‘White British’ group was significantly under-represented, the ‘White Irish’, ‘White other’ and ‘other ethnic group’ slightly under-represented. All other groups were over-represented to some degree; with the ‘Asian/British Pakistani’ group significantly overrepresented. This will be the result of targeting population groups who are using maternity services.

Data shows that some communities use maternity services at CHFT more than would be expected from their population profile, such as Pakistani heritage women and ‘white-other’ women. (CHFT Maternity Reconfiguration Analysis, April 2014- March 2015)

We do not have data readily available for paediatric service users by ethnicity.

**Themes from Maternity Section:**

- Black African heritage women were unaware of or felt that they were not being offered home births as an option
- Some Indian, Bangladeshi and Pakistani heritage respondents expressed concerns about communication difficulties with community midwives. The respondents felt that because they didn’t speak English or spoke limited English the midwives did not understand them. They felt that they received the wrong or worse care because they couldn’t explain their needs. The suggestion was to recruit more bilingual staff, or staff from differing ethnicities who could communicate in other languages or provide interpreters. This would also be useful with regard to providing ante-natal classes in community languages
- A recurring theme from many of the female Pakistani heritage respondents was that homebirth was culturally inappropriate and considered unsafe
- Whilst the Indian heritage respondents highlighted not being given the option for homebirth which they would have preferred.
- Privacy and confidentiality were very important for the Chinese heritage respondents.

**Themes from Paediatric Section:**

- Black African heritage respondents were mainly using public transport
- Lack of use of interpreters or staff who spoke community languages was a concern for some Pakistani heritage respondents when their child was in a life threatening / urgent care environment. They felt this meant they couldn’t understand what treatment their child was having or may have implications with regard to informed consent if they didn’t understand what was happening.
Religion
To some degree the religion data reflects similar results to ethnicity, with significant under-representation of Christians and under-representation of those of no religion, with most other groups significantly over-represented.

Themes
There were no themes identified in relation to religion of respondents.

Disability
There is limited data available about the local population of disabled people. The census has 2 measures; ‘day to day activity limited a lot’ and ‘day to day activity limited a little’. These are used to provide a comparator to assess the representativeness of our sample.

<table>
<thead>
<tr>
<th></th>
<th>Day-to-day activities limited a lot</th>
<th>Day-to-day activities limited a little</th>
<th>Respondents ‘do you consider yourself to be disabled’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale %</td>
<td>8.2</td>
<td>9.7</td>
<td>4.6</td>
</tr>
<tr>
<td>Kirklees %</td>
<td>8.4</td>
<td>9.3</td>
<td></td>
</tr>
</tbody>
</table>

Themes from Maternity Section:

- Limited choice for women to give birth if they have a disability and usually not at home, a wider choice would be preferred
- That in particular for disabled women an “under staffed birth is really scary” There was also particular concern about staff being overtired and the risk this posed.
- Post-natal services need to be more advanced (patient centred) involving mothers/parents in decisions about what services they need and when they are no longer required
- More support for women who experience post-natal depression or who have pre-existing mental illness.
- Limiting patient information sharing on a need to know basis and respecting confidentiality
- Travel for disabled respondents was important to be kept within 15 to 30 minutes with more using public transport, access bus and volunteer transport only a few used patient transport

Themes from Paediatric Section:

- Not having transport or access to transport when trying to access urgent care for their child is a major concern for disabled parents. “I have to rely on others if I could be somewhere straight away I would”
- Rehabilitation services need to be accessible for both children and parents, concerns raised about services being placed in unsuitable buildings with poor access.
Sexual orientation

Of the respondents 5.3% identified as lesbian, gay men or bisexuals (LGB).

Sexual orientation is not included in the census so it is difficult to demonstrate a local picture, but the Integrated Household Survey, (Office of National Statistics), gave the following figures for the period April 2011 to March 2012:

- 1.1 per cent of the surveyed UK population, approximately 545,000 adults, identified themselves as Gay or Lesbian.
- 0.4 per cent of the surveyed UK population, approximately 220,000 adults, identified themselves as Bisexual.
- 0.3 per cent identified themselves as "Other".
- 2.7 per cent of 16- to 24-year-olds in the UK identified themselves as Gay, Lesbian or Bisexual compared with 0.4 per cent of 65-year-olds and over.

Anecdotally, Calderdale and specifically the Upper Valley is known to be the home of many LGB people so we would want to reflect this in the sample size.

There is a perception that many people chose ‘prefer not to say’ (8.1%) or skipped (36.4%) this question for a number of reasons reducing the number of respondents identifying as LGB.

Themes in Maternity Section:

- Fear of perceived homophobia in hospital for women who identified as lesbian: “I gave birth at home and this was really good for me as I have had bad experiences in hospitals and I think I would have ended up having unnecessary intervention at hospital. I was also scared of homophobia in hospital which I didn't feel would happen in my own home”
- Negative experiences for some women: “Visited the hospital and the midwife who showed us round, was really patronising and homophobic and told me I wouldn't be able to have a home birth with my first baby. She didn't acknowledge my partner, made inappropriate jokes and excluded me and my partner from what she was saying when we looked round. As a result I did classes with the NCT instead of the hospital and did everything I could to avoid contact with anyone at the hospital.”
- Training for staff is needed both for hospital and community midwives about LGBT families and their needs: “treat LGBT or non-traditional family models with sensitivity and understanding”.

Gender reassignment

One of the greatest difficulties in measuring or estimating the size of the Trans population is that no systematic or reliable data has been collected through the Census or through other Government-sponsored surveys. However in 2011 research by GIRES* concluded, organisations should assume that 1% of their employees and service users may be experiencing some degree of gender variance. At some stage, about 0.2% may undergo transition. The number who have so far sought medical care

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* GIRES (Gay and Lesbian Educational Support) is a UK-based charity that supports and provides information and resources to LGBT individuals and their families.
is likely to be around 0.025%, and about 0.015% are likely to have undergone transition. (*Gender Identity Research and Education Society, 2011) of the respondents to the survey 1.5% said their gender identity was different to the sex they were assumed to be at birth.

Pregnancy and maternity

Of the respondents 10.3% said they were pregnant or had given birth in the last 6 months.

Themes from Maternity Section:

- Women who were pregnant rated being able to have a choice of how and where they give birth much lower in importance than those who were not pregnant,
- Women who were pregnant also felt they often did not have a choice for a home birth due to lack of staff.
- Safety was also very important to pregnant women which may have been reflected in their responses.

There were themes that resonated for women who had given birth within the last 6 months and those who were currently pregnant, these were:

- Continuity of staff, with regular contact, regular check-ups, and good information which is easy to understand
- Sensitivity training for staff on how to deal with patients at emotional times, some midwives unable to be empathetic e.g. at bereavement, still birth, miscarriage etc.
- More Ante-natal classes, ante-natal exercise classes and parent craft in accessible places in the community held at times that are convenient to those attending
- “Bring back the home birth team for continuity of care. Feeling like you had a relationship with them before 25 weeks.”
- “Feeling like you had support in early pregnancy when you have history of miscarriage”
- Effective pain management and skilled, experienced staff who were not too tired or overworked
- Care Closer to home
- Bilingual staff and or language support and training for staff around diversity issues
- Breastfeeding classes and support: “Had to go to the breastfeeding cafe as my baby had tongue tie. They weren’t able to book me an appointment at the hospital so had to visit the cafe to book an appointment and had to wait two weeks to be seen. I had my baby at Huddersfield but a friend who had her baby at Halifax whose baby also had tongue tie was able to book an appointment via the hospital so got an appointment whereas I had to wait till I could get to the cafe myself to book the appointment and then had to wait.”
- Post natal support improved including support for post natal depression, exercise classes, drop-ins, emotional support, check-ups and home visits after birth.
• Discharge planning after birth if in hospital and easy to understand and clear information
• Access to right equipment, birthing pools
• Support for high risk pregnancies
• Support for partners and families regarding the birth/pregnancy
• Reduce waiting times for appointments
• 24/7 helpline for concerns or advice

Women who had undergone IVF, Caesarean section or high risk pregnancies felt that there was little or no support / understanding of the physical / emotional experiences they had undergone.

Travel:
• Respondents who had given birth in the last 6 months would predominantly be prepared to travel under 15 minutes and up to 30 minutes in a car or by public transport to receive maternity services
• Whilst those who were pregnant were in the majority prepared to travel only 15 minutes by car.

Carers
Of the respondents 9.3% identified themselves as carers, the 2011 census found 10.5% (Calderdale) and 10.4% (Kirklees).

Themes from Maternity Section:
• It is important to have staff listening to women and being aware of previous medical history – for one respondent their concerns had been dismissed and this resulted in her child being born with disabilities.
• Care closer to home and less waiting times for appointments
• More knowledge on dealing with babies born with special needs. Less pressure to have testing for things like Down Syndrome when parents decide not to.
• Sensitivity from staff when dealing with bereavement
• To provide support and guidance e.g. parenting guide and / or “someone available to give advice when needed give more information on parenting, parenting classes from NCT too expensive.

Themes from Paediatric Section:
• Being listened to by healthcare professionals and concerns taken seriously.
• Stress for parents with additional needs caused by unnecessary or lengthy travel: “Asking parents of children with additional needs to take on even more unnecessary stress by having to travel to another town for services that should be available locally.”
• GP was the majority first point of contact for carers unless emergency care was required for their child

Urgent care:
• “Consider disabilities i.e. autism loud noises bright lights can prove traumatic. There needs to be thought around the care in a hospital environment about the needs of children with these conditions and how staff deal with them.”
• “I'm happy with the provision for minor injury or illness, waiting times at the local GP surgery is reasonable. My concern is with the moving of many children's services from Huddersfield to Halifax. I have had occasion to call an ambulance for one of my children due to breathing problems and they had to be driven by ambulance to Halifax to be treated. This surely increases this risk for children in life threatening situations in the Huddersfield area.”
• Needs to be accessible. “Anyone with a poorly child will not want to have to travel further than necessary for that first point of contact. Then if prolonged stays in hospital are needed be aware of the impact on families having to travel to visit/stay/access treatment.”

Rehabilitation services:
• Access to regular therapy with a trained professional. “This is usually the problem at the moment - one of my children requires regular speech therapy, occupational and physiotherapy and it is difficult to get regular access to these services in the Huddersfield area.”
• Time when rehabilitation starts and gaps between the visits. “The waiting lists can be too long. Rehabilitation should go straight after the injury rather than in a year's time.”

Equality Findings - Paediatric Survey

379 people partially or fully completed the equality monitoring form.

Sex
There were more girls and young women who responded to the survey, 57%. Given an expected even use of paediatric services this would mean that boys and young men were significantly under-represented. This may mean further work may be required to understand the needs of this group.

Age groups
Respondents from Paediatric survey – Age
The survey was targeted at children and young people (age range 5 to 69) but it is clear that a number of adults completed the survey. 16.6% of the respondents who gave an age were over 18. Over 16% of the overall number of respondents did not declare an age.

The number of under 18s represented a significant over-representation of the population as should be expected as the survey targeted young people, however, a closer look at the data shows that the group reached were not representative of the detail of the age of the population. This demonstrates that the reach of the survey was to the over 10’s (of those who stated an age) and that the group who responded most were over 15. This would suggest that we still have a gap in understanding how children feel about paediatric services. Looking at the data further the majority of respondents were over 11. In the concurrent maternity and paediatric survey some children and young people responded to the paediatric survey, with 66 responses from under 18s.
Themes:

When looking at the themes by age range 5 to 18 the key themes identified were:

- Feeling safe and being seen quickly
- Having toys to play with and not waiting round in hospital / A&E
- Not having to travel far
- Having parents with them
- “To have someone understand my mental health issues”

Ethnicity

In terms of representation, ‘White British’ children and young people were underrepresented; this in part will be due to targeting voices from particular communities who have historically not been heard. While the number may not reflect the percentage in the local population they still make up over 40% of the views captured so their voices have been heard and reflected in the engagement feedback.

Notably the survey was completed by an over representation of ‘white other’, this may be the result of reaching new European communities. Other communities overrepresented compared to the expected population are; children and young people of Pakistani heritage however are significantly overrepresented.

Themes
There were no significant themes that could be identified in relation to ethnicity.

Religion

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<tr>
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<th>Islam</th>
<th>Hindu</th>
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<td>0.6</td>
<td>2.6</td>
<td>34.4</td>
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</tbody>
</table>

The range of religions reached reflects the same patterns as ethnicity, with some groups significantly overrepresented and some under.

Themes
There were no significant themes that could be identified in relation to religion.

Disability
There is limited data available about the local population of disabled people, the census has 2 measures; ‘day to day activity limited a lot’ and ‘day to day activity limited a little’. These are used to provide a comparator to assess the representativeness of our sample.
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**Themes**

**Emergency care:** Respondents ranked these as themes being significant to their experience of services for children and young people.

- Knowing I can be seen straight away by a healthcare professional
- Knowing I will get the treatment I need
- That there was a need better adolescent mental health services, “CAHMS are diabolical” and “there needs to be a better system in place for adolescent mental health services faster response and more on call medical support.”
- Confidentiality for young people aged 16 plus was very important
- Care closer to home “making me feel comfortable and not going further away and being treated in my home town where I am raised” and “keeping it local”.

**Urgent care for a minor injury or illness:**

- To be seen straight away was particularly important

**Travel:**

- 15 – 30 minutes by public transport was considered acceptable
- Concerns were raised about not attending hospital because it cost too much to travel, that for some it took 2 buses to get to hospital or that parents had to use a taxi that they couldn’t afford because it was a Sunday and there were no buses running.(A&E)

**Rehabilitation services:**

- 73 % of respondents wanted this to be at a GP practice
- Being fully informed and understanding what’s happening was very important as was not being patronised and being involved in making decisions about their own care

The majority of respondents who identified as disabled were from the Huddersfield area.

**Sexual orientation**

Of the respondents 9.7% identified as lesbian, gay man or bisexual (LGB). Lesbian (3.9%), Gay (0.3%) and bisexual (5.5%)
Sexual orientation is not included in the census so it is difficult to demonstrate a local picture, but the Integrated Household Survey, (Office of National Statistics), gave the following figures for the period April 2011 to March 2012:

- 1.1 per cent of the surveyed UK population, approximately 545,000 adults, identified themselves as Gay or Lesbian.
- 0.4 per cent of the surveyed UK population, approximately 220,000 adults, identified themselves as Bisexual.
- 0.3 per cent identified themselves as "Other".
- 2.7 per cent of 16- to 24-year-olds in the UK identified themselves as Gay, Lesbian or Bisexual compared with 0.4 per cent of 65-year-olds and over.

Anecdotally, Calderdale and specifically the Upper Valley is known to be the home of many LGB people so we would want to reflect this in the sample size.

There is a perception that many people chose 'prefer not to say' (8.1%) or skipped (36.4%) this question for a variety of reasons reducing the number of respondents identifying as LGB.

**Gender reassignment**

One of the greatest difficulties in measuring or estimating the size of the Trans population is that no systematic or reliable data has been collected through the Census or through other Government-sponsored surveys. However in 2011 research by GIRES* concluded, organisations should assume that 1% of their employees and service users may be experiencing some degree of gender variance. At some stage, about 0.2% may undergo transition. The number who have so far sought medical care is likely to be around 0.025%, and about 0.015% are likely to have undergone transition. (*Gender Identity Research and Education Society) of the respondents to the survey 2.2% said their gender identity was different to the sex they were assumed to be at birth.

**Pregnancy and maternity**

Of the respondents 12.1% said they were pregnant or had given birth in the last 6 months.

**Carers**

Of the respondents 11.2% identified themselves as carers, the 2011 census found 10.5% (Calderdale) and 10.4% (Kirklees).

**Themes:**

**Emergency Care:** Respondents identified these themes as being important to them:

- Reducing waiting times
- Knowing I can be seen straight away by a healthcare professional
- Knowing I will get the treatment I need
- Feeling safe, this was particularly important for children and young people aged 5 – 18 age group
Minor injury or illness: Respondents age range 5 - 18 told us that:

- More likely to go to GP but less likely to ask family or friend
- More likely to ring 111
- Speak to their Teacher or their mum/parent

Travel:
- Travel needed to be under 15 mins by Public transport

It was very important for young people and children to have care and treatment provided by someone who understands and lets you speak too and that treatment was available closer to home. A theme throughout was that mental health support needs improving for young people and children.

3.5.7 PALS, Patient Opinion and Complaints
During the reporting period March 2013 to August 2015 we reviewed 663 Patient Opinion comments (see appendix 5.6) and 400 PALS enquiries (see appendix 5.7) for both Calderdale and Greater Huddersfield. Of the comments received the findings were analysed and the key emerging themes are set out below.

- Lack of interpreters for hospital visits and support for gender reassignment
- Lack of coordination between hospital services and GP practices resulting in delayed appointments or treatment
- Confidentiality and how information is shared including the wording in letters to patients which are not always clear
- Waiting times for referrals and treatment
- Hospital appointment being cancelled on the day or at short notice
- Availability of GP services for urgent appointments
- Managing medication and support with long term conditions
- End of life care including the treatment for patients and support for families
- Delayed diagnosis of conditions including ‘Asperger’s and Autism’
- A number of complaints regarding mental health services
- A number of complaints about wheelchair services

3.5.8 Equality
The pre-engagement consisted of two separate activities; a survey and focus groups. In terms of equality these will be reviewed separately. Consideration will be given to whether the sample is representative of the local community and whether any trends or themes emerged that relate to protected groups.

Focus Groups
In July and August 2015 local groups hosted a number of discussions in Calderdale. By being hosted by local groups the engagement activity was able to target people who may often be ‘missed out’ or unable to engage with traditional methods of engagement to share their views. 24 discussions were held across a number of focus groups (see appendix 5.8) for details.

Using the records from each focus group the following themes from protected groups have been identified.
Age
- It was strongly felt that no assumptions should be made about the availability of older people, particularly with respect to booking patient transport a long time in advance of the appointment.

Disability
- Location of services was noted as important to consider – the area has many hilly areas which can be inaccessible for people with mobility impairments. Accessibility should be considered in a wider context than the building itself.
- More training for hospital / ambulance staff on mental illness, physical and learning disabilities as understanding among clinical staff was 'patchy'.
- Changes to services can have a particular impact on patients with rare conditions requiring specialist knowledge. Patients / parents were prepared to travel for specialist services.
- An example was given by a parent with problems on the new personal budget arrangements for their child. Senior nurse questioning an occupational therapy report, delaying access to treatment. New reforms need to be properly co-ordinated ensuring different bodies / branches of NHS / Education / Social Services are working together.
  - Specific comments re service delivery related to disability:
    - Hospital food should cater for people with allergies or special dietary requirements.
    - A wheelchair user was not aware of the easy access Dental Suite in Todmorden and was using a dentist in Halifax that he could access. The learning from this is that information about accessibility of services needs to be well communicated.
    - Access to wheelchair friendly transport, many wheelchair users require a carer to accompany them, consider whether wheelchair accessible travel is available after 5pm
    - ‘Disability equipment’ (e.g. wheelchairs and other mobility aids) should be transported with the patient both too and from the hospital / point of care. This was important for the dignity and independence of the patient. It was noted that currently separate transport for equipment was needed for homeward transport.
    - The Butterfly Scheme for patients with Dementia was referred to as a way of significantly improving the experience of patients and carers.
    - Call button needs to be within reach of patients, especially those with disabilities

- Mental health-related issues / issues raised by mental health engagement focus group:
  - Self harm injuries needing stitches – go to A&E as nowhere else to go
  - Staff attitude (kind, caring and helpful) is particularly important
  - Need to be able to see someone straight away in an emergency
  - Important that clinician understands the person’s condition
  - Feeling safe is very important
  - Prevention and a person centred approach are important. Many health problems caused by poverty and can be prevented
  - People with mental health problems may find it particularly difficult to get from one place to another, therefore transport should be provided
- Cancellation of appointments for has a particularly negative impact on a person’s mental health
- Concern about using technology as worried about data security
- Post crisis / admission treatment must be easily accessible to ensure rehabilitation

- Child Adolescent Mental Health Service (CAMHS) hard to access (Tiers 2 & 3), lack of children’s counselling / group therapy services. Parent felt let down by CAMHS service.

- Issues raised through engagement with Deaf people:
  - Very important to have access to BSL interpreters (NRCPD qualified – check)
  - Would like to be seen by a person with expert knowledge, not too far away from home (no more than 30 minutes away where possible).
  - Hospital / other patient records need to flag up BSL interpreter need so that this can be booked in advance
  - Confidentiality is important
  - Would like to be with a member of family / friend to help fill in forms on admission
  - Communication via text improves accessibility for deaf people, being able to make appointments and getting reminders.
  - Deaf people would prefer face to face contact for appointments
  - Deaf awareness training to be provided to all NHS, including CCGs, frontline staff of all medical service providers
  - Would prefer all Deaf rehab services (e.g. gym / swimming groups), this aides communication and may speed up the rehabilitation process

**Ethnicity**
- Many said that their English language skills were limited; therefore they needed access to an interpreter, and were not confident that they would get this in services not provided by the hospital.
- They also said that this needs to be taken into account when providing information about services and making some services online, many were concerned that not being able to speak English would have a significant impact on accessing service.

**Religion or belief**
It was suggested that the CCG sets up engagement events in partnership with local mosques and churches.

**Pregnancy or maternity**
- Concerns were raised about the location of maternity services (raised by BME focus groups)

**Carers**
- Travel and parking was raised as an issue. Carers said that parking concessions are important and that carers can be restricted from travelling further away.
- Relatives / carers would appreciate parking concessions if patient has a longer stay in hospital.
● They also said that they may need same day appointments due to the unpredictability of when they had time to themselves.
● The loss of walk-in centres was particularly felt by carers who said this gave them the flexibility to manage both their health and those they were caring for better. They suggested practices offering an hour a day of drop-in slots for patients.

General issues raised:
● Anger and concern at the prospect of closing A&E
● It was noted that take up and effectiveness of services will be limited if accessibility is not considered in its wider sense.
● There are many excellent services in Calderdale, e.g. Neighbourhood Schemes, Hope Recovery College.
  ○ “However, if you can’t use public transport and don’t drive, there is no way to get to them without using expensive taxis. The people who would really benefit from them cannot afford to travel to them. So, unless Care Closer to Home addresses this issue, the take up and effectiveness of those services will always be limited.”
● People thought the change would particularly affect children, older and disabled people
● Concerns about the quality of new services in terms of equipment and staff training
● People wanted greater representation on decision making bodies and also wanted to see decision makers at community engagement events.
● There was a lot of concern that A&E would no longer be available and questions raised about the provision of specialised equipment and skills in more localised services
● Many people wanted more information about what happens next and what other changes are being planned
● Rehabilitation services were felt to be lacking in Calderdale
● More holistic approaches to care were needed, e.g. offering reflexology, acupuncture, massage etc. Focusing more on the cause of illness rather than just trying to treat the symptoms.
● Those who had used online other tech services did not have a good experience and had to call in to the surgery anyway – example given re not being able to co-ordinate multiple meds prescriptions online. Also relies on a good broadband / Wi-Fi connection
● Hospital transport was noted as particularly requiring improvement, with very long journeys involving many stops that could mean a hospital appointment resulting in a pick-up at 9am and a drop off as late as 7pm. This could have a particular impact for patients with diabetes who need to eat regularly.
● There should be more awareness of self-help / prevention techniques
● People still not familiar or confident with 111 service
● Cancellations of procedures creates a lot of stress for patients and carers which has a big impact on patient’s and carer’s wellbeing
● It was noted that if someone has a bad experience using one avenue for treating minor illness or injury they would go somewhere else next time. Therefore it is important that appropriate services provide patients with a good experience
● More local minor injury services needed
- Text reminders are good, but the information needs of each patient should be taken into account (in line with Accessible Information Standard)
- Planned minor surgery is better at GP surgery than the hospital in terms of ease of access, location and parking
- Will new services be available at weekends and after hours?
- Many people noted that they liked text reminders and are happy to use online services, e.g. Skype consultations

In terms of equality monitoring we received 79 data capture forms from people who attended focus groups (see appendix 5.9). Unfortunately these were not attached to the responses so we cannot identify trends from the focus groups.

The forms do not reflect the diversity of the groups who were engaged as not all groups’ submitted equality monitoring forms so it is difficult to measure the representativeness of the population reached.

**Surveys**

292 completed equality monitoring surveys were received (see appendix 5.10). To understand if the survey reached a representative sample of the population an analysis has been undertaken contrasting the data with data from the 2011 census. This is included in detail (see appendix 5.11).

Some data is not reliably available through the census or other sources.

**Representation**

Following consideration of the previous Right Care, Right Time, Right Place engagement activity which supported this pre-engagement it became apparent that some groups were underrepresented. The pre-engagement looked to address some of this disparity. The main areas of concern were related to Greater Huddersfield where there were previously fewer respondents. Other areas of concern were age, religion and ethnicity. The survey managed to reach the same number of residents of Greater Huddersfield as Calderdale, although Greater Huddersfield has a slightly bigger population. The focus groups were only undertaken in Calderdale. Following the analysis there are still gaps in the representative sample for age with those under 55 less well represented with children and young people not represented as they will be engaged separately. Some of the gaps in terms of ethnicity and religion have been addressed, though Christians and white British groups remain underrepresented.

**Calderdale**

The surveys were successful in reaching communities who have often had less of a voice in engagement or who are seldom heard, for example certain BME communities, people with disabilities and carers. However, this has resulted in White British and Christians being under-represented. In terms of age there is under-representation for all under 45 year olds, with no under 16’s engaged, and ages up to 75 are over-represented.

**Greater Huddersfield**

The surveys were successful in reaching communities who have often had less of a voice in engagement or who are seldom heard, for example certain BME communities, people with disabilities and carers. However, this has resulted in White British and Christians being under-represented. In terms of age there is under-representation for
all under 55 year olds, with no under 16’s engaged, and ages over this are over-represented.

**Trends**
Analysis of the content of the survey was undertaken to note any significant trends, due to the small number of respondents there were very few trends identifiable. However those that were noted are detailed below.

**Minor injuries**
In terms of minor injuries women were much keener to prioritise ‘see/speak to the person I want to see’ than men. Carer gave a higher priority for ‘walk-in’ centres compared to those with no caring responsibilities.

**Planned Hospital admissions**
Women were much more likely to prioritise ‘To know I can plan my life around my appointment – that it’s at the time specified’ than men. Carers were also more likely to prioritise ‘To know I can plan my life around my appointment – that it’s at the time specified’ than those without caring responsibilities.

**Travel and transport**
To access minor injury services women were more likely to use a car than men and men were more likely to use taxis than women. Men were more likely to prioritise travelling less than 15 minutes than women to receive the right services. Disabled people were more likely to use patient transport and taxis than those without an impairment that were more likely to use cars.

**3.5.9 Stakeholder event 1 – August 2015**
NHS Calderdale CCG and NHS Greater Huddersfield CCG held two events, hosted in each locality in August 2015. The events were part of a planned approach for pre-consultation engagement, with the primary aim of listening to stakeholders. In addition the events were set up to:

- Provide an update on the journey so far for Care Closer to Home and Right Care, Right Time, Right Place (Hospital services Programme)
- Present the findings from the engagement activity since March 2013 to the present date
- Sense check the findings from the engagement and give stakeholders an opportunity to comment further
- To explain the next steps including stakeholder event 2, which will be a joint event
- To use the findings to help shape the options likely to be considered for formal consultation

In addition it was to ensure the CCGs have listened to and gathered all the points of view we need to consider from staff, patients, carers and the public to further develop our plans for ‘Care Closer to Home’ and ‘Right Care, Right Time, Right Place’.
NHS Greater Huddersfield CCG held an event on Wednesday 19th August 2015 from 1-4pm at the Textile Centre, Huddersfield. In total 64 people attended the event. NHS Calderdale CCG held an event on Thursday 20th August 2015 from 3-6pm at the Shay Stadium, Halifax. In total 100 people attended the event.

The joint key messages which have emerged from both stakeholder events are set out below. Most replicate what we already know and there were very few additional concerns that have been highlighted that we are not already aware of. The key messages are:

- A need to communicate our plans to the wider public, explain our reasons clearly and in plain language and be honest about our constraints and resources.

- That Care Closer to Home is the way forward and some progress can be seen, more should be done to demonstrate it is working, again more publicity.

- The public want to stay involved in the development of any plans and want us to improve our engagement to ensure everyone has an opportunity to influence services in the future.

- There was a general consensus that change needs to happen, but the pace of change is slow and we need to evidence why change is necessary to wider audiences.

- Travel and transport need to be considered as part of Care Closer to Home as much as hospital services and we need a plan to address this.

- Partnerships need to be strengthened we need to show we are working with colleagues from the local authority, ambulance service and the voluntary sector to ensure our plans work.

- We have a diverse population and we need to consider all our population when designing new services, current services still don’t address patient needs in terms of access, culture, information and communication.

- Workforce skills and capacity, estates and new technology are all highlighted as key areas requiring thorough consideration if models are to be delivered.

3.5.10 Stakeholder event 2 – December 2015

NHS Calderdale and Greater Huddersfield CCGs held the final stakeholder event on Thursday 10th December 2015 at Cedar Court, Ainley Top, Huddersfield. The event was part of a planned approach for pre-consultation engagement. The aim of the event was to:

- Provide an update on the journey so far for Care Closer to Home and Right Care, Right Time, Right Place (Hospital services programme)

- Present where we are up to with the clinical model and discuss and hopes and fears
• Present the appraisal criterial, how it has been developed and used and to engage with key stakeholders further
• To explain the next steps which includes plans for formal consultation
• To use the findings to help shape the options likely to be considered for formal consultation

In addition it was to ensure both CCGs have listened to and gathered any final contributions from key stakeholders.

The events also provided an opportunity for managers and clinicians to engage with key stakeholders as part of a table discussion to deliberate over the findings from the engagement activity and ensure any additional comments and considerations were captured as part of this process. The event was a joint event for both Calderdale and Huddersfield. In total 102 people attended the event. The key messages from the stakeholder event are summarised below.

The key messages include feedback from all activities including the comments clothes line, postcards and evaluation form. The messages are:

• In general people agreed with the appraisal criteria used. Additional considerations were captured that added value to the original description. There were only a few recommended changes
• The ranking of the criteria proved difficult with most tables agreeing that all were equally important. However the highest ranked criteria was ‘Quality of Care’ followed by either ‘Access to Care’ or ‘Value for Money’.
• The feedback received about the event was positive, with most attendees feeling they had been able to follow the journey.
• There was a general view that engagement had informed the plans and this was evident in the work that had been presented
• GP Practices and community services need to be working, joined up and coordinated with better appointment times and longer 24/7 access
• There were concerns that the plans would not deliver what was needed including the right staff with the right skills in the right locations
• Support for mental health and the services required needs to be considered as part of any transformation plan
• People need to understand how services currently work and what they will look in the future to be able to fully consult on any future service options
4. Appendices: section 2

4.1 Call to Action

Location: Calderdale

When the engagement took place: October – November 2013

Who led the engagement: Yorkshire and Humber Commissioning Support

Who was involved: Voluntary and community groups, Calderdale Health Forum, members of the public and people with a learning disability

Number of people engaged: 280

What the engagement involved:

A survey, available online and in paper format, was sent to voluntary and community groups, the Calderdale Health Forum and was available on Calderdale CCG’s website. Staff engaged with people with a learning disability at the ‘It’s My Health’ event and used an easy read version of the ‘Call to Action’ survey to gather feedback.

Two training sessions were arranged so that voluntary and community groups could become trained on community assets for the delivery of engagement; they were asked to deliver ‘Call to Action’ conversations as part of the training.

There was also the opportunity for local areas to respond to ‘Call to Action’ using film; this was hosted at a community venue in Ovenden, Halifax.

The ‘Call to Action’ asked members of the public to give their views on four broad but fundamental questions:

- How can we improve the quality of NHS care?
- How can we meet everyone’s healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

The findings are summarised in ‘Call to Action: Engagement Report for Calderdale CCG, January 2014’.

Key themes:

- All information from the NHS should be available in easy to understand formats and use a variety of different methods to reach the appropriate audience.
  - There needs to be more information about how to maintain health and wellbeing and how to avoid preventable conditions.
  - There should be more information on the services available and how to access them.
  - Education courses should be available for specific conditions and general health and wellbeing, preferably delivered by people with the condition themselves to provide peer support.
  - Education on diet, nutrition and lifestyle especially health eating and cooking skills should be available in public places through free classes in the community.
  - More education and information should be available for young people, starting in schools and Sure Start centres.

- Investing in community and primary care, as well as local community and voluntary groups that provide support for local people with health conditions.
• Utilise youth clubs and community centres, put services in existing community buildings, and identify community representatives.
• Give communities choice and control by talking to them and listening.
• Engage with work places in the local area.
• Look at transport, getting about in the area and parking.
• Reduce isolation and inequalities in health.

• Calling for changes to be made on a national scale to preventative health initiatives.
  o Changes should be made by government, such as charging for unhealthy lifestyles such as high taxes on sugar, junk food, alcohol and smoking to help subsidise healthier lifestyles.
  o Campaigns are needed to raise awareness of exercise and healthy food options.
  o There should be an acknowledgement that society needs to change, rather than relying on the NHS.

• Encouraging self-management of health conditions is very important.
  o Respondents used the term self-help, self-management (manage) or ‘helping people cope’ to cover self-care.
  o To patients this includes care that is personalised with the support of specialist staff; access to support groups with clinicians attending; places where you can drop in to get advice, support, assistance and equipment in the local community; courses on self-management, nutrition, prescribed exercise; involvement of wider networks such as carers and families; community assistants, champions and buddy schemes; advice and helplines available 24/7.
  o There is also a need to offer ‘Self Care’ to those who are not unwell and those who have caring responsibilities to ensure that they don’t become unwell. This could be through well-being courses for the community, or breaks and support.
  o It’s useful to encourage people to form relationships with local pharmacists to manage medication.

• Improving access to health services.
  o This included opening times and appointment availability, particularly aimed at GP practices and primary care.
  o Provide services on varying days and times.
  o Increasing awareness of access issues for all staff, especially around disabilities.
  o People with a long term condition would like to access their services through one point.
  o Some people need longer appointment times, so more time can be spent listening to the patient.
  o Improvement should be made to home visits, GP services should be more available in community settings.
  o Reducing waiting times for appointments and change the booking system
  o Making appointment available in the evenings and at weekends, and ring fence appointments for people who work.
  o Employing the right staff who can communicate in the right language or format, and having specialist staff working in GP practices

• Training staff including changing the culture of the NHS, communication and transparency.
  o Train all staff, including medical and administrative, to change the culture of the NHS, to make the NHS transparent at all levels.
• Improve communication with patients and ensure they understand their condition and treatment options and are able to make informed choices about their own care.
• Recruit the right staff that represent the language and culture of the local population.
• Train specialist staff (or have a matron lead) who understand different disabilities and mental health.

• Working together, across all agencies, not just health, to improve health and wellbeing.
  o Joint teams that are managed centrally, not just teams that work together.
  o Sharing of information and the ability to access a shared, patient owned record for those that need to.
  o All public services should have a remit to improve health and wellbeing.
  o Third sector should be an equal partner.
  o Utilise community assets and work with local communities on tackling inequalities and wider determinants of health such as housing.

• Providing regular check-ups, including annual check-ups or possibly more frequent depending on the age and condition, for everybody.
  o Patients should be offered a wide variety of health and wellbeing checks, many people described this as an MOT or health review, and more routine scans and screening.
  o There should be a call for more targeted check-ups for those groups at particular risk.
  o Early diagnosis can ensure early intervention including self-help.

• Improving hospitals and discharge planning.
  o There is a need for more staff in hospitals, respondents feel hospital services are under resourced.
  o Hospitals need to be clean and serve nutritional food to support recovery.
  o Bringing hospital services into community settings.
  o Ensure that when people are discharged they have a robust plan that is backed up with a health and social care services, available 24/7.
  o Ensure patients are fully recovered before they are discharged.
  o Assign a professional to keep regular daily contact in the first week, fund and use local VCS organisations to support the individual.
  o Train and support carers in their duties so they can manage.

• Importance of keeping people safe when they were unwell, managing risk and safeguarding.
  o Increasing community staff and regular house calls, whilst making sure that people have named key workers who consistently provide them with care, to provide more emotional and social support at home.
  o Prevent isolation through regular contact with the local community, offering good sheltered housing with wardens and more health visits for vulnerable families.
  o Providing more nurses on medical elderly wards.
  o Make sure interpreters are available so people can understand information.
• Offering more services in the community.
  o The public would like to see more staff working with and supporting local people in their own home and community, including health assistants, social workers and nurses, offering better quality home care.
  o There should be better access to equipment to use in your own home, and more day care and respite care for carers.
  o Nursing and residential care need to be affordable.

• Using technology better and investing in future technology, especially for monitoring and sharing information between services and patients.
  o Understand that things that are working should be left.
  o Educate people through social media, and consider using Apps to support people.
  o Make sure people can access training to use computers and Apps, and offer access to technology for those who do not have a computer.

• Ensuring that providers are accountable for the quality of the care they are providing.
  o There should be clear ways of measuring quality of care in all settings.
  o People should be aware of their rights and responsibilities as patient, so they know what they should expect and find it easier to report incidents.
  o The process for giving feedback should be accessible for public and staff, and there should be learning from mistakes and listening to peoples complaints and problems. This would improve openness and transparency.
  o Treat everyone equally and fairly, consider equality.
  o When contracting at scale, using money wisely and basing decisions on research and guidance i.e. NICE

Equality issues:
Specific feedback was received from some groups:
• People with a learning disability
  o Appropriate information and practical sessions to raise awareness, educate and promote healthier lifestyle choices i.e. healthy eating, exercise, smoking, alcohol.
  o Ensure all information is accessible and easy to understand for all the population.
  o Ensure ALL staff have 'Learning Disability' awareness training.
  o Encourage support mechanisms for elderly and vulnerable people.
  o Ensure information and resources are shared between services to help them work together better for the patient.
  o Make accessing healthcare easy, which will help everybody.
  o Communicate better with patients and be more open about decisions.

• People with a disability
  o Sometimes hospitals find it hard to care for disabled people, so there should be a focus on the problems that disabled people face when staying or visiting hospitals
  o Also, focus on disadvantaged groups and encourage better access to healthcare
  o Provide information in accessible formats for people with disabilities
  o Have a link between disability and different cultural groups
  o Could a forum be established to raise concerns with health professionals?
• Older people with dementia
  o Some fear that diagnosis always comes too late for dementia.
  o Help people to retain their independence through more social interaction and stimulation and getting to know them properly, not just drugs.
  o Staff should be dementia aware so they can properly support the individual, but support should also be offered to carers and their family, as they often need a break.
  o GP’s should be more involved in prescribing creative art sessions

• Women
  o Make GP surgeries more accessible with specialised GP services for women and female GPs. These services should be available extended hours, in evenings and at the weekend, and over the phone and online, to make accessing an appointment easier. The appointments should be longer than 5 minutes. They should be aware of their right to ask for a home visit from their GP.
  o Improving the information and communication with vulnerable groups and more communication between reception staff, doctors and nurses. Spend more time listening to patients.
  o Find new ways of reaching people who find it problematic to go to the GP’s.
  o Do more outreach work and have GP’s stationed in Children’s Centres, Women Centres etc… as well as walk in centres. This should include making specialist services more available in the community, such as breast and cervical screening programmes.

4.2 Care Closer to Home - Stakeholder Event December 2014

Location: Calderdale

When the engagement took place: December 2014

Who led the engagement: Yorkshire and Humber Commissioning Support

Who was involved: Various stakeholders; local councillors & MPs, Healthwatch Calderdale, GP Practice Patient Reference Groups, The Third Sector, Right Care, Right Place, Right Time Reference Groups, Clinicians and staff from a number of local health and social care organisations

Number of people engaged: 79 people attended the event

What the engagement involved: One engagement event including presentations about progress around Care Closer to Home and table top discussions about self-managed care and developing a single point of access, summarised in ‘Care Closer to Home’ Report of Findings – Stakeholder Event Thursday 4th December.’

Key themes:
• Providing clear information with choice at the right time in the right place.
  o This means offering a consistent, reliable and accessible way of accessing information about available services, which should be available online and in other way to meet the specific needs of elderly people, young people, disabled people, carers, etc…
  o Professionals have a role to play in making sure people are signposted to other services or to a central resource to find information appropriate to them, or offering that information themselves.
  o The information provided should cover health, social and mental health care services, plus those in the voluntary and community sector.
Giving patients more options for their care can help to facilitate self-care by allowing people to choose their own path, and offering options tailored to their needs.

- Being able to access community services that are closer to home and are available to them 24/7.
  - This includes access to a 24/7 Single Point of Access, to localised community health services, and to primary care services.

- Joining up services and sharing information with health and social care organisations and the third sector so people only have to tell their story once.
  - Attendees at the event felt this could be achieved through providing a single point of access (SPA) from which people can be referred to and get access to other services. Being referred to a service should be simple for the patient as this central information point will hold your information.
  - Creating a healthcare system that is patient-centred and multi-agency means patients will be supported and treated as an individual rather than their specific conditions, which people felt would be beneficial to care.
  - This includes a shift away from the medical model of care, enabling voluntary and social care partners to make a greater offering to support people and meet their needs.
  - It’s essential that patients do not feel they are being pushed from pillar to post and have to tell their story again and again to different clinicians.

- Increasing access to health services through variety of methods for example over the phone, face to face, through technology and the internet.
  - When discussing the SPA, people felt this should be fully accessible and inclusive, enabling digital, telephone and face to face access and be available 7 days each week.

- Accessing support and advice from fully skilled and trained workers and acknowledging that patients and carers could also be up skilled and trained.
  - It’s important in the delivery of any health care service, to employ the right people who ask the right questions and be able to retain them. This helps people to feel that they are being well cared for and that they can trust the advice they are being given.
  - The initial contact that people make with services needs to be with an intelligent and skilled handler, not a ‘robot’.
  - Patients and carers are often best placed to explain what it is that they are looking for from services, and to offer support to others in similar situations, for example, through peer mentoring.

- Developing a properly resourced, detailed plan with a clear purpose for the service so changes work right first time.
  - It’s important to look at what similar services already provide, and what has worked well or not so well, and learn from that.
  - Make sure that new initiatives offer top class advice and use up to date technology to ensure their success.
  - The plan to offer care closer to home is very ambitious and utilises fresh and interesting ideas, but it is important to consider the cost implications of these things and make sure that they can be properly resourced from the beginning.
Equality issues:
The engagement event was largely attended by people who are White British, more attendees were women than men, and most people were aged over 40. It is difficult to use this feedback to assess the impact of changes or preferences of people from groups that were not represented.

4.3 Care Closer to Home – Stakeholder Event March 2015
Location: Calderdale
When the engagement took place: 4th March 2015
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Staff, representatives from key stakeholders including local councillors and MPs, Healthwatch, GP practice patient reference groups, the third sector, clinicians and staff from local health and social organisations
Number of people engaged: 8 to 10 people with a facilitator per activity (two activities in total)

What the engagement involved:
A stakeholder event took place at which attendees held two table top discussions:

- Activity 1: A discovery session where groups of 8 to 10 people discussed when care was at its best, when they felt inspired, what strengths they bring to the organisation, how they would like Care Closer to Home to be

- Activity 2: Each participant wrote their frustrations and dreams for the future. These post-it notes were then produced into a piece of graphic artwork with key messages.

Key themes:
- Providing services closer to home, delivered by the right, well trained staff in the right setting.
  - Care closer to home needs to be “rock solid” in order to make changes to the way that services are provided.
  - Increasing nurse prescribers and community matrons who can help to provide and support more complex care in people’s homes.

- Considering transport networks including parking in addition to the best use of estates and community buildings that may offer bases for staff or provide an opportunity to deliver services closer to home.
  - Patients wish for improved transport services and better parking.
  - There needs to be more services based in community buildings and schools (like neighbourhood schemes, outpatients, diagnostics and third sector) which can be closer and more accessible for the public.

- Delivering a model of care that reflects the diverse population and is not ‘one size fits all’ for those who are more vulnerable and require different approaches and support – young people and those with mental health problems and substance misuse were a particular focus for specific plans to address issues.
• Being mindful of cultural differences and reducing health inequalities, by accepting that we are all different with different needs and no “one size fits all” approach could possibly meet all the different needs.
• It’s important to look at creating a group to look at alcohol abuse across Upper Valley, where this issue is more prevalent than people think.

• Including all sectors in key roles in developing and delivering these services at a local level in a variety of community settings in a coordinated way.
  o There should be a co-located network of care centred on the client/patient with all organisations involved working together to get their care right. The co-location could be physical or virtual.

• Ensuring the right skill mix across the work force and that staff work holistically and seamlessly together.
  o Patients want to see multi-disciplinary teams in hubs providing joined up services which are seamless, with different organisations working together as teams.
  o There should be one key person involved in each individual’s care that would co-ordinate their care.
  o There should be no more silo working, service and staff need to be more joined up, with better integration of services.

• Delivering a single point of access which included information sharing, and involving GP practices as a more central part of the community model.
  o People want to see multi-disciplinary teams, joined up, centred on each practice, offering a village model for the way services are provided.

• Continuing to involve stakeholders in making decisions about future services.

• Improving the communication and information on offer throughout the system so patients know what’s available to them and how to reach those services.
  o Better communication and greater clarity in communication is needed with patients.
  o Communication between services could be improved and more effective between agencies, particularly health and social care.
  o There should be some positive messaging about local services being there to support people.

• Supported self-care and prevention was less of a key focus than it was for the public but it still received a mention.
  o There was an acknowledgement that people needed to be supported to self-care.

Equality issues: No information
4.4 Care Closer to Home – What is it and what does it mean for the voluntary/community sector?

Location: Calderdale

When the engagement took place: 1st April 2015

Who led the engagement: Calderdale Clinical Commissioning Group, Calderdale Council, Voluntary Action Calderdale (VAC) and North Bank Forum (NBF)

Who was involved: Representatives from voluntary and community sector organisations and the public sector

Number of people engaged: 121 delegates

What the engagement involved:
The stakeholder event was made up of a combination of presentations, table top discussions and a question and answer panel.

Key themes:
- Making full use of voluntary and community sector partners can be beneficial in a variety of ways.
  - Utilising their knowledge of localities, communities, networks, cultures, needs, and barriers, gained through grass roots experience, and the relationships and trust the community has with them.
  - Communicating at a local level through the organisations’ networks and tools.
  - Identifying harder to reach groups and involving those who are not engaged, such as those who are isolated and lonely, or more vulnerable.
  - Working flexibly and in a responsive way to meet needs of both the individual and the community.
  - Identifying gaps through their intelligence, both in need and service provision.
  - Being independent and innovate, and able to create and try new things.
  - Providing value for money, and adding value beyond what is commissioned or expected.
  - Focusing on prevention and early intervention, to support the objectives of delivering care closer to home, and stopping people from becoming more unwell, or unwell in the first instance.
  - Allowing services to be delivered in non-medical buildings, facilities and community spaces, such as community centres and libraries, which can be more accessible, or offering non-medical services in GP practices and health centres during out of hours.
  - Facilitating partnership working and signposting, without being in competition.

What would you need from the Clinical Commissioning group to help maximize this?
- Funding and sustainability
  - A higher and more consistent level of funding.
  - The involvement of the VCS needs proper recognition, support and funding.

- Communication and understanding
  - Communication needs to be better.
  - Listen to us - we have the answers to people’s issues.

- Equality and value
  - See the VCS as a serious partner who is included in decision making.
• Work with GPs and health professionals
  o Tell GPs and health professionals that it is ok to work with the VCS.
  o Facilitate more access to GPs and partnership opportunities.

**Equality issues:**
The main target audience for the event was representatives from Third Sector organisations, however representatives from both public and private sectors were also in attendance. Organisations working with a range of individuals from protected characteristics were represented at the event including:
  • Maternity and pregnancy
  • Disability - including learning disability and mental health
  • Age
  • Race
  • Gender
  • Religion and belief
  • Sexual orientation

There was no representation from organisations working specifically with individuals who identify as transgender or specifically due to marriage and civil partnership status. In addition to organisations working with the protected characteristics a range of other organisations were represented including those that work in the following areas;
  • Parent and Carers
  • Substance misuse
  • Vulnerably housed and homeless
  • Cardiac rehabilitation
  • Stroke
  • Welfare rights

4.5 Continence

**Location:** Calderdale

**When the engagement took place:** February 2013

**Who led the engagement:** Calderdale PCT

**Who was involved:** Calderdale Disability Partnership

**Number of people engaged:** 10 people, including 1 carer

**What the engagement involved:** A discussion group. For more details see the meeting notes, *Issues from discussion on continence with Calderdale Disability Partnership – February 2013.*

**Key themes:**
• Importance of having a personalised service with person-centred assessment, planning and review.
  o There are different factors to consider in the way that the service should be provided for different people, for example, are they male or female, are the managing their own continence or are they being care for? The service should meet the different needs of different users, be bespoke to that individual, as one size doesn’t fit all.
  o The individual needs to have a plan with them in the driving seat.
- Involving service users/carers in the choice of products.
  - Often they know best what their needs are and what fits most conveniently with the lifestyle. Dictating numbers of pads and types based on a short assessment means that some people feel these do not meet their needs.

- Need for empathetic staff that listen and give people time to describe the impact of incontinence on their life, giving particular consideration to protecting dignity and privacy.
  - People working in the service should have empathy with people with continence problems and behave accordingly. People are embarrassed and need time to talk about their concerns before a mechanical assessment is undertaken.
  - From a hygiene point of view, why should you smell or have to sit in a dirty pad because you are incontinent, and may not have an allocation of pads that meets your needs.

- Having a flexible and responsive service, especially for people with fluctuating conditions.
  - If your need decreases temporarily you end up only able to have the lower amount, so you are encouraged to stockpile in case things become worse in the future.
  - People’s need should be regularly reviewed and their views, and the views of carers should be given full consideration.

- Improving promotion of continence services, making sure people know about all the different types of support available.
  - Publicising and promoting the service in an accessible way, involving external agencies like the Disability Partnership in doing this.
  - There is no information provided about the laundry allowance. People have to change their clothes and wash them straight way, which can have an impact on household bills, supplies etc. Not providing this information could mean that people struggle with their finances unaware there is support available.

- Improving mechanisms for people to feedback their experience of using continence services which will enable service providers to effectively monitor, evaluate and respond to issues which may need to be addressed.
  - This could be through a telephone survey after contact with the service, by providing a paper copy of a survey, or asking people to give the service a call to chat about their experiences.
  - The evaluation should be transparent and objective, enabling the service to improve.

**Equality issues:** No information
4.6 Cardiovascular Disease (CVD)
Location: Calderdale
When the engagement took place: 8th August 2014
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: No information
Number of people engaged: No information

What the engagement involved: A stakeholder event took place at which attendees discussed:
- What works really well in CVD services?
- What works well but needs tweaking?
- What needs to change and how?
- Other ideas
- General comments

Key themes:
- Good quality care available for urgent problems, but greater variation in care for non-urgent/planned care.
  - Several comments were made that the parts of the service responding to urgent cardiac problems and offering rehabilitation were working efficiently with specific reference to first responders, cardiac and stroke rehabilitation, the delivery of angiogram and angioplasty at the same time, and thrombolysis.
  - Providing the automatic defibrillator in GP practices has been effective and needs expanding to other public places where people can be trained to use them appropriately.
  - Further improvements to services are needed for early diagnosis and long term conditions.
- Developing clearer and simpler referral procedures.
  - Many comments indicated that pathways both between and within the CVD services needed to be clearer. This applies at any stage in the care of the person, from their initial assessments to moving from service to service. Along the patient journey, professionals report poor quality referral processes and forms and limited preparation of patients, and felt that some service pathways needed to be integrated, e.g. there is not currently a clear pathway to the anticoagulation service, which is likely to be a service used by people with cardiovascular problems.
  - Early diagnosis and long-term condition pathways are not being fully utilised as heart disease and risk of heart failure are not always detected soon enough.
  - It’s important to make sure an appropriate assessment has been completed before referring someone for an appointment, e.g. some people are referred in to the CVD service when they have gastric problems.
  - A lack of referral form for assessment of Peripheral Vascular Disease has meant that up to 70% of the service users have not had an assessment.
  - There are delays in discharge to tertiary services in the amputee pathway.
  - Patients should be able to access information about social and preventative support, and be signposted or referred on.
  - Early supported discharge was seen as a good part of the CVD service.
- Developing effective and timely discharge procedures.
There were some concerns around the care that people receive following a stay in hospital under the CVD service. Patients are waiting up to 4 weeks for a post-procedure social care assessment, which is extending their stay in the hospital beyond there being any clinical need.

It was felt that there should be an increase in the number of check-ups in the community to make sure people are safe, and that there should be more follow up about medication to make sure it is being used appropriately.

- Maintaining a strong public health programme encouraging people with cardiovascular conditions to stay active, eat well, and stop smoking.
  - The focus on public health initiatives in Calderdale was highly commended, with CREW and Upbeat, and stop smoking support all being mentioned as assets to reducing the impact of CVD.

- Ensuring patients have the information they need to properly manage their condition.
  - Both patients and clinicians need to be more aware of the services available and how you should be referred in to them.
  - Public awareness of the pathway should empower patients as they could question and ask for what they need and should have had.
  - If GPs were more aware of the diverse range of services available, they could market these to people who are regularly accessing their services for support, reducing confusion and boosting confidence in self-caring.

- Making better use of primary care and community services and staff in the delivery of CVD services.
  - Community nursing staff and specialist staff should be working together to meet the needs of people with CVD, but there should be understanding between the two as to who has responsibility for what and how this will work so there isn’t overlap and discrepancies in the quality of the service
  - Practice nurses could also be utilised to deliver care to people using a GP surgery as well as the CVD service.
  - If GP services could be made more accessible to people this could increase the early detection of CVD, but people are hesitant to go to their GP because they struggle to get appointments.
  - Pharmacies are key in the provision of medication for CVD, but are underutilised. They could assist in the diagnosis of hypertension, reviewing medications and helping people to understand what they are used for, and identifying through review when people are not taking medication as they should.

- Developing the use of technology in delivery of CVD services.
  - There is only limited use of technologies to share information and communicate with patients at this time, and more could be done that would drive up standards.
  - Consideration should be given to using text message and social media to make contact with patients and carers for reminders or with public health messages.
  - Telehealth could be used to communicate with some patients from home.

**Equality issues:** No information

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4.7 Care Closer to Home - Calderdale Health Forum
Location: Calderdale
When the engagement took place: 17 June 2014
Who led the engagement: No information
Who was involved: Calderdale Health Forum
Number of people engaged: No information

What the engagement involved: A discussion group with attendees at the Calderdale Health Forum reported in Calderdale Health Forum Meeting – Care Closer to Home discussion meeting notes.

Key themes:
- Providing continuity and consistency of care for patients and carers.
  o Patients should be able to speak to the same professional who would understand their condition and their history, enabling them to offer tailored advice and support.
  o The quality of the service should be reliable, so patients know that they will receive the same high quality service each time they access health care.
  o Some examples were cited where people believe others had received a better service than them, and substantial discrepancies are not acceptable.
- Listening to and fully including patients in decisions about their care, so that plans can be made jointly.
  o People want to be involved in decisions about their care; this helps them to manage their own care, allows them to have their say about what will and won’t work for them, and increases the overall effectiveness of any care plan.
  o Specifically, they want to be fully involved in discharge planning, to make sure that this is timely effectively.
- Providing information about conditions and treatment options from diagnosis to discharge
  o In order to help people to care for themselves, they need to have a clear understanding of what their symptoms are, what they might experience, and what will help to alleviate symptoms. This information should be accurate and reliable.
  o Patients should not to be told to go home and “google it”. Information should be accessible to all, not just available online. Searching for your own answers online can be motivating, but it can also be very worrying. When people have had serious diagnoses, such as cancer, there needs to be a more sensitive way of providing the information.
- Being open and honest about their treatment options
  o People want better information on how to choose the service which is most appropriate to their needs but struggle to choose well without understanding the full suite of options.
  o Offering care closer to home through community and primary care service.
  o People want more community-based services, and/or better use of existing services such as pharmacies, to ensure medical conditions are monitored regularly.
- For specialist services, people want their ongoing care and treatment closer to home, such as from health centres and GP practices.
- Ideally people would like local, 24 hour access to a GP/health care professional.
- Some preventative or non-clinical services should be provided more locally, as long bus journeys can often be off putting to someone seeking help.

- Improving communication between hospital and community services, making discharge safer.
  - People are very concerned about unsafe discharge, especially for older people who live alone, who may be going in to the community without a clear plan for their care or any allocated responsibility for someone to care for them.
  - Communication between hospital services and community services is not working as effectively as it should. People don’t know how to navigate around the system to get the support they need and without this support, discharge can be unsafe and can lead to readmission.
  - Carers need to be involved in the discharge planning, so they are fully aware of what the care needs of the cared for are.

**Equality issues:** No information

### 4.8 Musculoskeletal Services

**Location:** Calderdale  
**When the engagement took place:** June-July 2014  
**Who led the engagement:** Yorkshire and Humber Commissioning Support  
**Who was involved:** Public (particularly users of the musculoskeletal services), key stakeholders, providers and voluntary and community sector organisations  
**Number of people engaged:** 40 stakeholders at an event, 114 survey respondents

**What the engagement involved:** Review of local engagement work and literature surrounding musculoskeletal services, 1 public event, and a patient experience survey were summarised in 2 reports, *NHS Greater Huddersfield CCG, MSK Services Engagement Report, August 2014*, and *NHS Calderdale CCG, MSK Services Engagement Report, August 2014*. This is a summary of the information in the Calderdale based report.

The CCGs completed this work because there was a need to review the service pathway, explore opportunities for delivering care closer to home, and ensure the service is equipped for future demands.

**Key themes:**

- Improving the assessment process to include a triage service enabling patients to be seen by one person and being referred to the most appropriate service for them rather than having to access different services.
  - Patients said it was important that to simplifying the referral procedure, allowing them to be assessed quickly, and referred in to appropriate services
  - As some parts of the MSK service are funded by different parts of the health and social care system, they can operate in isolation and not communicate well, which can lead to delays in referral and care.
There were mixed reviews of the waiting times between referral and receiving the service, with some people reporting this was a good feature of the service, and others feeling they had waited too long for assessment.

It’s important to allow people to select the option that is best for them, which should be about their care needs, rather than their ability to travel to somewhere.

Some people felt that they could choose when and where their appointment was so it was convenient for them to use the service, others felt that they couldn’t get appointments at convenient times and locations.

Some felt that they did not always having the appropriate information to enable them to make an informed choice.

- Reducing the need for patients to access MSK services through prevention and the education of young people.
  - This could be through a screening programme for young people, using technology to make them more aware of the risk factors and how they can minimise them.

- Considering self-referral into services or back in to services where need arises.
  - Some patients want to self-refer directly to services (as they can in some cases) even if that’s just for advice and support to help them manage their own care.

- Supporting those with long-term conditions and appreciating the different need for ongoing support was also part of the feedback received.
  - For patients with long term conditions, episodic care for symptoms does not address their permanent needs; for them, a one-size fits all service isn’t appropriate, and they can feel that support is being rationed.
  - It’s important to give proper consideration to the person’s needs and to give them time to explain.

- Providing information for patients needing advice and support but also improving communication between services and with patients.
  - It’s important to provide information and advice as well as treatment, in order to help people to self-manage their pain and their conditions.
  - Some patients reported feeling that they had been given exercises to do without explanation of how to do them, which had impacted their impression of the service, and made them feel that they weren’t understood.

- Providing information on the services available and increasing awareness, both for patients and clinicians.
  - This was seen as helpful and something that would further improve the experience of care and referral. Patients reported a lack of awareness of what services are available from both the public and professionals.
  - Professionals need to know more about what other services are available that complement what they deliver so they are able to signpost.

- Good perception of the current service with the location within the Orthopaedics service providing opportunity for sharing of information and easy internal referral.
  - Patients thought it was helpful to have the MSK services located within orthopaedics as it led to good links between services.
Integrating services would improve the MSK pathway and levelling the differences between contracts and models would make it easier for staff working within the MSK service to navigate.
  - There is a need to better integrate MSK services from Huddersfield and Calderdale, so there is consistency in the way the service is delivered across the whole area.

Reducing in waiting times, increasing appointment duration and making the referral process faster were all seen as aspects that would improve the MSK service.
  - There is a need for a single point of access/triage type system to make referrals into the services smoother and allow patients to get to the right service the first time.

Working with the right staff to deliver care at the right place and the right time, without the need to refer back to the GPs each time, was seen as an opportunity to further develop the service.
  - Employing the right people who are knowledgeable, caring, supportive, and aware of other complimentary services.
  - The attitude of the staff was thought to be particularly crucial when dealing with more vulnerable people.

Increasing the use of technology and looking at sharing of patient records to support care.
  - Each patient should have a single record of their care needs that can be shared between services so patients receive consistent care, and don’t have to keep telling their story.

Equality issues:
Due to the limited number of responses to the survey from people who are not White British, it is difficult to identify whether there would be a specific impact. These services are accessed by some people with long term health conditions and disabilities, and older people, so it important to consider their needs more specifically in light of changes.

There is a comment in the work that there may need to be some improvements in the way that information is explained to people with learning disabilities.

4.9 Respiratory Services

Location: Calderdale
When the engagement took place: Between May 2013 and June 2014
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Patients and service users of respiratory services and members of the Breathe Easy Group
Number of people engaged: 7 members of the Breathe Easy Group, 9 patients/carers involved with the Experience Based Design Group, unknown numbers of survey respondents.

What the engagement involved: An outpatient survey, and patient satisfaction survey. Group discussion with the Breathe Easy Group and a focus group on patients’ views and experiences of the respiratory service using an Experience Based Design method.
Key themes:

- Positive experiences of the care provided by the community respiratory specialist nurses, but mixed experiences of hospital care.
  - It is important that organisations maintain and look to continuously improve this standard in community nursing, particularly as patients feel already that there aren’t enough of these nurses.
  - Patients feel like they have to wait around in hospital for a bed, medication or transport to get home after hospital care.
  - Patients would like to see all clinics running to time and well organised.

- Improving the experience of patients accessing their GP for support with respiratory conditions.
  - Patients have a variable experience of primary care and urgent care.
  - It would be beneficial for respiratory patients to have a care plan with their general practitioner, so they could be fast tracked for appointments in urgent situations, and GPs could pick things up quickly and take action.
  - Practices should provide respiratory patient with information and signpost them to groups and organisations that can give them specialist advice, guidance and peer support.
  - In some cases, patients feel that smaller practices offer better access to care, but in bigger practices, they struggle to get past the receptionist.
  - The benefit of the community specialist nurses is that they bridge primary and secondary care.

- Improving communication between patient, their loved ones and members of staff when in hospital, including communication about the patients care, and what is available for the carer.
  - Poor experience of hospital services due to poor communication, moved between wards without an explanation, losing personal possessions and staff shortage on hospital ward.
  - Some patients are unhappy that it was possible to overhear private conversations whilst staying in the hospital ward.
  - The hospital teams need to improve the quality of communication, particularly the explanation of the care patients receive when admitted in an emergency.
  - The hospital and healthcare community should look at how they support the loved ones of patients who are admitted to hospital in an emergency, particularly what support is available for those going home from hospital alone at night.
  - Providers and commissioners should have a continued dialogue with patients in order to continue to improve and enhance respiratory services.

- Considering all barriers to accessing supported self-management programmes, peer support and clinical services.
  - Providers should consider transportation to and from meetings and events and the follow up for patients after they have completed pulmonary rehab, including accessibility by public transport and the cost of parking. Patients are concerned about car parking availability and cost information not being shared between providers.
  - Peer support is critical in motivating people to self-care
Some patients had positive experiences of the pulmonary rehabilitation course; they found the booklet, exercises and facilities useful, although they expressed concern about lack of follow-up after rehab programme.

It’s important to offer follow up support but there needs to be a full consideration of what barriers there may be to accessing that, for example there is an exercise class available at Halifax Fire Station but the cost of £5 per session is expensive for patients.

- Providing more information in all aspects for care, from self-management, to during hospital stays, and after care.
  - Patients want information about available support services e.g. support groups and self-care tools
  - Relatives need more information and support when patient is admitted late at night.

- Delivering services locally to the patient, rather than in specialist centres.
  - Patients want continuity and services to be delivered locally - not having to travel to specialist centres.
  - Patients happy to have home visits from nurses and therapists but would like to see doctor at the hospital.

Equality issues: No information

4.10 Self Care

Location: Calderdale

When the engagement took place: January 2015

Who led the engagement: Calderdale Clinical Commissioning Group

Who was involved: Representatives from Calderdale Health Forum, groups of service users with long term conditions.

Number of people engaged: 30 people engaged at the Calderdale Health Forum Event, 40 people engaged through the Health Connections programme of focus groups.

What the engagement involved: Engagement tasks, facilitated by Engagement Champions, which involved focus groups to discuss Care Closer to Home/Supported Self Support Care.

Key themes:
- Importance of providing the information, advice, support and guidance that allows people to self-care, particularly for those with long term conditions and for those who are newly diagnosed.
  - ‘There is loads of rubbish to sift through, so many myths and variable opinions and advice. I get told different things about sugar levels by different health professionals’
  - The majority of people reported that following diagnosis of their long term condition, they are left to their own devices in terms of managing their illness. Health professionals assume that patients understand the illness/condition diagnosed.
  - One participant reported that despite undergoing major surgery for pancreatic cancer and subsequent diagnosis of diabetes, she was not informed of what support strategies were in place or services she could access to help her illness.
She was not taught how to do sugar level testing, nor had the knowledge of what testing kits to use. She strongly felt that she had to do a great deal of independent learning.

- ‘Need to know where to go. Still uncertain if it’s 111, 999, the GP. Who do you call? Where do you go?’

- Improving communication between different organisations to ensure services are seamless.
  - Poor communication between organisations/staff can mean that people are not assessed and treated holistically.

- Difficulties with managing and getting appropriate medication from pharmacies and hospitals.
  - Pharmacies don’t always hold enough or any stock of medication needed and there are supplier/manufacturer problems.
  - As medication is vital in the management of many conditions, sometimes patients share it or give it to other patients because of availability issues. These discrepancies have to be explained to Doctors who don’t seem to understand this need.
  - Sometimes a hospital prescription is offered but not always; this need to be more consistent.
  - Some people feel like they face a battle to get the medication which best suits their condition.
  - “…on researching the medication prescribed for the illness [she] became aware of some of the major side effects. Due to perseverance and countless visits to her GP she insisted for her medication to be reviewed”
  - “…doctors didn’t accept my word about contraindications so I had to argue about what food and what other medication I could take with my specialist Parkinson’s medication.”
  - Also, people want to have access to and choice of alternative, holistic therapies and treatment such as reflexology or acupuncture.

- Increasing the flexibility in accessing services, for example being able to book appointments out of work hours, being able to access walk-in centres with extended opening hours, and being able to get an urgent appointment, in between routine appointments, if they have concerns related to their condition.
  - “Diabetics get a yearly check-up and yearly eye and foot checks. If I get concerned before then I am told there is no need for more frequent appointments and made to feel a nuisance”
  - For some patient’s, attending a hospital appointment is not in their best interest, so having services which are flexible and responsive to individual patient’s needs would be beneficial.
  - “My mum has dementia. She lives in a care home and needs a regular gynaecological procedure that could be done at home. However, she has to attend a hospital appointment where she becomes distressed and stroppy and because of this it is not always possible for the procedure to be carried out.”

- For Care Closer to Home/Supported Self Care to work it will be essential to build on and develop new ways to deliver support in the community, and people have concerns about how this will be achieved.
Some people want to be able to access local, community-based support to help them manage long term conditions. This could include education programmes, support groups, social groups, activity groups, peer support and local hubs.

Groups and one-to-one support could be delivered/supported by local volunteers, possibly asking people dealing with similar long term conditions to become involved.

One participant said she would love the opportunity to support other diabetes patients with understanding illness, strategies to coping with illness, approaches to de-stressing using holistic approaches.

Increasing awareness of services that are not directly linked to their diagnosis, but that could offer them support, such as counselling services.

People with long term conditions often feel a huge amount of strain which can affect confidence, self-esteem, independence, finances and relationships with family and friend. This can all lead to stress, anxiety and depression. People reported that they were not aware of counselling services to help them cope with their diagnosis and the subsequent impact on their lives.

Also, the impact on carers, friends and family should not be underestimated.

Concerns about how ‘Supported Self Care’ will work in practice. Concerns mainly relate to how and where services can be delivered in the community and the extra burden this might put on already over-stretched GP services.

Some people prefer going to the hospital for their appointments because ‘the hospital has more autonomy and …they were in much safer hands with people having higher levels of expertise’.

Equality issues:
In one of the focus groups coordinated by Health Connections, 12 out of 14 people who accessed hospital services for their condition had to use interpreter services when they attend appointments. However, when newly diagnosed, they felt “it is not taken into consideration that due to language barriers, individuals will not necessarily understand how to cope with the illness”.

4.11 Unplanned Care

Location: Calderdale
When the engagement took place: June-July 2013, report produced in September 2013
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: The general public, with some targeted groups
Number of people engaged: 2437 people responded to the survey (statistically robust evidence base)

What the engagement involved:
A survey asking people what features they would like from an unplanned care service that was distributed widely across Calderdale through mailing list, and direct contact with specialist groups.

People were asked a series of questions; each presented various options for ways in which services people could be delivered, and people were asked to choose what
would suit them best. This provided an understanding of people’s priorities for urgent healthcare issues.

**Key themes:**
The results show that people in Calderdale prefer the following attributes in order of priority as follow:

1) Shorter waiting times for an appointment
   - People placed most importance on access, wanting to receive same day appointments compared to waiting up to two days for an appointment.

2) Shorter journey times
   - People prefer journey times within 10 minutes compared to more than 30 minutes.

3) A health professional known to them
   - Females prefer to know the health professional they see significantly more than males.
   - People aged 66 years old more concerned with seeing a health professional they knew compared to younger people (aged up to 35 years old).
   - Participants who reported having a disability preferred to see a health professional they knew.

4) To be seen by a doctor
   - Participants who reported themselves as Pakistani were significantly more likely to prefer to be seen by a doctor than a nurse.

5) To be given a choice of appointment time
   - People who reported they were British preferred shorter waiting times for an appointment and to have a choice of appointment time.

Additional themes included:
- Ensuring unplanned care services are available from 8am to 6:30pm on weekdays
- Monday to Friday between the hours of 8am to 6:30pm were considered most useful.
- Bank holidays were considered least useful.

**Equality issues:** The responses were analysed against equality monitoring data and the significant results are reported above.

**4.12 Anti-coagulation Service**

**Location:** Greater Huddersfield  
**When the engagement took place:** December 2013 – January 2014  
**Who led the engagement:** Yorkshire and Humber Commissioning Support  
**Who was involved:** User of the anti-coagulation service, members of the Patient Reference Group Network (PRGN)  
**Number of people engaged:** 1752 people completed surveys, 25 members of the PRGN
What the engagement involved: Existing data held by WSYBCSU was analysed, including engagement work and Patient Advice and Liaison Service records; a survey was sent to almost 3000 recipients of the service, an online link to the survey was opened; the PRGN held table top discussions about patient views of the anticoagulation service.

Details of this work can be found in *NHS Greater Huddersfield Clinical Commissioning Group Anticoagulation Service Engagement Report, January 2014*.

Key themes:

- **Staff are kind, friendly and provide an efficient, excellent and professional service.**
  - Many respondents felt they were receiving an excellent service, in particular, those respondents who access different clinics/GPs. They would like for the service to continue as it is - “why fix what isn’t broken”

- **Accessing the anticoagulation services closer to home.**
  - Some respondents would like the option of being able to access the service closer to their home. This means somewhere that is accessible by public transport or patient transport, and has adequate and inexpensive parking, particularly for disabled people.
  - The convenience of having it closer to home was more important to some than the immediate result.
  - People in receipt of home testing service were pleased with this and wanted to see it continue. For some people, home testing would reduce the burden on their family and the cost of getting taxis, so they would like to receive this service.

- **Increasing access to Warfarin through local GPs and chemists.**
  - The majority of respondents said that all GPs should prescribe Warfarin to give more timely access to prescriptions and medication.
  - Some respondents also commented that they would like instant prescribing by the service along with their results and being able to attend a local chemist and receive their medication.
  - The highest proportion of respondents want to be tested at their local GP practice but some thought community pharmacy testing could be a useful development.

- **Importance of a flexible and convenient service that enables people to choose to attend a drop-in clinic or book an appointment for convenience.**
  - There is a substantial need for flexibility in the way this service is delivered as it is something that has to be used regularly by so many people. The service needs to meet the needs of the individual.
  - There should be some built in flexibility around clinic times, such as ensuring early morning/evening appointments and drop-ins are available for working people.
  - It should be simple to rebook appointments if one has to be missed due to ill health or weather
  - Accessing the service should fit around you, for example, if your partner also needs to access the service, it would make sense to coordinate appointments.
  - Huddersfield Royal Infirmary was the most convenient location for testing for some people.
Respondents had their own preferences about how they were tested and when they received their results, with some wanting access to the finger prick test if they don’t already have this, some wanting to receive their results immediately, and others preferring to get a written statement to their home.

Some patients would like the opportunity to test themselves at home, if they felt confident doing this and had the skills and information.

- Providing more information, advice and support with taking medication.
  - When patients were provided with clear information, this enabled them to manage their conditions better.
  - Over 95% of people felt supported by the anticoagulation service to manage their condition properly.
  - Some had received conflicting messages about medication between hospital and GP, which had caused confusion.
  - Respondents thought it would be useful to receive the details of your test and changes to your dosage in a letter, with your next appointment date.
  - Some respondents expressed disappointment at the discontinuation of the patient advice line.

Equality issues:
Equality monitoring questions were asked as part of the patient survey. Of 1752 respondents, a majority were aged over 56 (84%), and were White British (81%). The views of disabled people were well represented with 35% of the total respondents saying they had a disability (physical and mobility issues, and long standing health conditions were most common). Around 10.5% of respondents stated they were carers.

4.13 Children and Young People – Health and Emotional Wellbeing

Location: Greater Huddersfield
When the engagement took place: Over an 18month period up to January 2015
Who led the engagement: Involving Young Citizens Equally
Who was involved: Children and Young People engaged with Involving Young Citizens Equally (IYCE) in Kirklees
Number of people engaged: No information

What the engagement involved: The evidence is a summary of responses from 4 consultations around young people and their wellbeing. Those consultations are Kirklees Young Council (KYC) Emotional Wellbeing Consultation Project 2013, Our Voice Homelessness Project 2013, Our Voice ChEWS Evaluation 2014, Our Voice Sexual Health Services 2012.

Key themes:
- Knowing who to ask for help when you’re not aware of what’s available to you.
  - Young people are often aware that there are lots of services that provide lots of different help, however, they don’t always know where to look or who to speak to.
  - They want to use their own coping and resilience skills but do need to know who to contact if they start to struggle or are in crisis.
  - “We need the confidence to talk to people – if people can’t talk then nobody can help”
• Understanding what confidentiality means for young people.
  o Some young people still don't believe what they share will be kept private. They understand rules on confidentiality exist, but have seen rules broken. Work need to be done bust any myths about which information will be shared with which people.
  o “I wouldn’t speak to the GP. My family go to the same one. Chances are I’d see someone I know in the waiting room. Then the questions would start ....”
  o Be clear with young people on the rules of confidentiality, explaining from the beginning what can be kept private and what can’t.
  o Think about where you meet young people, who might see them accessing help and how you let them know about appointments.
  o “If it’s a sexual health clinic, everyone knows why you are there. You feel like people know why you are going. You really feel judged, especially if you are under 16”

• Understanding what support, care or information the patient is receiving and what the outcomes are likely to be.

• Young people suggested a “Support Menu” which explains the interventions on offer, how long they last, what we will be doing and who the worker is likely to be.
  o Think about using less clinical language with young people.

• Using technology to share information and communicate with young people.
  o Young people often have smart phones, yet services seem slow in taking up modern technology and using it to communicate with them.
  o They ask that health services created phone apps, and offer free helplines and text services, as they are all quick ways to seek advice and support. They can be used anonymously too.
  o Sometimes a text is an easy first step to seeking help. Young people thought being able to text message simple questions, might be an affordable and easy way to gain quick and relevant advice.
  o “I get free texts. Sometimes when I panic I just want to know things will be ok. Being able to text for instant advice is really useful”
  o “Being able to pick up the phone and talk to someone is a good option. You don’t have to sit face to face with them and that can be easier”
  o Young people suggest a local phone/tablet app with recommended services would be useful.

• Offering drop in services for times when immediate advice and reassurance are needed.
  o Sometimes a problem seems very big, and what is needed is someone to talk the problem through with, especially when you are on a waiting list for other support.
  o Drop ins should offer a range of services to support mental health and wellbeing, including social activities/projects, peer support/buddying; support groups; family support; counselling; telephone and on line help pages; text messages service; printed resources
  o “The Marketplace (Leeds) has a young person’s feel. When you go in the waiting room isn’t like a Doctors’ waiting room. The people who work there take you to a seating area away from everyone and see if they can help you without having to go into a full consultation. The staff are all young and friendly.”
Equality issues:
The engagement events were completed exclusively with young people so all views represented here are those of young residents in Kirklees.

4.14 Call to Action

Location: Greater Huddersfield
When the engagement took place: October – November 2013
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Voluntary and community groups, members of GHCCG, members of the public and people with a learning disability
Number of people engaged: 195

What the engagement involved:
A survey, available online and in paper format, was sent to voluntary and community groups, GHCCG members, the Patient Reference Group Network and was available on GHCCG’s website. Social media was used to reach members of the public. Staff engaged with people with a learning disability at the ‘It’s My Health’ event and used an easy read version of the ‘Call to Action’ survey to gather feedback.
The ‘Call to Action’ asked members of the public to give their views on four broad but fundamental questions:

- How can we improve the quality of NHS care?
- How can we meet everyone’s healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

The findings are summarised in ‘Call to Action: Engagement Report for Greater Huddersfield CCG, 12 January 2014’

Key themes:

- Investing in community and primary care, as well as local community and voluntary groups that provide support for local people with health conditions.
  - Utilise youth clubs and community centres, put services in existing community buildings, and identify community representatives.
  - Give communities choice and control by talking to them and listening.
  - Engage with work places in the local area.
  - Look at transport, getting about in the area and parking.
  - Reduce isolation and inequalities in health.

- Training staff including changing the culture of the NHS, communication and transparency.
  - Train all staff, including medical and administrative to change the culture of the NHS, to make the NHS transparent at all levels.
  - Improve communication with patients and ensure they understand their condition and treatment options and are able to make informed choices about their own care.
  - Recruit the right staff that represent the language and culture of the local population.
  - Train specialist staff (or have a matron lead) who understand different disabilities and mental health.
• All information from the NHS should be available in easy to understand formats and use a variety of different methods to reach the appropriate audience.
  o There needs to be more information about how to maintain health and wellbeing and how to avoid preventable conditions.
  o The should be more information on the services available and how to access them
  o Education courses should be available for specific conditions and general health and wellbeing, preferably delivered by people with the condition themselves to provide peer support
  o Education on diet, nutrition and lifestyle especially health heating and cooking skills should be available in public places through free classes in the community.
  o More education and information should be available for young people, starting in schools and Sure Start centres.

• Calling for changes to be made on a national scale to preventative health initiatives.
  o Changes should be made by government, such as charging for unhealthy lifestyles such as high taxes on sugar, junk food, alcohol and smoking to help subsidise healthier lifestyles.
  o Campaigns are needed to raise awareness of exercise and healthy food options.
  o There should be an acknowledgement that society needs to change, rather than relying on the NHS.

• Encouraging self-management of health conditions is very important.
  o Respondents used the term self-help, self-management (manage) or ‘helping people cope’ to cover self-care.
  o To patients this includes care that is personalised with the support of specialist staff; access to support groups with clinicians attending; places where you can drop in to get advice, support, assistance and equipment in the local community; Courses on self-management, nutrition, prescribed exercise; involvement of wider networks such as carers and families; community assistants, champions and buddy schemes; advice and helplines available 24/7.
  o There is also a need to offer ‘Self Care’ to those who are not unwell and those who have caring responsibilities to ensure that they don’t become unwell. This could be through well-being courses for the community, or breaks and support.
  o It’s useful to encourage people to form relationships with local pharmacists to manage medication.

• Providing regular check-ups, including annual check-ups or possibly more frequent depending on the age and condition, for everybody.
  o Patients should be offered a wide variety of health and wellbeing checks, many people described this as an MOT or health review, and more routine scans and screening.
  o There should be a call for more targeted check-ups for those groups at particular risk.
  o Early diagnosis can ensure early intervention including self-help.

• Working together, across all agencies, not just health, to improve health and wellbeing.
  o Joint teams that are managed centrally, not just teams that work together.
  o Sharing of information and the ability to access a shared, patient owned record for those that need to.
• All public services should have a remit to improve health and wellbeing.
• Third sector should be an equal partner.
• Utilise community assets and work with local communities on tackling inequalities and wider determinants of health such as housing.

- Improving access to health services.
  • This included opening times and appointment availability, particularly aimed at GP practices and primary care.
  • Provide services on varying days and times.
  • Increasing awareness of access issues for all staff, especially around disabilities.
  • People with a long term condition would like to access their services through one point.
  • Some people need longer appointment times, so more time can be spent listening to the patient.
  • Improvement should be made to home visits, GP services should be more available in community settings.
  • Reducing waiting times for appointments and change the booking system
  • Making appointment available in the evenings and at weekends, and ring fence appointments for people who work.
  • Employing the right staff who can communicate in the right language or format, and having specialist staff working in GP practices

- Improving hospitals and discharge planning.
  • There is a need for more staff in hospitals, respondents feel hospital services are under resourced.
  • Hospitals need to be clean and serve nutritional food to support recovery.
  • Bringing hospital services into community settings.
  • Ensure that when people are discharged they have a robust plan that is backed up with a health and social care services, available 24/7.
  • Ensure patients are fully recovered before they are discharged.
  • Assign a professional to keep regular daily contact in the first week, fund and use local VCS organisations to support the individual.
  • Train and support carers in their duties so they can manage.

- Using technology better and investing in future technology, especially for monitoring and sharing information between services and patients.
  • Understand that things that working should be left.
  • Educate people through social media, and consider using Apps to support people.
  • Make sure people can access training to use computers and Apps, and offer access to technology for those who do not have a computer.

Equality issues:
Specific feedback was received from some groups:
- People with a learning disability
  • Appropriate information and practical sessions to raise awareness, educate and promote healthier lifestyle choices i.e. healthy eating, exercise, smoking, alcohol.
  • Ensure all information is accessible and easy to understand for all the population.
  • Ensure ALL staff have ‘Learning Disability’ awareness training.
  • Encourage support mechanisms for elderly and vulnerable people.
Ensure information and resources are shared between services to help them work together better for the patient.

Make accessing healthcare easy, which will help everybody.

Communicate better with patients and be more open about decisions.

4.15 Care Closer to Home – Public Event February 2015

Location: Greater Huddersfield and North Kirklees
When the engagement took place: February 2015
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Members of the public who had no conflict of interest with the Community Service procurement in Kirklees
Number of people engaged: 22 people attending the Huddersfield event, 8 people attended the event held in Batley

What the engagement involved:
2 engagement events that took place at the Textile Centre of Excellence in Huddersfield and Batley Town Hall.
Presentations about the Care Closer to Home programme were delivered to the meeting, then discussion groups took place focusing on:
1. Service Delivery
2. Service Capability
3. IT & Infrastructure
4. Engagement and Ongoing Management
5. Mobilisation

Key themes:
• Providing accessible communication and information is key in delivering this model.
  o If information is provided, it needs to be accessible to the person. It should be clear, not be full of jargon, real and understandable.
  o There should be a way that people can access all the information from one place, that could be a person, an advice line, a centre, but all information should be stored centrally. Some respondents would like a 24hr helpline for advice and information.
  o GP centres often have access to people at the right time to disseminate information about what is available to them, such as groups, but GP practices struggle to find the right person to give out information. It’s difficult for professionals to know what is out there.

• Treating people as equal partners in their care, enabling them to navigate the system and use services as they need to.
  o People want to be partners in their care, to have access to information that enables them to fully understand their care, and to have equal right to access their information.
  o Aiding people to understand their conditions and support themselves through self-care (including the self-care hub) helps people to feel like a partner in their care, as does trusting that they understand when they need to be referred in to services, and enabling people to self-refer.
  o It’s important to listen to people and meet their needs responsively.

• Providing seamless care with staff continuity embedded.
o People do not want to be able to see the joins in their care, they want to pass seamlessly from one part of the service to another, and through stages of care or treatment. Often the GP is the first point of contact for services. There is potential to do this through a care coordinator or navigator, someone to ease the transition between different parts of the care, to have a holistic perspective on the care needs of the individual.

o A provider needs to demonstrate low staff turnover, as people prefer to see someone they know to receive care, rather than new people, especially for intimate tasks.

o There were some concerns expressed about the difficulties with getting teams to work in a more integrated way, as many different services have different protocols, teams and systems, and bringing these together is a huge challenge. The local areas must also speak and work seamlessly, not just services, because there are currently different models of care in place in different areas.

o The transition between children and young people’s services to services for adults should also be smooth and well planned.

o 7 day provision is very important in the delivery of robust and seamless services.

- Delivering services through staff that have the right training and skills, represent the diversity of the community and are flexible. Staff also need to know how to navigate their own system.

- There was some concern that there was not a clear understanding what the full skill set of the staff is, and that it’s difficult to plan without this. There should be some analysis of this going forward, and any issues addressed through strong leadership and training.

- There needs to be a plan for educating the clinicians, it all needs to be done in a coordinated approach with all staff on board.

- Kirklees is diverse and the workforce needs to reflect this, culturally and religiously. Staff need to be fully aware of all barriers that might hinder access to services in line with the Equality Act.

- To change the way services are delivered, there needs to be a change in the culture of the staff; they need to come on the journey with the provider, not feel that change is being enforced, particularly when it comes to increasing working hours, providing services 7 days a week, etc… Boosting staff morale issue offering support is essential.

- Delivering care that looks at the whole person, including ensuring services are adjusted to support disabled people. The service should endeavour to meet the needs of patients and carers and not operate services for the convenience of the provider.

- Staff should listen responsively, revisit information and update it, so they can deliver care through an approach that is right for that person. There is no one size fits all way to meet people’s care needs.

- Enforcing the use of technology will not work for all people; it’s important to use effective communication methods to meet individual needs.

- Services should fit around the person receiving them, for example, if care from a district nurse is an essential part of a care programme, and they have to complete certain checks, this should be done at the convenience of the person, not theirs.
- Early access to care and support is needed and carers should also be supported to navigate the system.
  - People need to have the right intervention at the right time.
  - There should be a focus on the preventative elements of health care, so people know what can be put in place to minimise risks with regard to their conditions, such as support groups available for people with mental health issues.
  - There is a responsibility to educate people early so they understand what’s going on.

- Developing a model that works across the whole of Kirklees and takes into account community venues, buildings and transport systems.
  - The new model needs to clearly demonstrate how it can work with the community and voluntary sector by making full use of the voluntary sector services/estates for outreach, activities and appointments which are not intervention.
  - It’s important not to underestimate the support that the voluntary sector can give, both through local groups that reduce isolation and keep people happier and healthier, and incite community spirit to get people involved.

- Managing and sharing data about a patient effectively, but in a way that means it is protected.
  - Some patients are keen not to have to tell their story more than once, although others are happy to do so. In either case, a shared history of the person is useful for the different services they access, and should be available to each of these services.
  - People also want to be in charge of their story, and need assurances that it will be kept up to date. They want to be one of the stakeholders who has access to it, and to be able to check and alter it.
  - Eventually all patient information is digital and accessible to all health care providers.
  - Assurances need to be in place that patient information is safe and protected, and that every piece of information will be available through a digital system at some point in the future. Due consideration needs to be given to the cost implication of this.

- Concerns around delivering a single point of access should be addressed through good leadership from an organisation is required to deliver the model.
  - A Single Point of Access (SPA) will likely be led by one organisation, subcontracting to a number of others, which means a culture of sharing information and working openly is needed.
  - Multiple SPAs can cause confusion for professionals, so there should be one point, and it should cover the whole area, regardless of boundaries.
  - There should be access to the SPA by telephone, through the web, email, and information should be available in easy read format.
  - There’s a lot of pressure on Single Point of Access, and there were concerns that if this fails the whole system will fall apart.

Equality issues:
People attending the event were asked to complete equality monitoring forms. This allows for consideration of a representative sample. The response size was 34 people which would not be statistically representative; however the data will be shared below.
for information. Some facilitators at the event were asked to complete monitoring forms as they had participated.

Of the respondents 19 had Huddersfield postcodes and 8 had Wakefield postcodes, as North Kirklees residents. The majority were women 62%. There was mostly even spread of ages from 26-75. The majority of respondents were of White British ethnicity; 79.4%. There were 7 disabled people (20.6%) they had a variety of impairments and some had multiple impairments. 3 people identified as transgender attended the event. The majority identified as heterosexual (79%), 2 people were identified as lesbian, gay or bisexual the rest left the question blank or ‘prefer not to say’. 84% were Christian and 16% Muslim of those that declared a religion. 35% of respondents were carers.

4.16 Care Closer to Home – Stakeholder Event July 2014

Location: Greater Huddersfield
When the engagement took place: July 2014
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Public, key stakeholders, commissioners, providers and the voluntary and community sector
Number of people engaged: 37 people

What the engagement involved: This was the third event, which focussed on reflections from earlier events in January and May 2014 and aimed to establish the way forward in shaping and developing plans. Participants were invited to a brief event to help shape plans for Care to Closer to Home.

People were asked to consider the Care Closer to Home Outcomes Framework and to comment on the specific elements of the key outcomes which included the following:

a) More of my care happens nearer to home
b) I’m seen at the right time by the right person
c) Everyone involved in my care knows my story
d) Me and my carers know how to manage my condition

Key themes:
- More of my care happens nearer to home, including planned preventative care that treat me holistically and avoids unexpected urgent care.
  o Emphasis was given to the need for better forward planning of patient care to avoid ‘unexpected’ admission to A&E or a hospital bed.
  o The need to ensure ‘reflective’ practice to ensure ‘optimised’ care, was also a feature of this Outcome, viewing the patient holistically, rather than narrowing down the review of patient care to a purely clinical and medication focus. It was felt that this latter approach would lead to improved quality of life enabling a greater emphasis on retention of patients at home.

- I’m seen at the right time by the right person, and that person listens to what I say that I need.
  o The KPI regarding the timeliness of call answering was felt to be unclear. However, there was a general feeling that automated calls were not the best way of dealing with patients and that the human connection was important.
Across all elements of this Outcome measure, there was reference to qualitative assessment being a greater indicator of success in meeting the needs of patients’ rather than purely quantitative information.

There was reference to the need to ensure the patient’s voice is heard in any needs assessment, ensuring that this is balanced against the clinical assessment. In respect of meeting the needs of patients, it was recognised that these could change quickly. A realistic approach should be taken to provision of care taking into account these changing needs along with a preventative approach. It was felt that all KPIs should be set at 100% with a requirement to explain why the target hasn’t been met.

- Everyone involved in my care knows my story, from me and my carer to the provider, and I have one care plan that everyone feeds in to.
  - Ensuring the provider as well as the patient/carer is equipped with the correct level of information to inform any service transfer process was felt to be important, as was how and where this information should be held. The possibility of ensuring a contractual arrangement was in place with all relevant providers acting in partnership was proposed. An evaluation of all services should be ongoing.
  - There was reference to ‘planned’ versus ‘unplanned’ care and whether ‘90 days’ should be seen as the correct timescale given the uncertainty over needs of the patient in either scenario. The idea of home as the best place for some patients, particularly if care is ‘unplanned’ was also questioned.
  - The importance of hearing the patient/carer’s voice in the development of any goal-orientated plan was felt to be important. Taking a more reflective approach to planning care and ensuring information relating to patient care that is in danger of being missed is captured was a feature of this particular Outcome.
  - There was also reference to the need to balance quantitative with qualitative information, ensuring that personal feedback informed any care plans. The input of both patients and their carers into the development of any care plans was also felt to be important.

- Me and my carers know how to manage my condition, are aware of my care plan and my independence is maximised.
  - The importance of ensuring clinical input in evaluating the patient’s readiness to transfer was discussed, as well as ensuring clarity on the processes in place to support the patient following a transition from one to service to another.
  - There was also a focus on ‘maximising’ independence and ensuring the health and well-being of all patient groups.
  - Keeping the patient fully informed and ensuring their input into goal-oriented plans was also referred to.
  - The needs of people from a range of population and vulnerable groups including learning disabilities and dementia was referenced and it was felt that inclusive language and terminology should be a key factor in any forms of assessment or care-planning. The treatment plan should also take into account levels of confidence of patients through a ‘confidence-scoring question’.

**General comments**

- Ensuring inclusivity in care planning.
  - This was a major theme and reference was made in particular to vulnerable groups (learning disability and dementia where mentioned specifically). There
was also reference to inclusion of broader population groups reflecting the diverse demographics of the area. It also references the need to ensure that the patient or carer’s voice is heard in the development of any care plans.

- Consistency and clarity of communication.
  - This theme related to how people felt they were communicated with regarding the care they received and how they could be certain they were seen by the right person.

- Transfer between providers is clearly assessed.
  - Issues around the transfer of patients between providers of services should be addressed through understanding the risks to patients of transition. The assessment of patients should take into account the need to assess appropriately depending on the individual circumstances of the patient.

- Data sharing between providers should take place when necessary to ensure the right care is in place.
  - This theme refers to the extent of and need for data sharing practices and policies between providers to ensure appropriate, informed provision of care.

- Determination of outcome goals.
  - The feedback on the Outcomes Framework identified the issue of unplanned and planned care and the impact this had on how outcomes for patients could and should be assessed. The comments in this theme are an extension of these views.

- Consistent appropriate care.
  - This theme links to the ‘determination of outcome goals’ in that it questioned how an individual would know they were getting the right care and whether there was equity of distribution of care across the system.

- Preventative measures used to manage care needs.
  - This theme reflects the need to ensure early intervention in order to prevent long-term care.

**Equality issues:** No information

**4.17 Diabetes**

**Location:** Greater Huddersfield, particularly Ashbrow and Greenhead Wards  
**When the engagement took place:** Unknown  
**Who led the engagement:** Community Development – Kirklees Council  
**Who was involved:** Specific groups of people from the general public including white British, Pakistani (predominant group), Indian (predominant group), Sikh (predominant group) and Polish.  
**Number of people engaged:** 126 members of the public

**What the engagement involved:**
A combination of small and large group discussions and one-to-one interviews asking:

- What is working well?  
- What is working but needs some adjustments
What needs changing?

Plus the use of a specific survey developed for use by the Sikh community, asking more detailed and focused questions.

Key themes:

- Good local services are based on good relationships and clear communication between patient, GP and clinicians.
  - 40% were generally happy with the services they receive.
  - Communication between GP’s and Diabetes practitioners was felt to be generally poor leaving some people feeling very vulnerable especially when blood counts were low.
  - Some participants felt forums made from professionals and local patients should meet regularly in order to monitor concerns or capture ideas.

- Importance of fully exploring medication options with patients.
  - The choice of injections or pills was not consistently explored amongst patients.
  - Metformin/Insulin is readily prescribed and is of benefit to patients.
  - GP’s don’t always look close enough at the contents of what they are prescribing to patients. Some diabetic tablets contain sugar (Sugar coating) which some people have had to point out to their respective GP’s.
  - GP’s should explore/consider a wider range of prescriptions to address the problem of upset stomachs; some felt that GP’s don’t always explore offering alternatives.

- Ongoing inconsistency in the level of care and support provided for people with diabetes.
  - 60% of participants felt that there was a general inconsistency in the level of care and support provided by their GP’s and Diabetes practitioners.
  - The issue of exemption cards for prescriptions seemed inconsistent – some reported their GP’s ensured they were exempt based on their condition and age, others were not getting their cards despite meeting the criteria; this they felt should be looked at and corrected.
  - Some diabetics in the groups were unaware of this entitlement based on condition or age and some were clearly of pensionable age within the target groups but were still paying for prescriptions.
  - Regular and consistent appointments with diabetic nurse with a good friendly rapport helps.

- Delivering co-located centralised services, to make a range of services easier to access at one time.
  - A small number of participants had been informed of One Stop Shops for diabetic patients at their respective practices, one being the Grange practice in Freetown. They see a number of clinicians in one go – dietician, chiropodist, pharmacist. These participants were extremely happy with this service with a large number of other participants not aware that this service existed.
  - Increasing provision like this would avoid some patients having to visit a number of location’s e.g. hospital appointments, eye clinics, podiatry to receive their services.

- Increasing awareness of services available to people with diabetes.
- GP’s and practice staff should make patients at diabetes clinics more aware of the variety of services that exist.
- There should be much better promotion of local diabetic support and services to raise local awareness, although there is a plethora of advice is available in all forms – leaflets, online etc...

- Local and accessible facilities where people are greeted by a friendly and approachable face.
  - Offering more out of hour’s appointment times to accommodate working hours.

- Continuing to provide annual retina checks, foot care and so on which are currently routinely conducted.

- Being proactive more proactive in supporting those who are potential diabetes sufferers.
  - Dieticians/nutritionists should be more pro-active in reaching patients/potential sufferers.
  - PALS should do more to encourage patient participation in physical activities, than just dishing out leaflets and activity timetables.

- Improving the quality of training around diabetes for people with diabetes.
  - DESMOND is not fit for purpose; this is two days of training wasted at a critical time when patients who become aware of their illness need correct and effective advice programme.

Equality issues:
Views were sought specifically from South Asian people, for whom it is keenly important that diabetes services are accessible, as there is a higher incidence of diabetes in this community.

4.18 - Golcar Clinic – including Phlebotomy, Weight Management, Podiatry Services, and Locala staff (health visitors, district nurses, community matrons, school nurses, community midwives)

Location: Golcar, Greater Huddersfield
When the engagement took place: May–June 2013
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Residents of Golcar using services at the Golcar Clinic
Number of people engaged: 28 attendees at the drop-in event.

What the engagement involved: Golcar Clinic closed in June 2013 as it was in a state of unmanageable disrepair. This engagement took place in the run up to the closure to alert the public and explain new options for accessing care. The providers and commissioners of services at Golcar Clinic (Greater Huddersfield Clinical Commissioning Group, Calderdale and Huddersfield NHS Foundation Trust, Locala, and NHS Property Services) were present at a drop in session in May 2013; this was promoted through word of mouth, and a poster was created to be displayed in the Library, Children’s Centre, Church, Garden Centre, GP Practices and local shops, and local councillors were invited. At the drop-in, patients spoke with the professionals present, and were given the option to complete comment cards.
Key themes:
- Frustration that the clinic was closing and that there had been no discussion with the local population about this up to the drop-in date.
  - When distributing the posters for the event, local people explained that they did not want the Golcar Clinic to close.
  - People felt that the drop in session took place so late in the process of closing the clinic that it would have no impact on the outcome – “Why has this meeting been call today when everything was cut and dried before people knew it was closing.”
  - The lack of clear communication about the changes had led some people to inappropriately approach alternative services for an explanation, and others to feel nervous about where they should go without the services at Golcar Clinic.

- Difficulties getting to alternative locations for care and treatment.
  - Several of the people who attended the drop-in used the podiatry service at Golcar Clinic, and were very concerned about long bus journeys to Huddersfield Royal Infirmary for support, and longer walks to the bus stop to be able to get in to Slaithwaite.

- The need for some forethought about who the building will be sold or transferred to after the clinic has closed.
  - Patients suggested that the building ought to be used as a business hub for small businesses in Golcar, or as a GP practice.
  - They were concerned about the building being sold for residential development when parking in the vicinity of the clinic is already limited.

Equality issues: No information

4.19 Huddersfield Royal Infirmary

Location: Huddersfield Royal Infirmary, Greater Huddersfield
When the engagement took place: January 2013 – present
Who led the engagement: Healthwatch Kirklees
Who was involved: Public providing feedback about Huddersfield Royal Infirmary over the phone, in meetings, by email, and on patient feedback websites.
Number of people engaged: 169 comments

What the engagement involved: Healthwatch Kirklees gathers feedback from people who have used health and social care services in Kirklees. The feedback has been analysed to identify themes across the range of services being considered as part of the strategic review.

Key themes:
- Ensuring that discharge is timely and that an appropriate level of care is in place after someone has been discharged.
  - Some patients felt they had been discharged from hospital too early, with not enough support available once they returned home.
  - “…spent two and a half months in ICU. Was unable to walk when he got home. If I (wife) hadn’t been able to look after him at home I don’t know what he would
have done as he kept falling. Community rehabilitation was promised but it didn’t happen. I tried to chase this up but it was a 6 week wait to do initial assessment.” (Cancer Services)

- “…..a call was received from HRI to say she could come home. The manager (at Mencap) asked if she was mobilising and was told ‘yes she has been up to the toilet’…..Mencap staff noticed she could not use her right arm and was not able to walk unaided. Doctor said he would send her to physio. Mencap manager said she needs to be admitted to find out what has happened to her, not to a physio. She was then admitted to the Medical Assessment Unit” (Patient with a learning disability – Cardiology Services)

- “Discharged whilst still in a lot of pain. I was refused medication to help with pain. The pain killers I needed were crossed off my medicine chart. I went home but after two days I was in agony and was taken back to hospital by ambulance where I was re-admitted. I was told that whoever had crossed out my medicine should not have done that” (service unknown)

• Importance of employing staff with the right attitude and approach to caring for someone.
  - Some patients felt that they had not been treated well by staff working in the hospital, with a lack of care and empathy shown by some staff.
  - “The staff on ward 3 are extremely rude. They need further training on how to provide care and cleanliness. Their attitude stinks and it seems to me they don’t think of their patients whatsoever. They don’t have any dignity towards caring” (Ward 3)
  - “I was insulted not only by the nurses but by the doctors too. One doctor told me that I was not in pain when I winced at him touching my stomach and another nurse yelled at me for being sick on the floor when she had taken my bowl away” (A&E)
  - Other patients had nothing but praise for the staff who treated them, giving recognition to staff who were compassionate, reassuring and understanding despite working in often stressful and busy departments.
  - “The staff were approachable, friendly and very helpful, despite being very busy. They explained what had happened and the medication I would need. I cannot rate them, the speed with which I was treated and the effectiveness of that treatment, highly enough” (A&E)
  - “…feel very grateful to the staff for their professionalism and compassion. Nurses and health assistants are very good – providing treatment, support and understanding” (Urology)
  - “The nurses are fantastic and extremely caring. I was very nervous but felt extremely at ease, especially by the level of care and time from the nurse who took me to theatre and who explained every stage to me of what was happening” (Minor/Day Surgery)
  - “A wonderful hospital where the staff deserve much more appreciation or the excellent jobs they do” (A&E)

• Reducing any concerns raised around the quality of care to zero.
  - Some patients were concerned about the clinical treatment they received:
  - A manager from Mencap Kirklees felt that there may have been an assumption by medical and nursing staff that a patient’s symptoms were the result of her learning disability, rather than looking for the real cause which was actually a
stroke. Symptoms had been dismissed by clinical staff which delayed stroke treatment by 5 days.

- A parent told us about her 7 year old daughter being admitted to HRI with a locked right knee, in extreme pain. She wasn’t given appropriate pain relief until 84 hours after being admitted. She then developed deep bed sores from being left in a urine-soaked bed and because staff didn’t use an appropriate air bed during her stay.

- Importance of reducing delays and providing information about why a delay might have happened and how long a patient could be waiting.
  - There were significant delays in some outpatient clinics and when waiting for surgery. There was very little information given to patients to explain the reason for the delay and how long they should expect to be waiting.
  - “I had an outpatient appointment on Friday 14 June 2013 at 4.10pm…..I waited and waited until approx. 5.50pm then had to leave due to having other commitments (I am a carer for my elderly mother….). No-one explained that there was going to be a long wait or posted any comments on the white board on the corridor giving details that there was a long wait” (Urology Outpatients)
  - “Took my son to HRI for an adenoid operation. Arrived with my son being nervous and frightened. He wait 6 hours before taken to theatre, so more time spent being scared. It’s abysmal”
  - “Hospital appointments and not seeing patients at the time stated on the appointment card. People turning up for appointments shouldn’t have to wait over half an hour before they’re seen. If this happens someone needs to apologise and given an idea of length of time they need to wait” (Outpatients)

- Minimising clerical and administrative errors which can result in wasted time and unnecessary cost for both staff and patients.
  - “I saw a different consultant, who was excellent, but explained that my GP’s referral was to dermatology, whereas his specialism was colo-rectal and….he could do very little for me beyond making sure that I was fast-tracked to a relevant specialist. Thus the whole wonderful system sabotaged by petty administrative incompetence” (Dermatology)
  - “I got a letter 12 months in advance and then received 3 or 4 letters rearranging my appointment. It would be better not to send out the annual review letters so early” (Service unknown)

- Delivering excellent specialist care and treatment to patients with learning disabilities, and improving to consistency of this across the hospital.
  - Treatment and care is excellent when specialist staff are involved, but at other times the quality of the care and treatment of these patients can be below the standard expected.
  - “On the second day, with Community Learning Disability Team support, the medical care greatly improved….The Learning Disability matron has trained Learning Disability champions on the wards, but it is still not certain you’ll get someone who understands your needs” (Urgent Care)
  - “[the Learning Disability Matron] is very experienced and is a source of support for people with learning disabilities, accessing their appointments and treatments. She will fast-track people with learning disabilities through A&E (if necessary) and is a general all round help. Unfortunately, when [she] is on leave
or sick the good practice grinds to a halt as other parts of the hospital (reception, A&E etc) are unaware/unskilled in dealing with people with learning disabilities.

- Concerns expressed about potential closure or changes to services available at Huddersfield Royal Infirmary.
  - “Reading in recent news that this hospital was at risk of closure of the A&E department absolutely petrifies me. Had it not been for the services of this hospital, I would have been in agonising pain to travel further”
  - “Do we have to set off hours before needing A&E services if it is moved to Halifax?...I think we need an A&E at each hospital”
  - “I am concerned that more of these services will now take place at Calderdale Royal Hospital according to the planned changes to hospital services and I have to travel on public transport so I’m going to really struggle to get there. I have already cancelled one appointment in Calderdale because it was too far to travel on public transport, especially when you have to do all that waiting when you get there”

**Equality issues:** Specific issues have been raised around the experience of people with severe learning disabilities. When specialist staff are available, reasonable adjustments are made to the way that care is provided, but on occasions when those staff are not available, more problems are experienced with care.

### 4.20 Medical Assessment Area Huddersfield Royal Infirmary

**Location:** Greater Huddersfield  
**When the engagement took place:** 17th December 2014  
**Who led the engagement:** Healthwatch Kirklees  
**Who was involved:** Patients and visitors in the Medical Assessment Area  
**Number of people engaged:** 8 patients or carers, 1 staff survey completed  
**What the engagement involved:**  
A 2 hour observation of the Medical Assessment Area at Huddersfield Royal Infirmary (HRI). Semi-structured interviews with patients and visitors to the ward on that day, who were willing and able to speak to us. Not all questions were asked of every individual.

**Key themes:**
- Efficient, understanding and helpful staff delivering high quality care.
  - Patients and visitors commented that they had received excellent care during the period of time that they had been on the ward, and that they had gone out of their way to go above and beyond the level of care they expected.
  - “If I need help I just ask. A young guy came and helped me earlier, brought me a commode. It could have been embarrassing but he didn’t make me feel that way.”
  - “They’ve been exceptional, brilliant since we got on this ward.”

- Concerns about the welfare of the staff.
  - Some patients expressed concerns for the staff working with them who they felt were run off their feet and struggling to fit in the correct breaks.
  - “I worry about the staff; they’re always telling me to slow down and have a drink, but they aren’t getting their breaks and they need them.”
• Providing clear information about the patient’s health and the care they are receiving.
  o Most patients and visitors spoke positively about the information that they had received from staff on the ward. They felt that they were being kept up to date with their assessment and treatment and knew what was planned for their care, but were also being reassured.
  o “They’ve given me information about my treatment, but they give it with a comforting message, saying ‘you will live longer’ which helps me.”
  o There was a great deal of signage around the ward providing information about what to expect there, health conditions, etc... but this was a little cluttered and could have been overwhelming. Some signs needed to be updated daily as they reported staffing levels/gender of people on the ward, but these hadn't been updated.

• Long waits for initial care at the Accident and Emergency Department.
  o Some of the patients had experienced long waits in A&E for initial assessment for their health problem, and whilst they acknowledged that this wasn’t unexpected because A&E was so busy, it hadn’t been a positive experience.
  o “I’ve been on here for a couple of hours, but I’ve been in A&E since 4 o’clock this morning. It’s really busy so it’s understandable.” (Comment received between 2 and 4pm)

• Importance of discharging people in a timely way.
  o Staff at the ward explained the discharge procedure and the use of dedicated discharge coordinators during the week, and that they were working well, however, the Medical Assessment Area is an urgent care area, which means that it doesn’t only admit patients during the week and there is a need for effective discharge at a weekend.
  o One patient had been on the ward for over 5 days, although the maximum stay on this ward should really be 48hrs.

Equality issues: No information

4.21 Musculoskeletal Services

Location: Greater Huddersfield
When the engagement took place: June - July 2014
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Public (particularly users of the musculoskeletal services), key stakeholders, providers and voluntary and community sector organisations
Number of people engaged: 40 stakeholders at an event, 114 survey respondents

What the engagement involved: Review of local engagement work and literature surrounding musculoskeletal services, 1 public event, and a patient experience survey were summarised in 2 reports, NHS Greater Huddersfield CCG, MSK Services Engagement Report, August 2014, and NHS Calderdale CCG, MSK Services Engagement Report, August 2014. This is a summary of the information in the Greater Huddersfield based report.
The CCGs completed this work because there was a need to review the service pathway, explore opportunities for delivering care closer to home, and ensure the service is equipped for future demands.

Key themes:
• Improving the assessment process to include a triage service enabling patients to be seen by one person and being referred to the most appropriate service for them rather than having to access different services.
  o Patients said it was important that to simplifying the referral procedure, allowing them to be assessed quickly, and referred in to appropriate services
  o As some parts of the MSK service are funded by different parts of the health and social care system, they can operate in isolation and not communicate well, which can lead to delays in referral and care.
  o There were mixed reviews of the waiting times between referral and receiving the service, with some people reporting this was a good feature of the service, and others feeling they had waited too long for assessment.
  o It’s important to allow people to select the option that is best for them, which should be about their care needs, rather than their ability to travel to somewhere.
  o Some people felt that they could choose when and where there appointment was so it was convenient for them to use the service, others felt that they couldn’t get appointments at convenient times and locations.
  o Some felt that they did not always having the appropriate information to enable them to make an informed choice.

• Reducing the need for patients to access MSK services through prevention and the education of young people.
  o This could be through a screening programme for young people, using technology to make them more aware of the risk factors and how they can minimise them.

• Considering self-referral into services or back in to services where need arises.
  o Some patients want to self-refer directly to services (as they can in some cases) even if that’s just for advice and support to help them manage their own care.

• Supporting those with long-term conditions and appreciating the different need for ongoing support was also part of the feedback received.
  o For patients with long term conditions, episodic care for symptoms does not address their permanent needs; for them, a one-size fits all service isn’t appropriate, and they can feel that support is being rationed.
  o It’s important to give proper consideration to the person’s needs and to give them time to explain.

• Providing information for patients needing advice and support but also improving communication between services and with patients.
  o It’s important to provide information and advice as well as treatment, in order to help people to self-manage their pain and their conditions
  o Some patients reported feeling that they had been given exercises to do without explanation of how to do them, which had impacted their impression of the service, and made them feel that they weren’t understood.
  o Terminology used during treatment and when explaining a condition was also noted as an area where improvements could be made. All services need to
speak in a unified language so that patient understand what is happening with their care, and whether all the treatment they are receiving is work correctly together.

- Providing information on the services available and increasing awareness, both for patients and clinicians.
  - This was seen as helpful and something that would further improve the experience of care and referral. Patients reported a lack of awareness of what services are available from both the public and professionals.
  - Professionals need to know more about what other services are available that complement what they deliver so they are able to signpost.

- Integrating services was seen as a positive step in improving the MSK services.
  - There is a need for a single point of access/triage type system to make referrals in to the services smoother and allow patients to get to the right service the first time, and improve referral to treatment time.

- Increasing availability of complimentary therapies to patients as part of treatment.
  - Patients would like to see the MSK service providing hydrotherapy, massage and complimentary therapies.

- The MSK service was rated positively with patients appreciating the partnership approach.
  - 95 survey respondents answer the question about what was good about the MSK service, and many of them stated they had received a good quality service.
  - Listening to patients and taking a partnership approach with them when planning their care was greatly appreciated, and helped patients to feel their care meets their needs and focuses on the outcomes that can be achieved.

**Equality issues:**
Due to the limited number of responses to the survey from people who are not White British, it is difficult to identify whether there would be a specific impact. These services are accessed by some people with long term health conditions and disabilities, and older people, so it important to consider their needs more specifically in light of changes.

There is a comment in the work that there may need to be some improvements in the way that information is explained to people with learning disabilities.

### 4.22 Patient Reference Group Network – Community Services

**Location:** Greater Huddersfield  
**When the engagement took place:** December 2013  
**Who led the engagement:** Yorkshire and Humber Commissioning Support  
**Who was involved:** Members of GP Surgery Patient Reference Groups who attend the quarterly network meetings  
**Number of people engaged:** No information

**What the engagement involved:** Table top discussions about what services could be delivering in the community, or could be delivered differently. This was followed by a discussion about the anticoagulation service.
Key themes:
- Many services could be moved from hospitals in to the community.
  - These services could be diagnostic, such as phlebotomy, ultrasound, X-rays and Doppler testing could be provided in community locations; they could be minor surgery, such as cataracts, removal of skin tags; they could be treatments or preventative care, such as podiatry, weight management and physiotherapy.
  - Although some parts of some of these services are already provided in the community, there was a feeling that the whole care pathway could be moved, with consultants delivering clinics in the community.
  - There needs to be clear consideration of the impact that this could have on the capacity of community health centres; GP’s may be equipped or skilled in delivering these kinds of care, or have the room to host more clinics/sessions.
- Reduction in travel times and transport costs when delivering services closer to the patient’s home.
  - This could be very beneficial for some patients who may struggle to get to the hospital for their care.
  - Hospitals do tend to be well served by buses and that is not always the case for community locations.
- Working together with other health providers in the local area to create hubs for specific clinics.
  - GP surgeries could cluster together to provide more specialist services closer to a patient’s home, but not necessarily at their own practice.
  - This could help to address issues around space and having the right specialisms available in the team delivering care.

Equality issues: No information

4.23 Patient Reference Group Network – General Practice

Location: Greater Huddersfield
When the engagement took place: March 2014
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Members of GP Surgery Patient Reference Groups who attend the quarterly network meetings
Number of people engaged: 4 tables of representatives

What the engagement involved: Table top discussions about what is most important about General Practice, and what they would like to see change. Views were also sought about specific areas for development:
  - Development of care out of hospital and integrated care
  - Patient experience
  - Quality and clinical variation
  - Patient access to primary care services

Key themes:
- Delivering high quality care provided by competent, knowledgeable, and proactive staff.
  - It’s important that all staff working in a GP surgery respond to patients in a sensitive way. Particular problems with GP receptionists were mentioned; as the
first contact someone often has when they book an appointment, it’s important that the person makes them feel welcome.

- Staff should have relevant knowledge for what they do. For doctors, they need to be competent and provide accurate diagnoses, but also be aware of activity in the community that might complement a person’s care, and be able to signpost effectively.
- People want to be able to see the same person and have continuity in their care so they can build a rapport with that person, especially if they will be seeing them regularly due to a long term condition

- Variety in the way you make appointments and can access the GP service.
  - Consider providing appointments and drop-in sessions so people can access their GP service in the way that best suits them.
  - Using effective triage to assess what level of service someone needs, but that is flexible enough that if someone would like to see a GP but their needs aren’t seen as high enough, they can still get access.
  - If you have an allocated GP due to your long term condition, but then a different problem arises, you should be able to access other GPs in your practice to get the care you need.
  - Providing alternative booking systems, such as going online, but still being able to book over the phone.
  - Telephone system should be easy to understand; you should be able to get through to make an appointment, and you shouldn’t have to ring a premium number.

- Longer opening hours.
  - People would like to be able to access GP service in the evenings and at weekends.

- Providing a wider range of clinical services but not at the expense of the general practice.
  - You should always be able to access a GP at your surgery for a standard appointment, but surgeries should consider expanding to offer access to simple diagnostics, like phlebotomy or minor surgery.

- Using all resources possible to get out health messages.
  - There is not one specific approach that can be used that will get health messages and information about service changes out to the population. There needs to be variety in the way that information is shared so everyone can find it accessible. For some people this will come through word of mouth, online or on social media, on the digital screens at the GP, and in local community locations.
  - The communication can’t all be digital or in practice because it’s only a specific proportion of the population who access that.
  - Campaigns need to be targeted at the appropriate age group, etc…
  - The information should be changing all the time, so it is eye-catching and people pay attention. Often in GP practice waiting rooms there is information overload.
  - Take the time to get the message out about how important it is to give feedback about your experiences, whether that is good or bad, and encourage people to do this in any way they see fit. This could be in many different ways, from through showcasing examples on the GP practice wall to sending out links to Patient Opinion
Equality issues: No information

4.24 Patient Reference Group Network – Use of technology

Location: Greater Huddersfield
When the engagement took place: October 2013
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Members of GP Surgery Patient Reference Groups who attend the quarterly network meetings
Number of people engaged: No information

What the engagement involved: Table top discussions about using technology to improve health care systems and experiences.

Key themes:

- Using new technologies can be difficult for older people.
  - People are wary of the accessibility of technology, mostly assuming that older people will be adversely affected.
  - Many of the attendees called for 24/7/365 support for anybody using health technology.

- Offering an alternative to a face to face appointment through technology for low level interaction is positive and can release resources for people who can’t use technology.
  - Technology is seen as being most useful for sharing test results, booking appointments and sending reminders, repeat prescriptions and information giving about health advice and available services.

- Consulting using different technologies could mean less waiting and travel for patients and professionals.
  - Consultations can be given using different methods such as telephone, e-mail and video conferencing.
  - There was a note of caution that these should be a choice and not the default.

- Sharing patient information respectful, whilst enabling other professionals to respond appropriately to a patient’s need.
  - Privacy concerns were raised about the sharing of patient information and who should have access to this.
  - The benefits of transparency and information being available to health professionals so that people don’t have to repeat their story were also noted.

- Peer support and the support of self-care were seen as areas where technology can be effective.

- Addressing barriers to the implementation of new technology.
  - The need for a culture change for health professionals and patients was seen as essential to integrating technology into healthcare.
  - Costs were also seen as a barrier to introducing technology.

Equality issues: No information
4.25 Patient Reference Group Network – Vulnerable Adults / Over 75s

**Location:** Greater Huddersfield

**When the engagement took place:** June 2014

**Who led the engagement:** Yorkshire and Humber Commissioning Support

**Who was involved:** Members of GP Surgery Patient Reference Groups who attend the quarterly network meetings

**Number of people engaged:** No information

**What the engagement involved:** Table top discussions about services that will help vulnerable adults and over 75s maintain and enjoy their independence for longer, focused around 6 key options that could help to achieve this:

- Practice based discharge coordinator service (not hospital based)
- Care co-ordination
- Targeted social care services
- Practice attached district nursing
- Dementia care workers
- Review of poly pharmacy for over 75s

**Key themes:**

*Overarching themes*

- Ensuring that carers are fully support and respected through the development of new initiatives.
  - Family carers provide crucial support to NHS services; without them often patients would often need far more care at a greater cost to the system.
  - Additional support should be made available for carers as part of the changes to the way services are delivered.

- New proposals should be considered in light of their impact on crisis avoidance.
  - When people are left without the right care and support for extended periods, they can end up in crisis, which is very detrimental for that individual and their family, but also very costly for the NHS. Any proposals to change the way services are delivered should be considered in light of this.

**Themes for each option discussed by the network**

**Practice based discharge co-ordinator service (not hospital based)**

- This proposal was seen as a good idea that met all the aims.
- There were questions over the level of support that would be required for different individuals.
- The service should have the patient at the centre acting as a central contact for a wider multidisciplinary team.

**Care co-ordination**

- There was concern that this could duplicate on work already being done, but was seen as the most beneficial proposal if this could be avoided.
- It was recognised that regular meetings must take place and that this has worked well where it already exists.
- There was a call for more social care involvement if this was to work as this has been missing in current similar meetings.
Targeted social care services

- The group felt that this proposal did not meet all the aims and was unrealistic, but they could see the improvements that it could bring.
- They did not understand whether the role was about signposting or care coordination, and felt that a Care Coordinator may be better placed to do this kind of role.

Practice attached district nursing

- It was felt that this proposal may bring better communication between district nursing and general practice, but that it did not meet all the aims.
- The current district nursing service was considered to be good.
- They suggested that consistency and a familiar face was important to this particular client group, but that this might just be a ‘nice to have’ and that an efficient service was more of a priority.

Dementia care workers

- The group recommended that this proposal should be considered as it met all the aims.
- Discussions centred around crisis avoidance which would have a positive impact on patients and families as well as being cost effective to the NHS.
- It was also seen as a way to promote independence and provide joined up care for patients.

Review of poly pharmacy for over 75s

- The group felt that this proposal met all the aims.
- Medication reviews were seen as an easy way to save money through preventing unnecessary prescriptions. It was suggested that this would benefit other groups, not just over 75s, especially people on numerous medications.
- The group discussed the current inconsistency in medication review dates across the area and the need for patients to have more information and understanding of what medication they were taking. More involvement from pharmacies was seen as a way of improving this.

Equality issues: No information

4.26 Princess Royal Community Health Centre (PRCHC) – including Audiology, Podiatry, Children’s Therapy, Community Paediatrics, Diabetes, Dental Services, Looked After Children and Sexual Health services

Location: Greater Huddersfield
When the engagement took place: October 2013
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Stakeholders including the public, health professionals and voluntary sector organisations
Number of people engaged: Specific numbers are not stated in the report – 14 comment cards were received from users of Sexual Health services, 64 comment cards came from wider engagement events, and 15 parents and carers took part in Child Development Service focus groups.

What the engagement involved: A review of all engagement work and patient feedback completed or received by the Calderdale and Huddersfield NHS Foundation
Trust (CHFT), Locala, and Greater Huddersfield Clinical Commissioning Group related to PRCHC in the 2 years prior this engagement period. A programme of engagement with stakeholders comprised of:

- 4 drop-in sessions at PRCHC which were promoted to stakeholders directly and through social media and the websites of the providers involved. They took place at different times of day to encourage different attendees.
- Comment cards were available at every service delivered at PRCHC, and were distributed at wider engagement events over the course of the engagement period.
- Focus groups were held with the parents and carers currently using the Child Development Centre (Ellerslie Unit) based at PRCHC using “Experience Based Design” methodology.

Key themes:

- Importance of moving the services at PRCHC to a central location with easy access for people using public transport.
  - A significant portion of the people involved in the engagement shared negative views about the service moving to a new location; some of these acknowledged that this was necessary, but people liked its current location and access by public transport.
  - As the service must move, it needs to be provided in a central location; podiatry patients expressed particular concerns about any increase in distance from a bus route or the town centre.
  - People involved in the engagement were keen to keep the service in a non-hospital, community setting, and possibly see more services delivered from that location.
  - For people using the Child Development Service, they were often happy to travel to wherever the best care for their child was available, but longer travel times, responsibilities to other children, etc... meant that a local, expert service is beneficial to them.

- Considering the accessibility of any new site for people with disabilities and wheelchair users.
  - The needs of people who might face additional barriers when attending a service should be taken in to account when selecting a location, then delivering services from it.
  - Wheelchair access should be available to all parts of the building both for wheelchair users, and those who struggle on their feet, as some users of podiatry service do.
  - There should be clear signposts guiding people through the building; people with diabetes commented that the signage internally and externally at PRCHC was poor.

- The need for a better environment and comfortable waiting areas with consideration for privacy and dignity.
  - 9% of comments reflected a need for better and more comfortable waiting areas, in particular the users of the Contraception and Sexual Health clinic (CaSH) would like to see larger waiting areas.
  - 6% of comments concerned catering for disabled, older people and having private waiting areas for the sexual health service.
• The need for adequate parking facilities.
  o There should be an adequate number of parking spaces available at any site, with special focus on making sure there is enough disabled parking available.
  o The car park should be in a safe location and the price of parking should be as low as possible.

• Importance of friendly and helpful staff consistently providing high quality care throughout the different services at PRCHC.
  o Around 20 people involved in wider engagement activities felt that the PRCHC was a valuable community health resource, meeting the needs of a cross section of the community.
  o Of 70 podiatry service users, over 90% said they would recommend the service to a family member or friend.
  o Of 40 Sexual Health and Genitourinary clinic service users, over 97% would recommend the service to a friends
  o Child Development Service users felt that the staff had provided them with lots of support; that they had the right knowledge and advice to give to families, and a really positive “can do attitude”.

• Carers using the Child Development Service appreciate the co-location of child therapies and community paediatrics, which enables contact with other families.
  o Parents liked that on their first visit they could be introduced to other families who were in similar situations; it was reassuring for them and made them willing to offer their help to other families.
  o It’s helpful for the young people to have a mixture of group support and one-to-one care.
  o Providing all the necessary services from one place, in a one-stop-shop style, reduces the need for the parents to tell their child’s story again and again and smooths transitions between services

Equality issues:
The engagement team reviewed a relationship matrix to ensure a diverse group of people were invited to attend the events and share their understanding. It’s unclear from the equality data how many people attended or what the full picture of the ethnicity of the attendees was, but there was a reasonably equal representation of men and women; around 30% of people who attended had disabilities and long term health conditions.
The services within the PRCHC that are targeted most specifically at groups with protected characteristics are Sexual Health and Genitourinary services, which is frequently used by those age 16-24, and the Child Development Service, used by children with developmental issues and disabilities.

4.27 Continence

Location: Greater Huddersfield and North Kirklees
When the engagement took place: September 2014
Who led the engagement: Healthwatch Kirklees
Who was involved: Carers group C3, Locala Continence Service, St. Matthew’s Carers Group.
Number of people engaged: 17 members of the public, 7 professionals
What the engagement involved:
An online survey, asking people about their experiences of using continence survey. Attending meeting with different carers groups to discuss issues around continence services. Speaking with professionals/ service providers.

**Key themes:**

- The need for understanding that there is a difference between the assessed clinical need of a person and the practicalities of dealing with incontinence.
  - There is often a marked difference between what people are assessed as needing and what carers and individuals feel they need to manage their personal care.
  - Specific types of pads suit certain types of individuals, for example, pull ups might help someone with dementia who still has the urge to pull up their underwear after going to the toilet, but they are often not assessed as having that clinical need, so are allocated different pads.
  - “There are limits to how many pads you can have regardless of clinical need. Pads are being rationed, pull up pants are impossible to get, I don’t know of anyone that is receiving them.”

- Difficulties affording continence products when the allocation does not meet the practical needs of the individual and the carer.
  - As many carers feel that the allocation of continence products doesn’t match with the level of need, they often have to spend their own money on buying additional pads for the person they care for. This puts strain on their finances which can have a negative impact on their ability to manage.
  - “Caring is expensive when you have to incontinence to deal with as well. I spend money from my own pocket. I don’t bother buying new clothes for myself as the pads are more important. My appearance, diet and health all are affected when I don’t have enough money left over.”

- Difficulties accessing the required amount of products.
  - “I used to get 4 pads a day and 1 kylie, but when I asked for another kylie they took away one of the pads. I used to use that pad inside the bigger pad as due to the nature of my husband’s incontinence that was the best way to manage. I thought it was a trade-off that was worth it.”
  - “It’s ridiculous the way the service decides how many pads a person needs, when my wife is at home they expect us to make do with 3 pads a day but when she’s in hospital they’ll use up to 7 pads for her.”
  - For some patients, the need for additional pads is linked to observing religious traditions, and the need to be clean when praying.
  - “I have to buy extra pads for my grandma as she prays 5 times a day, praying helps her keep calm and it’s the only thing she really remembers and finds comfort in. Locala only give 3 pads and they’re not exactly the best quality. I have tried to explain to them but they’re not interested, they just don’t understand why people want to keep clean when praying.”

- The impact of struggling to access incontinence pads on patients dignity and wellbeing.
  - Using pads can be a source of embarrassment or difficulty for service users and carers, particularly if there are limited numbers of pads, meaning that some individuals are spending time wearing used pads. Continence products can enable people to live with dignity, but for some carers, the limited number makes
them feel like the dignity of the person they care for isn’t respected by the service.
  
  “If we received more pads I could take him out more. His incontinence should not be a barrier to him socialising and doing the things he likes to do, but unfortunately it’s preventing him from doing activities that he really enjoyed before he became dependant on pads. I think the incontinence is the only issue that makes me think of sending him into a home, it’s the last thing I want, but I have to think about myself and his quality of life”

- Offering more support to carers to help them to care for the person with the continence issue.
  
  o Continence issues have a significant impact on both the carer and the cared for, and managing this can be one of the most stressful parts of being a carer. There is a need for additional support to be in place to meet the needs of carers who are struggling with this.
  
  o “At night if he has a leak or an accident on the floor, I have to clean it up straight away in case he gets up and slips. If they gave me pull ups then this would eliminate this problem, but pull ups are expensive so I don’t expect them to give me them. Changing the pad of a fully grown man, who doesn’t understand what is going on is not an easy task! The NHS need to think of us carers who have to deal with this without any training, support or equipment. We save the NHS so much money but as carers we are being run into the ground.”

Equality issues:
This issue impacts people who follow a religion that requires them to be clean and have a clean pad on when praying.

4.28 Hospital discharge into care homes

Location: Greater Huddersfield and North Kirklees
When the engagement took place: November 2014
Who led the engagement: Healthwatch Kirklees
Who was involved: Staff at the discharge lounges at Huddersfield Royal Infirmary and Dewsbury and District Hospital, care home managers in Kirklees.
Number of people engaged: 25 care homes took part in the survey. Engaged with 2 staff members at Dewsbury hospital and 2 at Huddersfield Royal Infirmary.

What the engagement involved:
Visiting the hospital discharge lounges to observe and speak with the staff about their experiences.
A survey asking care home managers about their experience of hospital discharge, which could be accessed online or completed over the phone as part of a telephone interview.

Key themes:
- Difficulties coordinating and discharge times with care homes.
  
  o The time when a resident is discharged from hospital was the most common raised issue by care homes. Care home managers reported that the hospital would give a certain time for when the patient will be discharge but then send the patient either too early or too late.
• Discharging patients with incorrect or incomplete information, meaning care homes do not have a full understanding of how to care for the person discharged to them.
  o In some cases, care home managers described instances when residents had been discharged without discharge letter and where care home staff had not been informed of changes to medication.
  o Some residents were in need of additional equipment following a hospital stay, but care homes were not always provided with information about this.
  o 25% of care home surveyed strongly disagreed that they are given accurate care plans, whilst 29% strongly disagreed that they were being notified of any changes to the care plan.
  o “Residents often arrive at the home without notice, without discharge letters, catheterized residents are sent to us without catheter books, no information on size or type of catheter and nothing to say when the catheter was last changed. Residents often have pressure sores and no dressings are sent. Care plans are never sent to the homes.”

• Importance of accurate and up to date care plans.
  o 83% of the care home staff said good care planning and good discharge had a significant impact on the resident.
  o “If you’re not given good care package it’s not going to be a good impact on the residents”
  o “A good discharge, including full care plan/information would ensure a smooth transition from hospital to care home and not put a strain on our resources, which are needed for the client. More often than not clients are discharged with no paperwork or inadequate paperwork. Medication is often missing.”

• Discharging patients at inconvenient times.
  o 30% of care home reported that hospital discharges were never convenient. The key reason for this was lateness.
  o Some care homes reported that they are not always notified when a resident has been discharged.
    “The patient sometimes arrives later than agreed with hospital or two patients will arrive together.”
    “Times that residents arrive at the home, often late at night when there are fewer staff to greet, settle and make the resident comfortable. We often have residents discharged from hospital with zero notice.”

• Importance of being respectful to patients during discharge.
  o Care home reported that they felt the hospitals weren’t always respecting the dignity of the person when they were being discharged, in some cases sending people home inappropriately dressed, without medication, or without their personal belongings.
  o “Never dressed, not dignified, come out in slippers soaking wet!”

• Improving verbal and written communication between the hospitals, care homes, patients and families.
  o “Communication needs to be improved. Thought needs to be given to the care home, i.e. ensure client is discharged with all medications, care plan and or discharge notes. It is essential that medications are returned with the client. More often than not the DNAR is not returned with the client. This causes the care
Equality issues: Elderly people or vulnerable adults are most likely to be transferring between hospitals and care homes, so problems with this process disproportionately impact them.

4.29 Integrated Care

Location: Greater Huddersfield (in conjunction with North Kirklees)
When the engagement took place: Over 7 weeks from 23rd December 2013 – 9th February 2014, with follow-up events in May 2014.
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: The public, key stakeholders, representatives from the voluntary and community sector, clinicians
Number of people engaged: 112 survey respondents, 50 attendees at the initial engagement event for the public, 30 attendees at the initial engagement event for clinicians, 32 attendees at the follow-up engagement event for the public, 28 attendees at the follow-up event for clinicians

What the engagement involved: A comprehensive review of all patient comments and engagement work held completed by the Commissioning Support Unit relevant to the integration of care types, including self-care and prevention, diagnosis and care planning, preventing admission to hospital and discharge planning.
A survey that asked respondents to reflect on what they would need to equip themselves to manage their care, and how other services could support this. This was distributed by email and across social media.

Four engagement events:

- Initial public event – exploring the views of the general public around integration of care, focusing on group discussions about self-care and prevention, diagnosis and care planning, preventing admission to hospital and discharge planning.
- Initial clinician event – making sense of the patient journey by reviewing questions from the clinician and the patient point of view. The questions were:
  - What are the features of a good community service?
  - What do you want the new community service to do or deliver?
- Follow-up public event – reviewing the progress to date, confirming that the CCG were moving in the right direction, and identify if they had missed anything. They did this by reviewing finding posters and the proposed new model for integrated care.
- Follow-up clinicians’ event – reviewing the specifics of the new model of integrated care, such as whether the speciality and core functions were listed correctly, and what the footprint should be for the delivery of those community services.

Key themes:

Overarching themes

- Importance of providing regular reviews, follow ups and ongoing support and for this to take place at home or closer to home.
  - These should be provided by community services, in turn supporting patients to stay safely at home whenever possible, and providing an early alert when problems are arising, rather than those problems turning into crises.
The community service’s culture should be to take responsibility for home-based patient care based on patient’s needs, providing them with the services to remain well and independent in their own homes.

Fundamentally, this about doing the right thing for patients and their families by supporting them consistently to maximise independence in locations that are local to them.

- Involving patients and their families / carers in the planning and delivery of their care and enabling them to make informed choices.
  - For patients to feel fully involved they must be provided with information that they are able to understand which enables them to make informed choices.
  - Patients need to know about their diagnosis, what to expect, how to manage their condition, what their treatment options are, what ongoing support or care is available and who to contact for further support. This must cover information about what social support as well as medical care is available, including Experts by Experience programmes and voluntary sector groups.
  - Carers needed to be consulted in the development of any plan, as their involvement is often crucial to the management of a patient’s condition.

- Providing care navigators to coordinate care for a patient and their family.
  - These would help prevent fragmentation of services, multiple ‘hand offs’ and referral barriers that currently exist in pathways of care by taking responsibility for coordinating this.
  - A care coordinator or navigator ought to be able to make sure that appropriate services for the individual are being engaged at the right time.
  - If the coordinator isn’t able to meet the needs of that patient because their support needs have changed, there should be the option of retaining for continuity, or changing care coordinator.

- Offering access the right services at the right time and for more services to be available in the evening and at the weekend.
  - The services delivered under integrated care should be reactive and capable of providing rapid input and treatment whenever necessary. This means a service would/could meet people’s needs in a crisis.
  - There are concerns about how we can ensure that services across the board are available 24/7 when there are currently gaps between services.

- Ability for services and patients to access their patient record.
  - Patients feel that their story should be shared between services, so that they do not have to repeat it every time they interact with a new health professional.
  - If services can access the medical records, patients ought to be able to see them too to understand more about their care and condition.

- Providing a seamless, integrated service staffed by a skilled and flexible workforce that wraps around the needs of the patient.
  - There is a need for a community service that proves holistic health and care needs to enable support for patients with complex care needs and multiple long term conditions, rather than only treating specific conditions.
The staff that deliver these services need to be understanding, knowledgeable and proactive; they need to be able to listen to and respond to the needs of the patient in order to empower and motivate them to maintain their health.

- Improving and increasing the use of technology, such as telemedicine, self-care hub and assistive technology.
  - This can be used in supporting people to self-care; access to information and peer support through apps can help people to manage their own conditions and maintain their health.
  - Assistive technologies can be used to help people in their discharge from hospital, but appropriate training to use them needs to be offer, and these shouldn’t replace care from trained professionals.

- Improving access to primary care
  - This could be through delivering community services through primary care clusters.
  - There is a need to increase awareness of the support you can receive from your local pharmacy, and possibly to extend their involvement in caring for people with long term conditions.
  - Some people access urgent care services because they have struggle to get appointments in primary care settings and the impact of this needs to be considered.

*Themes for specific parts of the patient journey*

**Self-care and prevention**
- Supporting patients to be healthy, take responsibility for their wellbeing and to be encouraged to self-care by providing access to information, advice and support with regards to diet, exercise, support groups / networks and who to contact for ongoing support.
  - This can be achieved through a community culture which provides patients with the tools to take control and self-manage their own care and conditions
  - Some consideration should be given to providing local, affordable gym and exercise / sport

**Diagnosis and care planning specific themes**
- Developing individualised care plans held electronically that can be accessed by both patient and professionals.
  - The plan needs to be outcome focused not just based on medical needs, refreshed regularly and with a holistic approach to care while improving safety and quality.

**Preventing admission to hospital specific themes**
- Ensuring patients are fully involved in the development of their care plan and informed of its content
  - This enables patients to know what to expect, who to contact, outlines the provision of ongoing care / support and regular reviews to help reduce the chance of a crisis occurring.

- Improving and increasing staffing at Care homes
This would include ensuring staff receive appropriate training and support to improve care and prevent high turnover of staff.

This may lead to some consideration of an increase in bed provision.

**Discharge planning specific themes**

- Involving patients and their families throughout the planning of their discharge.
  - To enable them to make an informed choice, they should be advised on what services are available and what their options are. Upon discharge, patients need to know what to expect and who to contact should they require any further advice or support.
  - The approach needs to be holistic and flexible to meet the individual needs of the patient.
  - This should be done early enough, to ensure that the appropriate services can be put in place.

- Increasing integration of care across pathways which break down traditional barriers in primary, community, secondary and social care.

- Changing terminology from “discharge” to “transfer of care”.
  - It was felt that discharge implies that a patient is no longer receiving care; however, in most cases the care transfers to another provider, this transfer needs to be seamless.

**Equality issues:**

In the second stage of the engagement process, people raised particular concerns about making sure that the new model of service delivery was suitable for people with disabilities, in particularly sensory impairments, e.g. ensuring that a Single Point of Access can be accessed in multiple ways, rather than simply over the phone, as someone with a hearing impairment may struggle to use this; increasing the amount of advocacy available from people who use communication using BSL if you intend to fully engage a patient in the development of their care plan.

Equality monitoring forms were distributed with the public engagement survey. 71 people chose to complete this, they were predominantly female (74%), White British (85.5%), Christian (40.6%) or had no religion (43.5%), were not disabled (88.2%), were aged between 36 and 65 (76%), and were straight (89.6%). Carers were quite well represented in the survey sample, with 40.6% of respondents having a caring responsibility.

### 4.30 Multiple & Complex Needs

For the purpose of this work ‘multiple and complex needs’ means someone who is experiencing two or more of the following: homelessness (including temporary accommodation), re-offending, problematic substance and/or alcohol misuse or mental ill health

**Location:** Greater Huddersfield and North Kirklees

**When the engagement took place:** Across various locations in Kirklees although most of the engagement took place in Huddersfield.

**Who led the engagement:** Healthwatch Kirklees

**Who was involved:** Providers of services for people with multiple and complex needs and people accessing those services.
**Number of people engaged:** Around 40 people.

**What the engagement involved:** Healthwatch Kirklees spoke to people with multiple and complex needs at a variety of locations including Huddersfield Mission; The Corner Recovery Project, Huddersfield; The Whitehouse Centre, Huddersfield and to clients being supported by Simon on the Streets in Huddersfield.

A survey was made available on-line and this was sent to staff working with vulnerable people.

Some people requested individual meetings so that they could share their experiences in detail.

Huddersfield Mission collected case studies specifically about people’s experiences of discharge from hospital and mental health units. These case studies contributed to Healthwatch England’s first ever Special Inquiry and also informed this piece of work.

**Key themes:**

- Greater use of emergency and urgent health care service by people with multiple and complex needs.
  - Half of the people we spoke to had used A&E in the last 18 months.
  - People with long term health conditions and other complex needs don’t always manage their health condition effectively. When accessing urgent care, sometimes clinical staff only treat the urgent medical condition and the management of long term health conditions or other underlying health issues remain a concern.
  - People with multiple and complex needs often don’t seek medical attention, even when they have concerning symptoms. We spoke to a man who had sustained a serious injury to his arm but would not seek medical attention and said he would just drink until the pain went off. We spoke to another lady who had a burn on her arm and who said she had broken her finger. She said she wouldn’t go to get treatment as she had no money to get to the doctors or A&E.
  - It appears that people sometimes neglect their health until it becomes a critical issue.

- Experiences of discharging people with multiple and complex needs in an unsafe way.
  - There is a need to have more co-ordinated, flexible and responsive services to support people once they are discharged.
  - Huddersfield Mission told us about a man with a history of depression and psychosis who was discharged after a one month stay in hospital. He was sent home with no claim for benefits, no food, no toiletries, no bed linen and no kitchen equipment. His support plan had been left blank by the hospital.
  - GP’s are sometimes not informed when their most vulnerable patients have been discharged from hospital, leaving those patients without the support and follow-up they need.

- Importance of providing flexibility in the ways to access health and care services for people with multiple and complex needs.
  - A single approach to offering health and care services to these individuals is unlikely to work, and excludes those whose needs don’t fit neatly into the package on offer.
  - More drop-in sessions are needed, rather than appointment only systems.
It would be helpful to have more outreach health and care services, based where people with multiple and complex needs already access services.

- Vulnerable people were not used to being asked their opinion on the services they access.
  - More opportunities should be available to give a voice to those who are often the most easy to ignore.

**Equality issues:**
Patients with multiple and complex needs often experience a different NHS and social care system to other patients. Standard, mainstream services on offer do not always work for those patients who struggle to make and keep traditional appointments or are unable to travel to access services. This contributes to a wider picture of health inequalities, with life expectancy significantly below the rest of the community in Kirklees.

### 4.31 Outpatient Clinics

**Location:** Huddersfield Royal Infirmary and Calderdale Royal Hospital  
**When the engagement took place:** December 2014  
**Who led the engagement:** Healthwatch Kirklees  
**Who was involved:** Patients attending the following clinics:
Breast clinic, Cardiology, Colorectal, Diabetes, Endocrinology, Gastrology, General medicine, General surgery, Gynaecology, Neurology, Oncology, Plastics, Respiratory medicine, Rheumatology, Stroke, Urology, Vascular  
**Number of people engaged:** 309 patients

**What the engagement involved:** A survey completed with patients in an interview style whilst they waited in outpatient waiting areas for appointments.

**Key themes:**
- Providing appointments at convenient times and in convenient locations, without a long wait for care.
  - In 87% of cases, patients hadn’t chosen their own appointments, they had either booked directly with the GP, who seemed to have selected the most convenient option for that patient, or had received a letter directly from the hospital, and were happy with what they had been allocated.
  - The majority of patients were happy with the length of time it had taken to get an outpatient appointment and hadn’t experienced problems with cancellations.
  - “This has been an exceptional turnaround for an appointment – seen by GP on Friday, got a phone call the following Monday to let me know I had an outpatient appointment that Wednesday”
    Patient at Calderdale Royal Hospital, Gastroenterology
- Welcoming and easy to use check-in system
  - Most patients said they were greeted by a friendly, welcoming member of staff.
  - Where a self-check in system was used, patients generally found them easy to use, but were able to get some help if they struggled.
- Ensuring patients have all the information that they need to be able to attend the appointment.
Generally, patients felt that their appointment letter contained enough relevant information to enable them to attend their appointment. Some who attended multiple clinics or needed a variety of tests felt it could be made clearer in their letter what the appointment is for, so they can prepare, and what they need to do to check-in when they get there.

Patients lacked awareness of their right to choice when arranging an outpatient appointment, e.g. right to choose which hospital to go to.

For some patients in particular situations, there may be concessionary parking rates, and there is little information available about this for patients to access.

- **Difficulties with persistent delays at some clinics**
  - Patients at particular clinics reported long waits after their arrival, and a lack of information about how long the wait would be.
  - “The problem is how long you have to wait – take your appointment time and add at least an hour on”
    Patient at Calderdale Royal Hospital, Plastic Surgery

- **Importance of providing a suitable and comfortable waiting area.**
  - Waiting areas were often very cramped particularly at Huddersfield Royal Infirmary (although this problem will be alleviated to some extent by most outpatient clinics now being located at Acre Mills). When accompanied by long delays, some waiting rooms were full and people were waiting in corridors.
  - “Awful. Hate coming here. Windowless, cramped. Not a great experience”
    Patient at Huddersfield Royal Infirmary, Surgical Outpatients
  - “Used check in screen. Told to take a seat in corridor 4 and I was then waiting over an hour. I eventually asked what was happening and was told I was sat in the wrong place”
    Patient at Huddersfield Royal Infirmary, Rheumatology Clinic

- **Importance of respecting patient dignity in the delivery of their care.**
  - “Last time I came I had to have an injection. All the clinical rooms were full so the injection was given to me in the staff room. I was asked to lean over a desk so that the injection could be given in my bottom. Someone knocked on the staff room door whilst this was being done which made me feel a bit awkward. I didn’t mind being in the staff room but I can understand why some people would find this unacceptable.”
    Huddersfield Royal Infirmary, Rheumatology Clinic

**Equality issues:** No information

**4.32 Mental Health – Section 136 of the Mental Health Act 1983**

**Location:** Greater Huddersfield and North Kirklees
**When the engagement took place:** January – April 2014
**Who led the engagement:** Healthwatch Kirklees
**Who was involved:** Service users and carers with experience of Section 136, professionals from South West Yorkshire NHS Partnership Foundation Trust (SWYT), Kirklees Council Emergency Duty Service and Approved Mental Health Professional Service, and West Yorkshire Police.
**Number of people engaged:** 33 service users and carers, 9 professionals working with people with mental health issues.
What the engagement involved:

- Review of existing national research looking into the use of Section 136.
- Attending 4 existing support groups and forums for people with mental health problems and carers provided by SWYT and St Anne’s Community Services to have an informal discussion with the attendees about their experiences.
- Distributing a survey that asked questions specifically about individual experiences of Section 136. This survey was added to Healthwatch Kirklees website, tweeted to the general public, and was distributed to the contact list held by the Inclusion Team at SWYT.
- One to one meetings with professionals

Key themes:

- Working better together both between agencies, and senior management and frontline staff
  - Professionals from all of the different agencies expressed frustration with each other; there was a lack of understanding of the role of each organisation, their limitations and how they should be coordinating the care for someone in crisis. Despite a multi-agency policy being in place, there was limited awareness of this.
  - In particular, there was tension between Yorkshire Ambulance Service and the other parties involved, as the conveyancing of patients in crisis should be done by ambulance, but when other agencies were already involved, it was difficult for them to deploy resource to assist. As service users reported that they felt criminalised by being transported in police cars, it was particularly crucial to resolve this issue.
  - Service users and carers explained that there had been a lot of variety in their experiences, and that in some cases, police had taken them to a Section 136 suite that was closed or full. Better communication was needed between the police and the suites.

- Increasing awareness of mental health issues and awareness of the care options available for individuals in crisis
  - Service users and carers reported that they had experienced a lack of awareness of mental health issues from the police in some cases. They did not expect that the police should have a full understanding of mental health issues but wanted to see more of this.
  - In their interaction with mental health professionals, service users and carers felt they had faced a greater level of stigma and assumption about their mental health.
  - Professionals highlighted that sometimes police had not chosen the best option for the person in crisis, and that there needed to be a greater awareness of the options available.

- Keeping patients at the centre of all services and ensuring that those hardest to reach are not marginalised
  - Some service users felt that their treatment in crisis was dependent upon their history rather than their current presentation, and that assumptions were made about how they would behave or what they needed, and that they wanted staff to treat their current problem, not refer back to the past.
  - Carers and service users felt that crisis services were very inaccessible. Often someone had to be critically mentally unwell before services would act to treat
that person. There was a feeling that more services should be available to intervene earlier, protecting the service users and keeping them at the centre of their care.

- Carers were concerned that if they cared for someone who was difficult to support, that the services did not make enough effort to maintain engagement with them, especially when that person has a dual diagnosis, such as substance misuse.

- Improving consistency of record keeping and ensuring that recorded information adds value.
  - The picture of detention under Section 136 in Kirklees was unclear during the completion of this work because records held by the police, SWYT and the AMHP service did not match. It's important to have an accurate record so we can clearly understand the issues.

- Assuring the quality of the service people receive under Section 136
  - More needed to be done to seek the views of service users and carers around Section 136, as due to the interaction of lots of different agencies, little had been done to make sure that the process was fit for purpose in Kirklees.

- Developing ways in which Section 136 and crisis mental health care could be delivered to meet the needs of patients and carers
  - Service users and carers felt that crisis care across Kirklees was not of a high enough standard. It does not do enough to support people who are struggling prior to going in to crisis and not paying attention to carers who can highlight the signs that someone’s mental health is deteriorating.
  - As there is no Section 136 suite in Kirklees to act as a place of safety, there was a feeling from professionals that additional capacity in appropriate places of safety would be beneficial.

- Reviewing the need for a Section 136 Suite and in-patient beds in Kirklees
  - Psychiatric inpatient care is no longer available in Huddersfield; instead patients from Huddersfield are placed in a ward in Calderdale. Carers in particular felt that this was unsuitable, and there should be ongoing review of whether beds should be made available in Greater Huddersfield.

Equality issues:
Equality monitoring was not completed as part of this piece of work. This focus of the work is people with severe mental health problems, who are a vulnerable group. Some national work has looked at the impact of Section 136 detention in police cells on young people.

4.33 Health care for people who are Deaf and hard of hearing

Location: Greater Huddersfield and North Kirklees
When the engagement took place: September – October 2013, report published in February 2014
Who led the engagement: Healthwatch Kirklees
Who was involved: People registered with Sensory Services at Kirklees Council who have a hearing impairment
**Number of people engaged:** 410 surveys completed, 50 people attended focus groups.

**What the engagement involved:** A survey sent to 1400 people registered with Kirklees Council Sensory Services with hearing impairments, distributed by post available online.
5 focus groups run at specific Deaf groups across Kirklees, coordinated with support staff and volunteers at those groups.

**Key themes:**
- Difficulties using existing telephone appointment booking systems to access GP and hospital services.
  - Most GP and hospital appointments are made over the phone; this can be very difficult for people with a hearing impairment. 39.5% of the people we asked said they felt they could call for an appointment themselves, but 39% rely on friends and family to call, and 48% have at some point visited in person to book an appointment.
  - Although many people were content to continue booking appointments in this way, around 25% of people would like to contact their surgery by email or text.

- Lack of awareness of whether medical records make a specific note of the individuals hearing impairment, prompting reasonable adjustment to services.
  - Over 50% of respondents did not know whether their impairment is recorded on the GP or hospital systems, so were unsure whether staff would be prompted to make adjustments for their needs, such as booking a BSL interpreter or passing on details of hearing impairments in referrals.

- Difficulties with verbal calling for appointments at the GP and the hospital.
  - Some patients reported missing appointments they had attended because they were verbally called in the waiting room and they could hear that. This was a particular issue in waiting rooms where the TV or radio was on leading to greater difficulty hearing someone calling you in for your appointment.
  - Some respondents preferred to be collected by the clinician from the waiting room, or to have a display screen showing who was being called in for an appointment.
  - Particular difficulties with this were experienced at Huddersfield Royal Infirmary (HRI) audiology clinics, where the environment was no conducive to being able to hear verbal calling, and the staff seemed to lack awareness.

- Difficulties with all types of staff at the GP and hospital lacking deaf awareness and communicating inappropriately.
  - Many respondents said that reception staff lacked awareness of the needs of hearing impaired people, and did not make arrangements that would help them through their appointment.
  - Patients are concerned about missing important information about health conditions and medications because the doctor or nurse doesn’t communicate clearly with them; key problems are medical staff not speaking clearly, or not facing the patient.

- Misunderstanding the information provided by clinicians.
Some people had asked a family member to interpret for them at appointments, but they felt this was inappropriate. Some had resorted to researching online when they got home.

Some medical staff have written things down for patients with hearing impairments, but staff don’t seem to understand that Deaf people don’t always find written English easy to understand.

- Negative experiences with BSL interpreters at HRI.
  - Several of the people involved in the focus groups communicated through BSL and raised concerns about the quality of BSL interpreters provided at HRI. Additionally, these weren’t always gender appropriate, with male interpreters being sent to gynaecology appointments.

- Difficulties accessing other primary care providers.
  - The survey found that, of the 139 people who had communication problems with other NHS service, 60% struggled at opticians, 59% at the dentist, 34% with pharmacies, 30% had problems accessing the NHS 111 service and 29% had problems with community healthcare services.
  - People felt that these providers were not deaf aware, and didn’t make adjustments to allow deaf people to access their services.

- Lack of awareness amongst Deaf people of their rights as consumers of other NHS services, especially specialist services such as maternity or emergency services.

- Further difficulties travelling for appointments at the hospitals for hearing aid aftercare, such as battery replacement etc.

Equality issues:
The difficulties reported here are experienced by people who having hearing impairments across Kirklees. Health outcomes for people who are Deaf are typically poorer and barriers to accessing health services could certainly be contributing to problems around understanding health conditions and knowing how to take medication.

4.34 Autistic Spectrum Conditions

Location: Calderdale, Greater Huddersfield and North Kirklees
When the engagement took place: October-November 2014
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Parents and carers of children using the service, professionals working within the service
Number of people engaged: 60 parents, carers and professionals at events, 48 survey respondents

What the engagement involved: Four facilitated engagements events with parents, carers and professionals, and a survey for parents and carers summarised in the “A review of services for children and young people with Autistic Spectrum Conditions across Calderdale, Greater Huddersfield and North Kirklees” Engagement Report (November 2014)

Key themes:
Providing a person centred system wide approach with services aligned to deliver timely, seamless and coordinated care is fundamental in the delivery of high quality care to people with autism.

- It’s necessary to put the needs of the child or young person at the centre of the way that the service is delivered. The current service model appears to focus on available resource rather than the child.
- Involving all family in the process of assessment and service provision means that the needs of the child are met more comprehensively.

Commissioning services coordinated across all relevant agencies and encompassing the whole autism pathway where multi agency staff work in partnership with the child or young person with autism and their family or carers.

- The approach to delivering ASD assessments and services needs to be holistic, considering all the needs of the child and providing care that meets all those needs. This should be enabled through good multi-agency working and integrated care.
- It’s important to simplify the pathway for access for children from referral to service delivery

Respecting and including parents and carers through appropriate communication techniques enabling them to be fully involved in the planning of their child’s care.

- Families felt that there was a lack of support for them as carers of children with ASD, and that providing more support for them would enable them to better care for their child.
- Parents reported that in their interaction with professionals, they felt their views weren’t respected, that they had to plead their case for their child. In some cases, the views of the school appeared to be prioritised over the views of the parents.
- “Treat service users and their families with respect… don’t assume parents are uneducated… your lack of support has made them the way they are, i.e. having to fight for help…”

The absence of a locally agreed model of care, limited capacity and the lack of integration between health, education, social care and the voluntary sector is creating significant delays, potential duplication and gaps in provision.

- Different care pathways exist across the three geographical areas. Current provision is delivered by a range of providers working in distinct silos resulting in services being fragmented.
- Parents and carers reported poor experiences with the ASD services overall. Although there were some positive references to the ASD team, largely there was critique of insufficient support, long waits for diagnosis and care, and poor links between services.
- “There is no service. Once diagnosed there is nothing provided.”
- “I don't think there is a good enough service provided for families with an autistic child. I personally think it's a massive let down from the get go; it's like constantly banging your head on a brick wall till someone takes notice…”
- Despite a shift towards assessing and managing needs rather than conditions, parents without a diagnosis of ASD are still struggling to get the support they need if they did not have a diagnosis.
- Families explained that the criteria for diagnosis of ASD and to access services were very restrictive. In their view, large numbers of children don’t meet the
CAMHs criteria so don’t get the support or care they need, leading them to question just how serious and urgent a need has to be before it is addressed. They felt that access to the services should be based on needs rather than diagnosis.

- Following delays in accessing assessment, some parents had opted for or were considering getting a private diagnosis for ASD, however they explained that these diagnoses often did not enable them to access the ASD services provided across Calderdale and Kirklees.
- The recognition of co-morbidity is important and needs to be identified as soon as possible. Some participants felt that services may be falling short with the diagnosis of co-morbidity and the provision of necessary support.

- Lack of clear pathways resulting in families experiencing a ‘pillar to post’ experience where they were referred to and from different points of contact e.g. GPs, schools or VCS groups.
  - It’s important make sure that detailed, up to date, clear information about a patient is passed between services involved in the patient’s care.
  - Details of the child’s care should be shared between departments and services so it isn’t necessary for family to tell their story again and again. This could simplify the pathway from referral to service delivery.

- Long waiting times for assessments and poor contact and communication.
  - Families are experiencing excessive waiting times for assessment, and some feel that the diagnosis hasn’t then led to appropriate or timely intervention
  - “I have left messages with CAMHS to try to speed things up and haven't been called back. I've given up going down this route and trying to get a diagnosis by another means.”
  - Whilst waits for assessment for ASD are so long, it’s important that some support is in place to assist the child, the family and their school prior to finalising a diagnosis.
  - As so many parents reported struggles in getting access to the initial assessment, and the different parts of the service after an assessment, they felt it was crucial that there was a single contact point for families where they could get information and referrals to relevant services. This would take the responsibility for coordinating the care of child away from the patient and place it with ASD services, preventing families from feeling that they are being passed from “pillar to post”.

- Limited capacity is a real concern of everyone involved.
  - The views of parents across Kirklees are that all services to support children and young people with ASC are resource-driven, not needs-led.
  - Many of the specialists interviewed expressed frustration and concern regarding current capacity to deliver high quality co-ordinated care to children and young people with suspected and diagnosed ASC.
  - Some clinical specialists are reported as having to carry out all administrative functions wasting valuable expertise time. For many, no cover or back-up is available during periods of holidays/sickness and when a member of staff leaves the organisation they are often not replaced.
  - The funding and resources for ASD services are scarce, and are far outweighed by demand; more is needed, not just to bridge the current gaps but to make provision for increased demand in the future.
Staffing shortages should be rectified in-house.

Cuts to social care services and funding are also impacting families caring for children with ASD.

A previous short term solution through non-recurrent funding provided an immediate answer to the waiting list problem but provided no continuity of care and support beyond diagnosis.

- Importance of experienced professionals carrying out the assessment of children with complex/behavioural difficulties, and retaining that level of expertise throughout the provision of ASC services.
  - Consistency in personnel is essential to ongoing provision. When changes occur, parents and carers need to be made aware of this to ensure they can communicate this with their child.
  - Awareness raising among and training for local professionals including health, social care and education sectors was also considered by participants as a contributing factor to effective delivery of ASC services.

- The provision of care for those aged 16+ also needs to be considered as part of developing local services to ensure adequate levels of support as well as smooth transition from child to adult services.
  - There needs to be a consistent approach to the transition between child and adult services supporting young people with ASD.

- Providing clear information about conditions and services, what services are available and what can be expected of those services
  - Enabling parents to have a clearer understanding of their child’s condition, their needs, the way they are being cared for, and what they can expect to receive from services should alleviate anxieties about whether the service is going to be able to offer what the child needs and what they can do to help.
  - Information for parents and carers needs to be jargon free.

Equality issues:
As this service is in place to support children with multiple health needs, changes to services and where they are provided could lead to a disproportionate impact on disabled young people.

4.35 Cancer

Location: Calderdale and Greater Huddersfield

When the engagement took place: Early 2014, report published September 2014

Who led the engagement: Calderdale and Huddersfield NHS Foundation Trust (CHFT)

Who was involved: Patients who had been discharged from receiving cancer care from CHFT between 1st September and 30th November 2013.

Number of people engaged: 423 patients (70% response rate)

What the engagement involved: A patient satisfaction and experience survey that was distributed by post, which asked questions about a patient’s experience of using cancer care services.

Key themes:
Calderdale and Huddersfield NHS Foundation Trust (CHFT) scored in the top 20% of hospital trusts across the country for these elements of patient care:

- Giving clear explanations of necessary clinical tests.
  - Staff gave complete explanation of purpose of test(s)
  - Given easy to understand written information about test
  - Given complete explanation of test results in understandable way

- Involving patient fully in their care and treatment.
  - Patient definitely involved in decisions about care and treatment
  - Taking part in cancer research discussed with patient
  - Doctors and nurses did not talk in front of patient as if they were not there
  - Hospital staff told patient they could get free prescriptions
  - Got understandable answers to important questions all/most of the time
  - Patient never thought they were given conflicting information
  - Patient offered written assessment and care plan

- Delivering care through competent ward nurses, allowing the patient to have trust in them.

- Planning and delivering effective discharge from care.
  - Given clear written information about what should or should not do post discharge
  - Staff told patient who to contact if worried post discharge
  - Family definitely given all information needed to help care at home
  - Patient definitely given enough care from health or social services

- Coordinating with the GP practice to make sure a high standard of care is ongoing.
  - GP given enough information about patient’s condition and treatment
  - Practice staff definitely did everything they could to support patient

CHFT scored in the bottom 20% of hospital trusts across the country for these elements of patient care:

- Some improvement is needed in parts of interpersonal interaction at a time when the person is very vulnerable.
  - Patient felt they were told sensitively that they had cancer
  - Patient definitely told about treatment side effects that could affect them in the future
  - Clinical Nurse Specialist definitely listened carefully the last time spoken to

**Equality issues:** No information

### 4.36 Child Development Service (CDS)

**Location:** Calderdale & Greater Huddersfield  
**When the engagement took place:** May-June 2014  
**Who led the engagement:** Yorkshire and Humber Commissioning Support  
**Who was involved:** Carers and young people using the Child Development Service, and professionals
Number of people engaged: 15 from carers, 2 members of the public, 2 organisations and 3 professionals

What the engagement involved: Due to the pending closure of the Princess Royal Community Health Centre, it was necessary to consult with the public to explore options for the move of the Child Development Centre at PRCHC. The expectation is that this service will be relocated to be close to the paediatric care provided at Calderdale Royal Hospital. This engagement involved a review of existing data from PALS and other engagement activity, a survey and a meeting with Calderdale Parents and Carers Group, which were summarised in the NHS Greater Huddersfield CCG Child Development Consultation Report (July 2014).

Key themes:
- Concerns about the impact of moving the CDS out of Huddersfield on Huddersfield residents.
  * For those who rely on public transport, this could mean far long journeys.
  * For those that have access to a car, it was suggested that more parking spaces would need to be made available at Calderdale Royal Hospital that should be allocated to the CDS.
  * Families spoke very positively about the current location’s accessibility and felt that some additional transport should be provided to allow families to travel to the new location, especially those with frequent appointments.
  * For specialist services, families are happy to travel further afield (up to 30mins).
- Developing the Child Development Unit into a one stop assessment centre that provided a wide range of services, such as diagnostic tests and assessments.
  * There is a positive approach by the service to meeting each individual child’s needs, through a “joined up” service, especially in the assessment of babies and young children with developmental problems, and this should continue.
  * This should mean that appointments and meetings can all be accessed at once, and provides opportunities to meet with other families.
  * One location should encourage multidisciplinary work/support that child and family receive, with improved links to other services and therapies, keeping the child at the centre of their care.
  * CDS is currently delivered by a specialist team of dedicated professionals, with the appropriate knowledge and skills, and any move to a different location shouldn’t mean loss of staff meaning families retain contact with the staff that they trust and respect families.
- Providing routine and ongoing therapies at locations that are closer to home.
  * Popular suggestions included at Huddersfield Royal Infirmary, GP surgeries and health centres.
  * Young people reported that they would like the venues to be friendly to them, as well as local, with information available on line or through youth centres/workers.
  * Appointments local health centres may be preferable for families with long travel times to a Child Development Centre.
- Improving the provision of the service by delivering it over 52 weeks a year.
  * It was felt that this was a helpful development that may help to reduce waiting times.
- Providing outreach within mainstream schools.
  - There was a feeling that children who go to special schools get better access to services than those in mainstream education.

- Concerns about the availability of appointments and potential increases in waiting times, if services for both Calderdale and Huddersfield areas are to be based at one centre.
  - Waiting lists are currently too long to get access to the highly commended services, and there were concerns that a merged site might lead to a longer waits.
  - There are concerns about the accessibility of appointments for young people; they need to be at convenient times, such as just after school, and in local venues.

- Importance of supporting and involving the family of the child using the service.
  - The priority should be providing families with a quality service that offers ongoing support and advice.
  - It's important to support parents, carers, siblings and friends so they can support the young person.
  - There is real value in having opportunities for children and families with similar needs to interact and support each other, with parents saying that play groups for their children were particularly helpful.

**Equality issues:**
As this service is in place to support children with multiple health needs, changes to services and where they are provided could lead to a disproportionate impact on disabled young people.

**4.37 Community Matron Service**

**Location:** Calderdale and Greater Huddersfield  
**When the engagement took place:** January – March 2014  
**Who led the engagement:** Calderdale and Huddersfield NHS Foundation Trust  
**Who was involved:** Patients who had used the Community Matron Service  
**Number of people engaged:** 141

**What the engagement involved:** Surveys were used to capture patient experience information from patients who have recently been under the care of the Community Matron Service. Patients were given blank questionnaires by the Community Matrons during their visits and asked to complete and return the form in a freepost envelope. A summary from the surveys is shown in ‘CHFT Community Matron Service Survey 2014’ April 2014

**Key themes:**
- Very good experience of the care provided by Community Matrons.
  - 95% of respondents stated that they would ‘definitely recommend’ the service to family and friends, should the need arise.
  - When patients were asked for comments on aspects of the service which are particularly good/need improvement, most commented on positive aspects of their experience.
“Everything was very good. If I needed her she was only a phone call away. Before she visited me I was going to my GP perhaps twice a week. When my matron started coming I didn’t need my GP half as much. She dealt with all my problems.”

“She gave us the feeling that she was on our side and gave strong emotional support as well as medical advice, she was available at the end of the telephone if needed.”

“(Name) feels like a very safe pair of hands, making the experience of terminal illness in the family less frightening. Very glad we’ve got him”

- Communicating well enhances confidence and trust in the Community Matron Service, and allows people to feel that their privacy and dignity are being respected.
  - Many patients gave positive comments about how their Community Matron spoke to them and dealt with their needs sensitively and respectfully. Patients spoke about how the information, support and advice given by the Community Matron gave them confidence to cope and manage their condition.
  - “She helped me to understand my illness and to help me with my fears and concerns”
  - “I was in quite a state when she came. I just could not get my head round the heart failure. I was really thinking life was going to be a nightmare but thanks to her way of getting me round, I have been able to be discharged”
  - “My community matron treated me with dignity and always listened to my choices”

- Improving the information that is provided by the Community Matrons about side effects of medications.
  - Some patients gave a negative answer to the question ‘Did your community Matron tell you about mediation side effects to watch for?’

Equality issues: No information

4.38 Diabetes
Location: Calderdale and Greater Huddersfield
When the engagement took place: Between January and October 2014
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: The public, key stakeholders, providers, voluntary and community sector organisations, in particular, members of the Calderdale Diabetes Support Group.
Number of people engaged: 65 people attended the event in January, 14 members of Calderdale Diabetes Group attended their meeting, and 47 people attended the October event.

What the engagement involved:
Group discussions and presentations about needed and possible changes to the way that Diabetes services are delivered, in light of the current challenges facing local care and support services from the ageing population and increasing numbers of people diagnosed with diabetes.

Key themes:
The engagement work took place in two stages. Stage one focused on the current services and looking at what works and what needs to be changed, whilst stage two
looked at the models that had been developed based on the feedback from stage one. The key themes that have emerged from each stage are as follows:

**Stage One**
- Enhancing services that prevent the onset of and health issues associated with diabetes.
  - Delivering more preventative services, such as weight management and exercise classes.
  - Offering screening for diabetes through NHS health check and other avenues.

- Enabling people to self-care through access to education and information.
  - Providing more education, and education in different formats to meet the needs of the population with diabetes.
  - Making sure that information about services and support is available and accessible.
  - Implementing emergency care plans so patients and carers know what to do if problems arise and act take action.
  - Resourcing community groups to work with people with diabetes.
  - Addressing the support needs of people in isolated communities.

- Improving standards in primary care.
  - Reducing variation in primary care by upskilling all practices to a standardised level of care.
  - There should be development of care standards that have to be met.

- Developing the workforce through training and education.
  - Ensuring that there is consistency in the training provided and that staff can access mentoring.

- Ensuring that everyone gets regular high quality foot checks.
  - This would include advice and signposting, then referral where problems are indicated.
  - There should be a broader plan to train a wide range of health and social care professionals to recognise diabetic foot problems and signpost or refer accordingly.

- Reviewing and increasing Diabetes Specialist Nurse provision.
  - Support should be in place for people with diabetes in hospital (around 1 in 5 patients in hospital at any one time have diabetes), including identifying people admitted for other conditions who have diabetes.
  - Offering more accessible specialist expertise/advice, including psychological support, out of hour’s services, particularly in relation to foot problems, and an expansion of outreach sessions.

**Stage Two**
Comments and views on self-care approaches to managing diabetes:
- Offering structured education, e.g. DESMOND, X-pert, and ongoing support to use the knowledge gained.
  - DESMOND was reviewed positively, although some felt that one full day was too long and would be better if it was delivered in shorter sessions. Some felt that
there was also a need for one to one support for those that wouldn’t feel comfortable in a group session.

- Upbeat, Slimming World and Weight Watchers were also reviewed positively.
  - They highlighted the need to provide participants with ongoing support to enable them to continue / implement the changes that they had learned. Suggestion was made to provide information that they could refer too after they had attended the course.

- Providing the option of E-learning.
  - This was seen as a valuable tool to be used alongside other mechanisms and was a good option for those that would struggle or prefer not to attend groups.
  - It was felt to be something that would not appeal to everyone but to encourage uptake could look at delivering sessions to help or train people to access information.

- Encouraging peer support/buddying to bridge gaps in service provision, especially for those people who are not newly diagnosed who seem to miss information about new services.
  - There was a lack of awareness of the availability of services. During the discussion people heard about Upbeat, Calderdale Diabetes Support Group, DESMOND, Health Trainers, buddying system at PRCHC but they either weren’t aware of their existence or they were only available one side of the patch.
  - Respondents had the view that most services are for newly diagnosed, and that there was a lack of services for people who needed ongoing support. Patients have reviews but don’t get offered ongoing support as part of this.
  - People felt positively about the idea of peer support and buddying and think it would give them motivation. Some preferred idea of it being in a group support format rather than 1-to-1, so there would need to be built in flexibility in the services for both.
  - Young people may access their peer support through social media such as Twitter.
  - The key to making this a success is ensuring that you have a buddy that is appropriate to you, someone you’ll get on with.

- Improving awareness of existing local support groups.
  - There was a lack of awareness of what was already in place and it was felt that existing services should be reviewed to see how useful they are and then establish what gaps, if any, there are.
  - There should be consideration given to how these groups are funded and how they are promoted.

- Developing a self-care handbook and other printed materials.
  - Mention was made of a patient handbook being in existence but people queried whether it was being used. Suggestions were made for it to be refreshed and to include dietary advice, recipes, FAQs, be interactive and consider it being available in different formats, such as large print, as an app or online.

- Increasing the use of websites for information about diabetes.
  - Websites were seen as a good way to access a lot of useful information; some people liked the idea of getting access to more online resources via their mobile phone.
This idea has to be considered in light of the fact that not everyone has internet access or is confident using technology.

Websites need to be designed in such a way that they can provide resources for the visually impaired and hearing impaired – perhaps a choice of talking videos and sign language videos, and consideration needs to be made for patients for whom English is not their first language.

Information on websites would be good to advise people of links between Diabetes and other conditions like Arthritis.

It can be difficult to know which websites are the best ones, so it was suggested that GP practices could have links on their own websites to direct patients to the best websites, both national and regional/local, then information would be more consistent and useful. This could also be linked to local CCG plans so patients could read up on what’s being done in their area to improve services and what the CCGs priorities are.

New Electronic Patient Record project could be tailored so that patients log in and are given advice/ signposting to advice that is suitable to their individual needs.

- Providing a telephone helpline.
  - A helpline was seen as a good idea and could reduce the impact on 111 and A&E if available 24/7. The current facility with the diabetic nurses asks for a message to be left which works but is dependent on the nature and urgency of the enquiry.
  - Diabetes UK – has a Monday - Friday ‘Careline’. Information about this should be given to patients within practices.

Future models of care

Key considerations raised by the public about developing new models of care:

- Properly resourcing any change in the way services are provided
  - Participants questioned the viability of the model in terms of resources. It was felt by some that this model could be more expensive and was unclear whether the necessary staff would be available to deliver this model or receive training.

- Addressing inequity in the delivery of diabetes services across the footprint.
  - There were concerns raised about services becoming a postcode lottery, if some GP registered to provide services and others didn’t. People wanted assurances that they would be able to access the same standard of care and information regardless of where they were living.

- Ensuring the involvement of multi-agency partners in the delivery of self-care models.
  - Participants queried the links to / roles of social care, community pharmacy, mental health, voluntary sector and the need for these to be factored into the models of care. Clear pathways would need to be in place, with clearly defined roles and processes.

- Considering all aspects of accessing a service and ensuring that these are accounted for in the new delivery style for the service.
  - This includes the impact on patients and carers in terms of transport, interpretation etc. whilst appreciating that the approach is ‘not one size fits all’.
Patients / carers need to be involved, engaged and informed throughout and need to realise that for some patients the move to the community may not be viewed positively. There is a need to provide education and support for newly diagnosed patients or those with a significant change in treatment.

Equality issues:
An equality monitoring survey was distributed at the October event. Some questions were left unanswered by many respondents and it’s unclear why this is. There was a reasonably even balance of men and women attending the event; no one declared they were transgender; 83% of attendees were White British, a limited number of representatives with a Caribbean background attended (9%); 89% of respondents were Christian or had no religion; 26% of attendees were carers; 27% of attendees consider themselves to have a disability.

4.39 HIV
Location: Greater Huddersfield and Calderdale
When the engagement took place: Report published July 2014
Who led the engagement: Healthwatch Kirklees
Who was involved: public, professionals, HIV support group (Brunswick Centre)
Number of people engaged: - 40 members of the public who are HIV positive, 2 professionals

What the engagement involved:
A discussion group with HIV positive patients at the Brunswick Centre, who shared their experiences when using health and social care services.
A Freedom of Information (FOI) to the Calderdale and Huddersfield NHS Trust and Mid Yorkshire Hospital Trust requesting that they send through their policies and procedures for providing health care to people who are HIV positive.
A survey to understand the experiences of HIV positive patients living in Calderdale and Kirklees when accessing health and social care services. The link to this survey was made available on the Brunswick Centre website and Healthwatch Kirklees website, and hard copies of the survey were available at the Brunswick Centre.

Key themes:
- Importance of NHS staff being open minded and non-judgemental.
  - Patients reported that they had experienced judgemental attitudes and inappropriate questioning by healthcare professionals about how their HIV was acquired.
  - “…the trainee doctor was very nosy about how I got HIV, and said the words "HIV you must be gay"
- Ensuring that the patient’s privacy and dignity are fully respected.
  - In some cases, patients explained that their HIV status had been mentioned in wards and other public places in front of other patients.
  - “When I had a sprained ankle, I was asked about any medication that I take, and the doctor at infirmary wrote on my notes that “patient with history of HIV”-- I didn’t like that.”
• "When I was first diagnosed in March 2004, it was broadcast by the doctor on his ward rounds to the whole ward. I was mortified."

• Understanding the patient’s medication and checking for interactions before prescribing changes.
  o Some respondents explained that Doctors (excluding those working in Genito-Urinary Medicine) were not checking for possible interactions with anti-retroviral medication before prescribing other medication with potentially dangerous consequences.
  o "I have to get a second opinion when I’m given new drugs, doctors are not checking how they interact with HIV drugs. This is negligent and dangerous. It’s placing the responsibility on the patient."

• The importance of supporting patients to self-medicate in hospital, rather than putting barriers in their way.
  o It’s important that anti-retroviral medication be taken at the right time. When in the hospital, some patients with HIV were not given their medication at the correct times and faced staff refusing to do this even when asked.
  o There was variety in this as some patients were allowed to self-medicate and some weren’t.
  o "When I was an in-patient I was told that I could not self-medicate, but the nurses were giving medication at incorrect times. Recently when I went to hospital, I was allowed but it’s not consistent"

• Routinely testing people for HIV without making assumptions about the likelihood that they would have it based on their background.
  o In some cases, people felt they had not being tested for HIV despite having signs and symptoms of HIV due to value judgements by doctors about their situation based on their outward appearance. (e.g., a white British man in a heterosexual relationship).
  o "I was dying in hospital, given two weeks to live, the health advisor talked me out of having the HIV test twice saying "you’ll never get a mortgage or travel insurance", I had the test eventually and I have got a mortgage and have health insurance, so the health advisor was wrong on both, and I could have started treatment sooner."

• Facing prejudices and inappropriate cautiousness from health professionals in their treatment for conditions unrelated to HIV.
  o Some patients have experienced unnecessary delays for day surgery as they have been put at the end of the list for medical procedures due to their HIV status, e.g., tooth extraction, dental surgery, and endoscopy.
  o "I have had bad experiences, whenever I attend my appointments at Calderdale conception unit I have to wait for longer periods, or be spoken to in way that I’m not a human being."
  o "I was made to wait til the end, because of my HIV status. The nurse told me that they would have to operate on me last as they will need to wash the operating table and theatre thoroughly after me. Surely this should happen after every patient not just those who are aware of their HIV status."
  o For some patients, they had experienced inappropriate gowning and “covering up” for medical procedures, such as wearing 2 pairs of gloves whilst treating a patient with HIV.
“Dentist when I had my implants, the doctors were in space suits. And treated me as if I was diseased. Whilst the nurse was dressed normally. This occasion was only to take a tooth out.”

- Fearing discrimination on the basis of HIV status
  - Patients explained that they do not feel able to disclose their HIV status for fear of discrimination.
  - “I have had to complain for discriminatory service in secondary care and occupational health due to my status in the past. On every occasion I have received an apology on the grounds that they did discriminate against me due to my HIV status.”

Equality issues: This affects people with HIV. The Equality Act 2010, which now incorporates the protections of the Disability Discrimination Act (DDA) 2005, defines everyone diagnosed with HIV as disabled and, therefore, entitled to the same protection against discrimination.

4.40 Single Care Plan – What do young people say?
Location: Calderdale, Greater Huddersfield, North Kirklees
When the engagement took place: Report written May 2014
Who led the engagement: No information
Who was involved: In Kirklees, young people who have involvement with Involving Young Citizens Equally (IYCE) and others who access youth clubs, schools, colleges and those in part time employment. Parents/carers were also involved.

In Calderdale, young people who attend Youth Works, Youth Council, Cartwheel Youth Centre, Queen’s Road Youth Centre, Brighouse Youth Centre and Calder High School.

Number of people engaged: Over 50 young people in Kirklees; 21 young people in Calderdale

What the engagement involved:
In Kirklees, discussion with young people focussed on how young people with asthma could incorporate a Single Care Plan (SCP) into their day-to-day lives. Parents/carers were also involved in these discussions.

In Calderdale, young people were asked to complete a short questionnaire which asked young people about the design of the SCP and which personal information it should include. A summary of all feedback is shown in ‘Single Care Plan: What do young people say? – Feedback from children and young people in Kirklees and Calderdale’ May 2014

Key themes: For Kirklees
- Young people understood the relevance of carrying something to explain to adults what their condition was and how to support them with managing it. Some young people said they would carry their SCP but were concerned about it being on paper. Some also said they were likely to forget/lose their SCP.
  - Suggested having an app, a plastic card which would fit in a purse/wallet or a band/bracelet containing information that professionals could access online.
• If a paper document was the only option, young people wanted the design to be interesting and to be of benefit to them.
  o They want the colour and design to be age appropriate.
  o It could offer discounts off certain activities/in shops.
  o It needs to be durable.

• Parents/carers thought the SCP would be useful as it would reduce the need to complete/update paperwork at school, out of school/holiday provision and other activity groups. They had concerns about their child losing the SCP which contains confidential, personal information.
  o Parents/carers favoured an app or a small plastic card which must be practical and durable.

Calderdale
• Young people favoured a colourful, small and simple, credit-card style SCP and they would like to have a choice of design.
  o When asked ‘what would make if cool for you to carry your SCP?’, out of 21 young people 7 said ‘colourful’, 4 said ‘small and simple’ and 4 said ‘choice of different design’
  o When asked ‘what would it look like?’, out of 21 young people 8 said ‘plastic, credit-card style’

• They feel the most important information for the SCP to show is their name, emergency contacts and medication details.
  o When asked ‘what information would you want it to show?’, out of 21 young people 12 said ‘emergency contacts’, 11 said ‘medication – dosage and methods’ and 7 said ‘name’

Equality issues:
This engagement work was conducted to look specifically at young people’s views of carrying a Single Care Plan, and the views of their parents.

4.41 South West Yorkshire Partnership NHS Foundation Trust
Transformation
Location: Calderdale, Greater Huddersfield, North Kirklees, Wakefield, Barnsley
When the engagement took place: June/July 2013 and October/November 2013
Who led the engagement: South West Yorkshire Partnership NHS Foundation Trust
Who was involved: Service users, carers, members of the public, voluntary and community sector organisations and mental health professionals.
Number of people engaged: Over 450
What the engagement involved: 7 large-scale events held across the Trust Localities where discussions were held around six key themes which had emerged from previous events. The feedback is summarised in ‘Feedback from the transformation events’ documents.

Key themes:
• I want services which keep me in the centre and which focus on my potential.
  o People feel that they want to be talked to as an adult, as an equal partner, with honest conversations that focus on their potential, not their illness.
  o They want to feel that they are in charge of their care plan, not the service, and
that their whole life is taken into account when creating the plan.

- If they have a long-term illness they want to be able to move back into services without complicated re-referral.
- People want to feel supported right from the start so if they have to wait for specific treatment they need to know where they are in the process, and they need access to some kind of support while they are waiting.
- If people are asking for help, staff need to really listen to that and recognise that even though someone may not meet the official guidelines for crisis intervention, they still need a rapid response. This is likely to prevent an actual crisis from developing.
- Building and using social networks is important, particularly for those who live alone, who don’t have good support networks or who find it difficult to engage.
- “Don't put me on a waiting list and just leave me”
- “If I say I need help, listen to me – I might not be in crisis but I need help now”
- “Recognise my expertise”
- “Wrap services around me, not me around services”

- If I choose to make use of technology, I want it to be available.
  - People want the choice to use technology to:
    - Share information and communicate with their care team
    - Access online peer support
    - Improve access to professionals and support
    - Manage as much as they can for themselves
    - Access recovery colleges online
    - Find out what is available
  - An assessment could be made to assess how technology can help to support people, although it is recognised that not everyone will want this. People could be given a smart device as part of their treatment, along with training and support on how to use this technology.
  - “Don't make me tell my story more than once!”
  - “I need to be able to find information easily”
  - “Don't assume technology will suit everyone”
  - “Don't forget that older people can use technology too”
  - “Make the most of the Facebook generation”

- I want all organisations, both big and small, to work together so I don’t see the joins.
  - People were concerned about how well statutory organisations were aligned at strategic and local levels and how they work together - police, primary care, secondary care, social services, housing, physical and mental health services all need to work together. People felt that care would continue to be fragmented if services didn’t become more integrated.
  - People want joined up care plans which they own.
  - There is very strong support for the role of the Care Navigator, but people recognise that people in this role would need extensive training, knowledge and experience.
  - People feel the Trust are good at looking after people when they are ill but they need to extend the pathway to help people when they are just starting to become ill and when they are starting to get better, and to do more to help people to stay well. There was a clear message that this can be done really well by the plethora of small, community based organisations that are already there. However, they need support to do this sustainably in the longer term.
The whole community's resources could be used more creatively, making the most of health champions, volunteers and connecting with very small, local groups as well as the larger organisations who know their communities well.

- “Work together so that we can't see the joins!”
- “Extend partnerships beyond local boundaries - think regional, national, international”
- “Fragmented services can't deliver value”
- “Are all statutory partners signed up to the same vision?”
- “We need better integration of physical and mental health services”
- “We need a workforce that is fit for the future”
- “Be open and realistic about constraints on our resources and how we can use them”

I want people to recognise early on that I'm beginning to have problems and to help me.

- People spoke about the importance of early education about health and wellbeing, to build awareness and reduce stigma, working in close partnership with schools, colleges and employers, housing and primary care.
- There is an important part to play in picking up issues earlier so that people don't get to a crisis point. People should be able to re-refer themselves quickly and easily.
- It is also important for primary care providers not to allow diagnosis of mental illness to overshadow other conditions and also to understand the impact of long term physical conditions on a person's mental health.
- “Schools and colleges are the place to start”
- “Carers need support and education”

I want you to offer me as much choice as possible and help me understand those choices.

- People want their choices broadening out to include alternative solutions which might include access to more creative activities, and they want to understand more about how this can help them.
- The decision about the service offer needs to be arrived at together.
- The key worker needs to have access to comprehensive, up to date information about everything that is available in their community.
- “Broaden your minds! Don't just offer more of the same.”
- “It can't just be a matter of only getting what your key worker knows about”
- “Arts aren't everybody's bag - we need lots of alternatives”

I want you to support my family and carers.

- Families and carers need more information, education and consideration from services.
- They recognise the need for confidentiality but feel that at present they are sometimes ignored and undervalued. They felt that they are an untapped partnership resource.
- “I want to make the decision on how to involve my family when I'm feeling well”
- “Don't forget about young carers”
- “If you support us, we can support our family member”

**Equality issues:** No information
4.42 Urgent and Emergency Care  
**Location:** Yorkshire and the Humber  
**When the engagement took place:** between January 2012 and November 2014, report published June 2015  
**Who led the engagement:** Patient Opinion  
**Who was involved:** Members of the public who had left reviews of urgent and emergency services on Patient Opinion  
**Number of people engaged:** 156 patient stories taken from the Patient Opinion website

**What the engagement involved:** A review of key patient stories that were shared on the Patient Opinion website discussing experiences of urgent and emergency care in Yorkshire and the Humber, comprised in to a report, *Patient experiences of urgent and emergency care in Yorkshire and The Humber: An analysis of stories from Patient Opinion.*

**Key themes:**

- Avoiding extended waits for treatment and offering an explanation for any longer waiting times.
  - Patients appreciate short waiting times and resent longer ones.
  - “I called 999 and a paramedic was there within 5 minutes followed by an ambulance 5 minutes later”
  - Longer waits were more acceptable where patients were kept informed of their own progress, reassured they had not been forgotten, offered refreshment when appropriate, had information on the reason for waiting, and did not feel that their own wait was the result of inappropriate demand by others.
  - “I understand they were busy with another patient but there were no apologies, no explanations, just a ‘wait there till I call you’. If they had just smiled and said I’m really sorry I’m dealing with another patient it would have been a different experience …”

- Delivering a high quality of consultation.
  - Patients placed high value on a “professional” consultation: this term encompassed ideas of expertise, competence, experience, thoroughness, efficiency and explanation.
  - “I was cared for by specialist trauma nurse whose knowledge and handling of the situation was second to none.”
  - “From the minute we came into A&E we were dealt with professionally, efficiently and thoughtfully.”
  - In addition patients placed emphasis on the importance of two-way communication: feeling “listened” to as well as talked to. Consultations which lacked these features tended to result in frustration, dissatisfaction and a loss of confidence in the care provided.
  - Patients lost confidence in their care if health professionals contradicted one another on treatment advice/decisions.
  - “The doctor who saw me said I was to have an enema and sent home. The nurse insisted that neither of these should happen as I was in too much pain.”

- Delivering high quality of interpersonal interactions.
Experiences of interpersonal interactions were by far the most frequent element of patient and carer stories, from those with receptionists through to doctors. They remarked on where staff appeared to work effectively as a team, or failed to do so.

“The whole atmosphere was of kindness and exceptional care... this has been the very best experience of NHS care that I have witnessed. Thank you to the excellent support staff, managers, nurses and doctors…”

Patients valued what they saw as personal, human care for them as an individual. Professionals who introduced themselves by name were seen as exemplifying this kind of care.

Where patients did not feel they were recognised or respected as individuals, they quickly lost trust in the professionals treating them, even to the extent of feeling unsafe and exiting the service.

“There was no eye contact from staff. I think so that you didn’t ask them anything as they were passing… They didn’t ask how patients, families were feeling even though some looked extremely scared…”

- Maintaining a clean physical environment that provides patient privacy.
  - The environment of care is important to patients, specifically in relation to cleanliness or its absence.
  - “The ward was spotless and been cleaned constantly.”
  - Some care settings clearly led to failures of confidentiality or privacy, with some patients feeling they lacked privacy at moments when they most needed it.
  - “I was inconsolable as I knew I was losing our baby and yet me and my partner were left with no privacy of a cubicle or room… just left in the corridor. Eventually we were moved to a curtained area but one which the public could look in to… We were just left with no privacy.”

- Delivering a joined up service, reducing the need to access multiple services.
  - Many patients commented on how well their care was “joined up” across multiple services, and conversely, on how sometimes it was not. Where the system did not seem to be “joined up”, patients reported accessing multiple services to resolve their problem, recognising that this carried greater costs to both themselves and the NHS.
  - “The Dr who took charge of my care made every possible effort to ensure that longer-term community support was put in place to help me to avoid acute admissions in future - so they didn’t just patch me up and ship me out, they enrolled me into the services I’ll need ongoing help from too”.
  - Many patients valued the provision of treatment outside of A&E departments, in minor injury units or walk-in centres. These were often popular because they were seen to avoid long waits, although sometimes led to frustration if the service was unable to deal with the presenting condition.
  - “Very grateful this service (MIU) is available. Would definitely use and recommend this service, sure beats waiting in … A&E for hours. Thank you.”

- Learning from patient stories about what works well and what needs to improve.
  - Patients posting their stories often gave explicit reasons for doing so. Positive stories were presented as expressions of thanks (and often as redressing what was seen as unfair media reporting) while negative stories were often intended to help improve care for others.
As well as expressing gratitude for the specific episode of care, patients would often also say how much they valued the NHS as a whole.

**Equality issues:**
More negative experiences with urgent and emergency care services tended to be reported by particular (often vulnerable) groups, including people with drug/alcohol problems, frail older people (including those with dementia), people with mental health problems, and women suffering miscarriage.

**4.43 Urgent Care and Accident & Emergency (A&E)**  
**Location:** Across England  
**Who led the engagement:** The Patient Association and the Royal College of Emergency Medicine  
**When the engagement took place:** September 2014 – February 2015, report published in May 2015  
**Who was involved:** Members of the public who had access accident and emergency services  
**Number of people engaged:** 924 survey respondents

**What the engagement involved:** An open access survey exploring how patients with urgent healthcare needs had accessed accident and emergency services. This was made available to the public on the Patients Association website. The survey provided definitions of urgent and emergency healthcare, co-location and primary care facility, and asked a series of questions to ascertain the experiences of patients, their awareness of alternatives, and their preferred treatment location.

**Key themes:**
- Patients choosing A&E because it is the most accessible and well known service.
  - The greatest proportion of respondents saw A&E as the most appropriate place to attend with a healthcare problem they regarded as urgent
  - “I use the A&E because I can attend when I need to, they have immediate access to diagnostic investigations and where needed I can see a consultant or specialist in the department.”
  - Around a quarter of patients had tried to access a GP appointment before heading to A&E, and 45% of those could get an appointment within 3hrs, but still chose to receive care from A&E, which implies that they have a greater confidence in the service they would receive from A&E
  - Ignorance of alternatives to A&E for urgent care needs does not adequately explain why patients choose to attend A&E departments.
  - Patient’s reported experience of A&E demonstrated the service to be prompt and effective for most respondents.

- Staff signposting to A&E because they acknowledge that it is the most accessible service.
  - Nearly 40% of those surveyed attended A&E because they had been advised to do so by other healthcare providers. Some of those providers could act to reduce A&E attendances.
  - This emphasises the lack of trusted, available alternatives.
• Delivering an out of hours primary care service that is co-located with A&E allows patient to make the choice to go to A&E for immediate access to care, but then be able to access the most appropriate type of care for their needs.
  o Through the co-location of urgent care services on one site, patients can be triaged appropriately to the necessary emergency or urgent care service.
  o This helps to minimise duplications and simplify a fragmented system of out of hours care.

• Integrating the workforces of A&E and a co-located primary care service allows patients to receive personalised and optimised interventions.
  o It’s important to recognise that this model of care requires the contribution of emergency medicine doctors, general practitioners, primary and secondary nurses, frailty teams, palliative care teams and mental health teams. Pharmacists and dentist's would add greatly to the efficiency and effectiveness of the service.

• Increasing capacity and awareness of alternative out of hour’s options should be a key priority for NHS England.
  o NHS England should make sure that the public is not only informed about appropriate service use, such as out of hours GPs, walk-in centres, and the NHS 111 service, but must also ensure that these services have sufficient capacity and are available when required. Unless this issue is addressed, there will be a continuation of the overstretching of the A&E system.

Equality issues: No information

4.44 Urgent Dental Care
Location: Calderdale, Kirklees, Wakefield, Leeds and Airedale and Bradford
When the engagement took place: 1 February 2013 to 26 April 2013
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Staff working for the NHS and local authority, voluntary and community sector organisation members, service providers, elected members, public
Number of people engaged: 547 responses were received

What the engagement involved: An engagement document was produced which included questions on what is important to patients and the public within the service. Copies of this document were sent out across West Yorkshire to a range of stakeholders including GPs, dentists, children’s centres and the voluntary sector. The engagement team attended meetings in the community, held drop-in sessions at local supermarkets, ran focus groups and spoke to patients in existing dental provider venues.

For full details of the engagement plan for each area, and to see the findings and recommendations, please see 'Report on the unplanned or urgent dental services consultation’ 7 June 2013.

Key themes:
• Currently providing an easy to access and satisfactory urgent dental care service.
  o Of the people who had used unplanned dental services, most said they had found it easy to contact, get an appointment and find the service.
Most people who used the service were satisfied with the service they received. 61.6% of people were either ‘very satisfied’ or ‘satisfied’ with the service.

- Concerns about the quality and appropriateness of treatment.
  - Responses regarding the quality of care were divided between issues of qualifications and experience of dental staff and the need for a sympathetic, understanding and friendly service.
  - Understanding of how to deal with a nervous patient was also mentioned by one respondent.
  - Some patients were concerned about the appropriateness of treatment, for example being ‘fobbed off’ with antibiotics when extraction or filling would have been better, or offering pain relief.

- Awareness and advertising is very important to ensure appropriate use and understanding of how to access and contact the service.
  - A significant number of individuals were not aware of the urgent, unplanned dental service and almost 75% had not used the service.

- Accessibility should be taken into account when considering any new sites for unplanned dental care services.
  - People felt it was important for services to be accessible to people with a disability.
  - Any proposed new siting of the service should take into account ease of access in respect of patients with a disability, including learning disabilities and appropriate training may need to be considered with this in mind.

- Ensuring any site providing the service is easily accessed by those patients using public transport and that car parking is available on-site or nearby.
  - Services should be accessible by public transport but should also have a car park for those using their own transport.
  - People want services to be within 15-30 minutes travel distance.

- Ensuring appointments are available at a range of times throughout the week.
  - Findings showed that there was a fairly even split with the time that people accessed the current services.
  - When asked ‘If the future service operated seven days a week, would you be more likely to choose an appointment in the morning, afternoon, evening or at the weekend?’, a higher percentage of people indicated that they would prefer a morning appointment, so additional morning appointments should be considered.

Equality issues:
Although carers are represented in the equality monitoring data, they have a response rate of 15%. Care should be taken that this is not under-represented and that adequate support is available to meet their needs.

4.45 Wheelchair Services
Location: Calderdale
When the engagement took place: December 2013
Who led the engagement: Yorkshire and Humber Commissioning Support
Who was involved: Wheelchair users, carers, Healthwatch Kirklees, staff who support wheelchair users in the community, e.g. Locala, social workers and learning disability support workers.

Number of people engaged: 13 people in Kirklees; 14 people in Calderdale; 21 people also completed surveys

What the engagement involved:
Two events were held; following a presentation, the participants were asked to discuss in their groups the following questions:

What is working well?
What is working not so well?
Are there any gaps in the service?
Is there anything else the CCGs need to change?

In addition to the discussions groups, a survey was developed to enable those people that were unable to attend the discussion to share their views. The questions for the survey mirrored the questions from the discussion groups.


Key themes:
- Delivering a quick and responsive service with knowledgeable and professional staff.
  o People reported that having access to a quick repair service for faulty equipment was useful.
  o Some commented that they had continuity of care due to being seen by someone who knew them and understood their needs.

- Concerns expressed by many with regards to the waiting times for assessments and the provision and repair of wheelchairs.
  o Some people said there were long waiting times for assessments, ordering, repair and adaptation of wheelchairs, which meant that people’s needs weren’t being met by the service during those waits.
  o There was a perception by some that the provision of a chair was based on budget rather than need, ‘pushier’ patients were assessed quicker and that eligibility for some equipment appeared to be inconsistent.

- Increasing staff awareness, understanding and knowledge, through training on:
  o Disabilities/conditions to ensure that they understand the progressive nature of disabilities/conditions and how patient needs may change.
  o Customer service training to ensure staff actively listen and respond to service users.
  o Assessment and referral process to ensure that there is consistency in the application of the eligibility criteria.
  o Comments were made about staff being unresponsive to complaints made/concerns raised and how lack of communication impacted negatively on patients.
  o Some people felt that staff didn’t know enough about different disabilities and conditions in order to meet the needs of people accessing the service.
• Providing a service that caters for the needs of those people who work or have other commitments during office hours.
  o Respondents wanted a service that would meet the needs of everyone, including those that work.
  o Suggestions were made to have a one-stop shop that was accessible seven days a week.

• The need for additional staffing and budget, including the provision of wheelchair therapists and an increase in technical support to meet demand and reduce waiting times.
  o People mentioned more therapists to visit palliative care patients.

• Poor communication between services and with service users which impacted negatively on the service that they received.
  o Service users wanted to be kept up-to-date on the progress of their case, receive information on types of wheelchairs available and to have an easy read guide and/or charter.

• Importance of providing wheelchairs that meet people’s needs.
  o People wanted the ability to have a wheelchair that meets their needs.
  o Concerns were raised that they were unable to access a powered wheelchair for outside use, choice of equipment being limited by cost rather than suitability and the difficulties in obtaining a non-standard wheelchair and adaptations.

Equality issues: This service is used specifically by people who have physical disabilities and are in need of a wheelchair. Any difficulties accessing this service has a specific impact upon those people. Equality monitoring data for the survey did not identify any specific issues for individual groups, although young people were not represented in the survey responses and most respondents were White British.

4.46 Equality extracts from the HW report

Calderdale Care Closer to Home – December 2014
The engagement event was largely attended by people who are White British, more attendees were women than men, and most people were aged over 40. It is difficult to use this feedback to assess the impact of changes or preferences of people from groups that were not represented.

Calderdale Unplanned Care – June – July 2013
The survey responses were analysed against equality monitoring data and the significant results are reported here:
  o Females prefer to know the health professional they see significantly more than males.
  o People aged 66 years old more concerned with seeing a health professional they knew compared to younger people (aged up to 35 years old).
  o Participants who reported having a disability preferred to see a health professional they knew.
  o Participants who reported themselves as Pakistani were significantly more likely to prefer to be seen by a doctor than a nurse.
  o People who reported they were British preferred shorter waiting times for an appointment and to have a choice of appointment time.
Calderdale and Greater Huddersfield Autistic Spectrum Conditions – October – November 2014
As this service is in place to support children with multiple health needs, changes to services and where they are provided could lead to a disproportionate impact on disabled young people.

Calderdale and Greater Huddersfield Child Development Service – May – June 2014
As this service is in place to support children with multiple health needs, changes to services and where they are provided could lead to a disproportionate impact on disabled young people.

Calderdale and Greater Huddersfield SWYT Transformation – June – November 2013
As SWYT services are in place to support people with learning disabilities and mental health issues, changes to the way that the service is provided would have a significant impact on those groups.

Calderdale and Greater Huddersfield Urgent Dental Care – February – April 2013
Although carers are represented in the equality monitoring data, they have a response rate of 15%. Care should be taken that this is not under-represented and that adequate support is available to meet their needs.

Calderdale and Greater Huddersfield Wheelchair Services – December 2013
This service is used specifically by people who have physical disabilities and are in need of a wheelchair. Any difficulties accessing this service has a specific impact upon those people. Equality monitoring data for the survey did not identify any specific issues for individual groups, although young people were not represented in the survey responses and most respondents were White British.

Calderdale and Greater Huddersfield Health Care for HIV positive patients – July 2014
This affects people with HIV. The Equality Act 2010, which now incorporates the protections of the Disability Discrimination Act (DDA) 2005, defines everyone diagnosed with HIV as disabled and, therefore, entitled to the same protection against discrimination.

Equality monitoring questions were asked as part of the patient survey. Of 1752 respondents, a majority were aged over 56 (84%), and were White British (81%). The views of disabled people were well represented with 35% of the total respondents saying they had a disability (physical and mobility issues, and long standing health conditions were most common). Around 10.5% of respondents stated they were carers.

Greater Huddersfield Emotional Health and Wellbeing for Young People – up to January 2015
The engagement events were completed exclusively with young people so all views represented here are those of young residents in Kirklees.
Specific issues have been raised around the experience of people with severe learning disabilities. When specialist staff are available, reasonable adjustments are made to the way that care is provided, but on occasions when those staff are not available, more problems are experienced with care.

Greater Huddersfield Princess Royal Community Health Centre – October 2013
The engagement team reviewed a relationship matrix to ensure a diverse group of people were invited to attend the events and share their understanding. It’s unclear from the equality data how many people attended or what the full picture of the ethnicity of the attendees was, but there was a reasonably equal representation of men and women; around 30% of people who attended had disabilities and long term health conditions.
The services within the PRCHC that are targeted most specifically at groups with protected characteristics are Sexual Health and Genitourinary services, which is frequently used by those age 16-24, and the Child Development Service, used by children with developmental issues and disabilities.

Greater Huddersfield and North Kirklees Continence Services Healthwatch Kirklees – September 2014
This issue impacts people who follow a religion that requires them to be clean and have a clean pad on when praying.

Greater Huddersfield and North Kirklees Hospital discharge to care homes Healthwatch Kirklees – November 2014
Elderly people or vulnerable adults are most likely to be transferring between hospitals and care homes, so problems with this process disproportionately impact them.

Greater Huddersfield and North Kirklees Integrated Care – December 2013– February 2014
In the second stage of the engagement process, people raised particular concerns about making sure that the new model of service delivery was suitable for people with disabilities, in particularly sensory impairments, e.g. ensuring that a Single Point of Access can be accessed in multiple ways, rather than simply over the phone, as someone with a hearing impairment may struggle to use this; increasing the amount of advocacy available from people who use communication using BSL if you intend to full engage a patient in the development of their care plan.

Equality monitoring forms were distributed with the public engagement survey. 71 people chose to complete this, they were predominantly female (74%), White British (85.5%), Christian (40.6%) or had no religion (43.5%), were not disabled (88.2%), were aged between 36 and 65 (76%), and were straight (89.6%). Carers were quite well represented in the survey sample, with 40.6% of respondents having a caring responsibility.

Greater Huddersfield and North Kirklees Multiple and Complex Needs Healthwatch Kirklees – September 2014
Patients with multiple and complex needs often experience a different NHS and social care system to other patients. Standard, mainstream services on offer do not always work for those patients who struggle to make and keep traditional appointments or are
unable to travel to access services. This contributes to a wider picture of health inequalities, with life expectancy significantly below the rest of the community in Kirklees.

**Greater Huddersfield and North Kirklees Section 136 of the Mental Health Act 1983 Healthwatch Kirklees** – January – March 2014
Equality monitoring was not completed as part of this piece of work. This focus of the work is people with severe mental health problems, who are a vulnerable group. Some national work has looked at the impact of Section 136 detention in police cells on young people.

**Greater Huddersfield and North Kirklees Deaf and Hard of Hearing Healthwatch Kirklees** – October – November 2013
The difficulties reported here are experienced by people who having hearing impairments across Kirklees. Health outcomes for people who are Deaf are typically poorer and barriers to accessing health services could certainly be contributing to problems around understanding health conditions and knowing how to take medication.

**Calderdale Continence** – February 2013
No information

**Calderdale Cardiovascular Disease** – August 2014
No information

**Calderdale Health Forum Care Closer to Home** – June 2014
No information

**Calderdale and Greater Huddersfield Community Matrons** – January – March 2014
No information

**Greater Huddersfield Care Closer to Home** – July 2014
No information

**Greater Huddersfield Golcar Clinic** – May – June 2013
No information

**Greater Huddersfield Medical Assessment Area Enter and View Visit Healthwatch Kirklees** – December 2014
No information

**Greater Huddersfield PRGN Community Services** – December 2013
No information

**Greater Huddersfield PRGN GP Services** – March 2014
No information

**Greater Huddersfield PRGN Use of technology** – October 2013
No information

**Greater Huddersfield PRGN Vulnerable Adults/Over 75s** – June 2014
No information

**Greater Huddersfield and North Kirklees Outpatient Appointments Healthwatch Kirklees** – December 2014
No information
Appendix 5.1 - Communication, Engagement & Equality Plan for Hospital and Care Closer to Home

Calderdale and Greater Huddersfield Hospital Care and Care Closer to Home

Communications, engagement and equality pre-engagement plan
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Appendix 1: groups to be targetted
1. Introduction

The purpose of the Communication, Engagement and Equality Pre-Engagement Plan is to describe our proposals for engaging with staff, the public, patient and carers on hospital services and care closer to home in Calderdale and Greater Huddersfield.

The plan does this by describing an overview of both hospital and care closer to home, and our plans for delivering targeted engagement activity which includes a brief summary of what people have already told us. This plan covers the scoping, pre-engagement and equality analysis elements of which will lead to a formal consultation process.

2. Background

In 2014, a strategic review was undertaken which aimed to begin to describe the challenges facing the health and social care system in Calderdale and Greater Huddersfield. It started to look to how services could be delivered now and in the future to deliver a sustainable NHS and continue to provide the right care to local people.

The review included some high level proposals from NHS provider organisations in Calderdale and Greater Huddersfield which described their vision for a preferred model of hospital service configuration. These were described at the time as the strategic outline case (SOC) and the outline business case (OBC).

A major engagement programme, Right Time, Right Care, Right Place was launched with over 40,000 people contacted for their views. Over 2500 people responded to the engagement activity which included an independent engagement by the ‘Peoples Commission’; a clear message that came back from the public was the need to address community services first, before beginning to look at the way that services in hospital were delivered.

NHS Calderdale and Greater Huddersfield Clinical Commissioning Groups have worked with their respective provider organisations and local authorities to establish a structured and phased approach to transformational change.

There are three interlinked pieces of work: Calderdale Closer to Home Programme; Kirklees Care Closer to Home Programme; and the Hospital Services Programme. Collectively, these programmes are developing proposals for what the future community services in Calderdale and Kirklees and the future Hospital services in Calderdale and Greater Huddersfield could look like. These proposals will be implemented in three separate phases over the next five years:

Phase 1 – Strengthen community services in line with the new model of care.
Phase 2 – Enhance community services.
Phase 3 – Hospital changes.
3. Care closer to home

Both NHS Calderdale and NHS Greater Huddersfield CCGs signed up to a single high level, phased approach to deliver their Care Closer to Home programmes. The CCGs worked together to develop a generic high level service specification which has been localised to take into consideration the varying needs of the different populations served.

3.1 Care Closer to Home in Calderdale

The Calderdale Care Closer to Home programme is working to strengthen community services with its existing community services provider – NHS Calderdale and Huddersfield Foundation Trust and other providers such as South West Yorkshire Partnership Foundation Trust (SWYPFT) and Locala who provide services in the local community.

Having agreed the scope of the new model the organisations are working together with other partners to develop new ways of working, starting in the Upper Valley.

The work in the Upper Valley will look at the development of new ways of providing services in the community and is now part of a national New Care Models programme making it a “vanguard” site. This means there will be further support nationally to help Calderdale deliver its plans at pace.

3.2 Care Closer to Home in Greater Huddersfield

The Greater Huddersfield Care Closer to Home programme is a joint piece of work with NHS North Kirklees Clinical Commissioning Group and has focused on reviewing existing community services including respiratory, MSK, dermatology and diabetes.

The CCGs have been working with local people through engagement to develop a new service specification, which will provide enhanced services. The current contracts to provide community services are coming to an end and organisations have been invited to tender for the contract under the new specification. The successful service provider will be appointed to begin providing services against a new, enhanced service specification from October 2015.

4. Hospital care

The hospital services programme covers Calderdale and Greater Huddersfield. Both CCGs are clear that transformational change is needed in our hospital services to meet current and future healthcare needs, but that they need to be confident that the work to strengthen community services has begun to indicate that it will meet the needs of the local population before we can start to make changes.

This hospital programme has focused on working with clinicians and service leads to scope the possible models of care that could be developed to deliver planned care and urgent and emergency care, maternity care and paediatric care. The feasibility of these models needs to be tested, and patient and public views will be used to further inform
the development of more detailed models. We expect to demonstrate readiness for consultation during 2015.

5. The purpose of the plan

The purpose of the plan is to provide information on our approach to engage, communicate and inform the following target audiences:

- Key stakeholders including partner organisations
- Staff
- Public, patients, carers and their representatives
- Local Councillors and MPs

The plan sets out why we need to engage with the key stakeholders, including the legislation we must follow and our approach to equality and communication. We want to involve as many people as possible, including diverse local communities, in the development of any proposals which will be formally consulted upon in the autumn. The CCGs are clear that transformational change needs to happen in Calderdale and Greater Huddersfield to create a sustainable NHS now and for the future. We already know from previous engagement activity what this could look like but we need to engage further to ensure we are ready for formal consultation in the Autumn.

There is a high likelihood of significant service change in hospital services and therefore a formal 12 week public consultation process will be required. It is anticipated that that the approach would be delivered through a large-scale public consultation supported by a communications campaign and Equality Impact Assessment (EQIA), with activity taking place in various locations across Calderdale and Greater Huddersfield.

The consultation plan will be developed separately to this plan to ensure that the approach for communications and engagement activity is informed by what people have said during the pre-engagement process. We will ensure that the consultation plan is tailored to meet any particular needs or differential impact on protected groups identified through the engagement process.

6. Scoping

6.1 What have public, patients and carers already told us?

We have been talking to staff, public, patient’s carers and their representatives for over three years on hospital care and in the last 12 months on care closer to home. The engagement activity delivered as part of the Calderdale and Huddersfield Strategic Health and Social Care Review took place from October 2012 to February 2013. With further engagement on Right Care, Right Time, Right Place in the spring and summer of 2014, the findings were:

- People wanted to see more care closer to home and in a variety of community settings
• The public in Calderdale do not want to lose their A&E as part of services changing
• Travel and transport needed further consideration as people could neither afford the time to travel; the cost, or find suitable parking on premises. People want services to be based locally
• Access to services in the community needed to be 24/7 including bank holidays and there was a strong message that GP access in particular needed to be addressed if the system was to change. People also wanted services they could drop in to
• People wanted more focus on prevention and innovative opportunities to keep themselves well or be educated, particularly at a young age
• Appropriate staff are needed in the community and this included more GP’s, district nursing staff and those with a particular focus on a specialism or to meet the needs of diverse communities
• There were concerns that the model looked good on paper but would it work in practice, this included comments relating to capacity to deliver including social care, how information is shared and how services are coordinated
• People did not understand the detail of any of the plans and wanted to understand this further
• People wanted the community to be part of the solution including design, delivery and estates with greater community participation being the key to delivering services for each community
• Mental health services were not working and there was a need to look at services further in both primary and community care
• Hospital services were poor on waiting times and needed to improve in addition there were a number of comments that people are discharged too early
• There needs to be more consideration for vulnerable groups, protected groups, carers and those with a disability

Both care closer to home programmes have used this information to inform local proposals and specifications. Stakeholder events have also been delivered to further support the commissioners thinking and strengthen any future plans.

6.2 What else do we need to know?

We need to ask more questions on hospital care, what services are best delivered in a hospital setting and what services are better placed in the community. We need to do more engagement to help us understand:

• Emergency and urgent care
• Hospital services
• Services as part of the Care Closer to home model for Calderdale and Greater Huddersfield, and
• Maternity and paediatrics
From this we want to further understand any impacts for service change, including what will work. How far people are prepared to travel to receive different types of service, including any planned or unplanned care they may need.

7. Aim and objectives of the engagement activity

The aim of the engagement exercise will be to engage with key stakeholders on both the services received in hospital and the care they may receive closer to home in a community setting. We need to understand the demographics of our local communities and how this relates to service use, access and patient experience, drawing out any potential differential impact on any protected groups.

The target audiences will include staff, public, patients, carers and their representatives and we will use a number of mechanisms and key activities to deliver this. We want to share what people have already told us, continue to listen to people’s views and ensure we have captured all the information we can to develop some future options for consultation.

As part of the engagement process we will build into our approach a joint process involving key stakeholders who can support us in deliberating on the findings from all the intelligence we have, including giving ‘due consideration’ to the information we gather as part of the engagement process. We need to ensure we can evidence how the intelligence and equality analysis (EQIA) will inform options for changes to the way services are currently provided and delivered.

Using this aim, the objectives will be to:

- Use evidence-based techniques including an equality impact assessment to identify groups who require further support to have their say;
- Support partner organisations to clearly and effectively communicate the background, progress to date and next steps for these programmes of work;
- Support people to gain a better understanding of hospital services so expectations can be better managed in future;
- Gather views from specific sample groups that will support plans to further develop care closer to home and hospital services.
- Gather the views of key stakeholders and ensure we have a representative sample of views.
- Deliver two stakeholder events to further analyse the feedback we receive.
- Use the information we gather to deliberate on our options for formal consultation.
- Be in a position to progress to formal consultation in the autumn.

8. Principles for Engagement

NHS Calderdale Greater Huddersfield CCGs both have ‘Patient Engagement and Experience Strategies’. These strategies set the commissioners’ approach to engagement and what the public can expect when we deliver any engagement activity. The principles in both strategies state that we will;
• Ensure that we engage with our public, patients and carers early enough throughout this process
• Be inclusive in our engagement activity and consider the needs of our local population
• Ensure that engagement is based on the right information and good communication so people feel fully informed
• Ensure that we are transparent in our dealings with the public and discuss things openly and honestly
• Provide a platform for people to influence our thinking and challenge our decisions
• Ensure that any engagement activity is proportionate to the issue and that we provide feedback to those who have been involved in that activity.
• We are clear about our plans and what the public can and can’t influence and why
• We make sure we engage with the right target audience and consider equality and the impact on diverse groups
• We can demonstrate that we have listened to people’s views in all of our plans
• We will provide feedback on our website, through newsletters and local media of any outcomes from engagement activity.

The strategy sets out what the public can reasonably expect us to do as part of any engagement activity and the process we need to deliver needs to preserve these principles to ensure public expectations are met.

9. Legislation

9.1 Health and Social Care Act 2012

The Health and Social Care Act 2012 makes provision for Clinical Commissioning Groups (CCGs) to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners. It also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution – and to promote awareness of the NHS Constitution.

Specifically, CCGs must involve and consult patients and the public:

• in their planning of commissioning arrangements
• in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
• In decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSCs) on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.
9.2 The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance ‘Equality of Opportunity’, and c) foster good relations. All public authorities have this duty so the partners will need to be assured that “due regard” has been paid through the delivery of this strategy and in the review as a whole.

9.3 The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains a number of patient rights which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and
- In the decisions to be made affecting the operation of those services.

10. Engagement

The engagement process will be delivered using a combination of gathering views through focus group activity and the circulation of a short questionnaire. Each of the service areas subject to engagement will be delivered differently to ensure we can capture a broad range of service user views. We will use the ‘Care Close to Home’ service areas to gather views on both the service, planned and unplanned care.

10.1 Services in scope

The services in scope for Care Closer to Home phase 1 and 2 for each CCG have been identified. Using the list of identified services the engagement team have worked with commissioners to understand if the services in scope have been discussed with those staff, public, patients, carers and their representatives as part of any previous engagement activity.

Services that have already been subject to sufficient engagement have not been included in this plan as they do not require any additional engagement to understand the views of the people who would be directly affected. The information gathered as part of this approach will be included in the pre-engagement report of findings.

The services still requiring engagement have now been identified and are tabled below (see table 1). This list of services includes the hospital services as a cross cutting theme.

The engagement conversations for each will contain questions and narrative on the service, emergency and urgent care and planned care. As the mapping suggests we
do not have enough service users to contribute to the conversation on paediatrics and maternity it is suggested that we adopt a separate engagement approach for these two services.

Table 1 – services in scope

<table>
<thead>
<tr>
<th>Service</th>
<th>Calderdale</th>
<th>Greater Huddersfield</th>
<th>Engagement conversations – questions and narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Service specific</td>
</tr>
<tr>
<td>Cancer</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Minor day surgery</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>CVD</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Therapies</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Rehab</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>DVT - unplanned</td>
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<td>✓</td>
<td></td>
</tr>
<tr>
<td>End of life care</td>
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<td>✓</td>
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<td>Colposcopy – upper valley only</td>
<td>✓</td>
<td>✓</td>
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</tr>
</tbody>
</table>

10.1.1 The people we will be engaging with

We will be engaging with a representative sample group of people who will be directly affected by service change. This will include:

- Those directly affected by the services identified in phase 2 of ‘Care Closer to Home’ model for Greater Huddersfield.
- Those directly affected by the services identified in phase 1 and 2 of ‘Care Closer to Home’ model for Calderdale.
- People who represent the protected characteristics as set out in the Equality Act to support the development of an EQIA.
- People from a sample group of local areas who can provide a local perspective to service change.
- People who use maternity services – separate plan to be developed.
- Children and young people on paediatric services – separate plan to be developed.

A list of the groups we intend to engage can be found in appendix 1, maternity and paediatrics will have a separate plan, which will be an appendix to this plan.
10.2 Narrative and questions for service users, carers and key stakeholders

The narrative for each of the engagement approaches will provide an overarching explanation of the NHS and why it needs to change as part of the local case for change. This narrative will be accompanied by a local explanation of the specific service area and any plans to change the way services are currently provided. The urgent and emergency and planned care questions will be added again with a local context.

The questions for each service will be service specific with additional questions on travel, transport and parking, emergency and urgent care and planned care. We will be equality monitoring all engagement activity to ensure the views gathered are representative of the local population.

10.2.1 Engaging protected groups and those representing local areas

In addition we want to ask a sample group of people their views on unplanned and planned care; from previous engagement activity we already know people do not want to lose A&E services, but we also know people prefer to use services closer to home in an number of urgent unplanned situations. We need to understand the reasons for this response by asking specific groups to provide more information. In addition we need to understand in more detail the impact of changing current services so we can consider specific needs further.

For planned care we want to engage in a more meaningful conversation. People have not adequately responded to the plans for planned care and we want to take into consideration the needs of different groups and so require more information.

By delivering this engagement we want to further understand if there are particular issues for specific groups of people living in Calderdale and Greater that we may not have considered before we progress to formal consultation.

10.2.2 Maternity and Paediatrics

We will provide a separate engagement plan which will focus on service users and their families to gather a sample group of views which will inform the future of maternity and paediatric services. By identifying who these people are, where they live, and their diversity we can engage further and fully understand the impact of service change and any other considerations we may need to make. This approach would include all protected characteristics to ensure we were upholding our equality duties.

Again we will engage service users and carers in focus group discussions using community assets and relationships to reach our target audience and questions to prompt conversations.

10.2.3 More about the engagement approach:

Focus group activity during pre-engagement will be delivered using the appreciative inquiry model – a model for analysis, decision-making and the creation of strategic change which focuses on enabling people to imagine the desired future state of our health and social care system.
Appreciative inquiry is the most appropriate model because it is highly collaborative and engages not only organisations but individual staff, service users and patients, and carers. The model can be adapted to account for people of all ages, backgrounds and health and social care needs. By focusing on the positives rather than issues or barriers, the model facilitates greater understanding of the potential for change and fosters the creation of a “can do” attitude among stakeholders.

The model has already been used to engage with health and social care staff, and third sector partners within the Calderdale Care Closer to Home programme and has proven to be a highly successful method of supporting a co-production approach.

Using this approach we will:

- provide further platforms for discussion by supporting third sector partner organisations to host conversations in their local communities or through established networks;
- directly target those groups who we need specific feedback from, respecting the potential differences in these groups between the two CCG geographies and the care closer to home models;
- use equality monitoring and impact assessment tools to identify the effectiveness of activities, potential impact on protected groups and how well they are reaching representative samples of the community;
- hold two large deliberative events in each local area supported by clear and consistent narrative to further deliberate on the findings.

The appreciative inquiry will be supported by a traditional questionnaire – available in paper form and online - for those not able to join a regular group. Using a combination of quantitative and qualitative questions that reflect the broad themes and approaches of the inquiry, the questionnaire will help the partners in this strategy to understand views of care in hospital, including specialist care and views of care in the community, as part of care closer to home.

10.3 What we already have in place

We currently have a number of mechanisms in place to capture the views of the public. These mechanisms will continue to be utilised throughout this process. The current engagement mechanisms are:

- **Staff, professionals and clinicians** are already engaged in our plans through a number of working groups.
- **Local councillors and MPs** have been kept up to date with briefings and a log of all conversations and contact has been established.
- **Overview and Scrutiny Committees and Health and Well Being Boards** are being kept up to date with our plans through presentations and briefings.
A dedicated website and partner websites which will contain information on how to contact us and also opportunities to post comments. This includes the use of social media such as Twitter and Facebook.

PALS and complaints services have been fully briefed and they will capture public views as part of their customer facing role.

We are working closely with Healthwatch colleagues to ensure we provide consistent messages to the public and capture views on a day to day basis.

We are briefing staff and member practices, including Patient Reference Groups so local staff can respond to public questions and comments.

We will trawl existing consumer websites including those attached to the local media, patient opinion and NHS Choices to gather feedback.

10.4 What else do we need to do?

In order to enable the public to engage with us we will need to provide further platforms for discussion, offer stakeholders the chance to host conversations and directly target those groups who we need specific feedback from.

The engagement activity will be delivered using a number of mechanisms and will need full commitment from all partners to provide staffing and appropriate key speakers if and when they may be required. The engagement approach will be to develop a questionnaire that can be used to facilitate written responses or in a focus group setting.

The questionnaire will include a set of questions that help commissioners understand the stakeholders’ view of care in hospital and care in the community as part of care closer to home.

We will need to identify key stakeholders who may be directly affected by any plans to change the way services are currently provided and delivered to ensure we have good sample groups for care closer to home. Some of these groups may be different in Calderdale and Greater Huddersfield so we will ensure each local area has a targeted action plan.

10.4.1 Deliberative events for stakeholders

The deliberative events in each local area will be delivered to ensure that the pre-engagement stage has concluded and the information gathered has been carefully considered. There will be three deliberative events; initially two events will be delivered, one in Calderdale and one in Greater Huddersfield. The first events will have a clear purpose. The purpose is set out below:

Deliberative event - 1: The purpose of this event will be to deliberate over the findings from all the engagement activity, and give due consideration to the findings including due regard to equality and diversity intelligence. The event will also provide a final opportunity to further inform any plans. The event will be delivered using appreciative enquiry techniques and approaches.
One to two weeks later there will be a second joint event which will be delivered in a central location where possible to accommodate a joint conversation between representatives from Calderdale and Greater Huddersfield. The purpose of this event is set out below:

Deliberative event - 2: The purpose of this event will be to provide an initial conversation on the emerging options, provide an evidence base to the option development and identify collectively which options have been adequately considered and could be consulted upon in formal consultation.

A detailed plan for each of these events will be developed. The plan will set out the target audience, approach, content and outcomes.

11 Communications

Communications during the pre-engagement stage will be targeted at current service users (including patients, families, carers and staff/support services). This will ensure that there is a proportionate response from current users in pre-engagement compared to future/prospective service users in the wider consultation phase.

Evidence shows that people who are already using services are more likely to respond to requests to be involved and therefore a larger proportion of resources will focus on the second phase to encourage the wider public to have their say on future plans.

11.1 Patients, carers and other service users

We will work with partner organisations to identify and maximise opportunities to direct mail the engagement documents to current patients, using a randomised representative sample. This will ensure that people, who can’t access events such as those in full-time work, can still have an opportunity to have their say. Information will also be made available online as targeted conversations held via mechanisms such as Facebook and Twitter to enable community groups and individuals to engage in the process. This activity will support the traditional face-to-face engagement activity delivered by, and on behalf of, the CCGs and support contact with protected groups or individuals who may want to respond in confidence.

11.2 Existing networks

We will use third sector organisations, community assets and partnerships, Healthwatch and membership networks to deliver this. All our engagement activity will be informed by local data and equality monitored to ensure we capture a representative sample of community views. This approach will enable us to ensure we reach protected groups who may have different experiences of health and social care services. Where we do not reach these groups we will deliver appropriate targeted engagement to reach them.

11.3 Staff Engagement

We will prepare core information for provider organisations to brief staff on the hospital services and Care Closer to Home, ensuring that all staff have a broad view of the
approach and how each programme fits together to deliver the vision of more proactive, joined-up, safe and effective care.

Staff will be offered opportunities to have their say as member of the public using the survey and through ongoing work-streams and events, which may include a tailored survey to ensure they can give their views on how the changes might affect their service directly.

11.4 Political stakeholders

Maintaining political relationships is key and the timing of the General Election in May 2015 has a significant impact on the delivery of this activity.

Relationships with statutory groups including the health and wellbeing boards and overview and scrutiny committees will be maintained throughout but new members will be offered additional support to be brought up to speed on the programme’s progress to date. This will be likely to take the form of a closed session with members to enable them to facilitate frank and honest discussions in a supportive environment.

New local MPs and councillors elected to seats in Calderdale and Greater Huddersfield will also be invited to find out more through a number of channels including a written briefing, and audio-visual solutions. Existing members will also receive this information to ensure consistency of message across all wards in our areas.

11.5 Media

As this will be a targeted approach, work with the media will be more low-key than in the consultation phase. Proactive press releases will be issued to ensure the public are aware that engagement activity has taken place. This will create a public record of the proposals for hospital and community services taking shape through the year, prior to the formal consultation process.

11.6 Online community

There will be no dedicated social media presence but CCGs and partner organisations will be asked to use pre-defined messages to keep followers up to date on the latest progress. The Right, Care, Right Time, Right Place website – www.rightcaretimeplace.co.uk – will be refreshed to provide a clearer picture of the “story to date” and next steps in the process.

12. Equality

All engagement activity will be informed by local data to ensure that we are engaging with the right people, and equality monitored (see appendix 5) to assess the representativeness of the views gathered during the pre-engagement process. Where there are gaps in gathering the views of specific groups relating to the protected characteristics, this will need to be addressed prior to formal consultation.

The supporting EQIA will be prepared for each of the affected services. This will require consideration of protected groups access, experience and outcomes through
evaluation of engagement and experience data and evidence of the user profiles and any research available.

This will be gathered from relevant services and other local health information. His data will not include all the equality protected characteristics as these are not recorded in all services, therefore we collect information as part of the engagement, and research other proxy data that can be utilised to give a profile of the local area.

The engagement activity is required to identify trends in opinion and these will form part of the engagement process with findings feeding directly into the Equality Impact Assessment.

Once analysed all data will be used to develop the EQIA and consideration given to the potential impact of any change to the commissioning of services which could have a differential impact on any protected groups. Where this is identified consideration will be given to any mitigation of the potential impact.

The completed EQIA will be used to support the relevant decision making body to be assured that they have given due consideration to any potential impacts on protected groups.

13. Budget

<table>
<thead>
<tr>
<th>Engagement Phase Non Pay Budget</th>
<th>Calderdale and Huddersfield Health and Social Care Strategic Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td>Estimated Cost</td>
</tr>
<tr>
<td>Community Champions/Community Assets - Calderdale</td>
<td>£10,000.00</td>
</tr>
<tr>
<td>Children and Young People – Greater Huddersfield engagement</td>
<td>£2,000.00</td>
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<tr>
<td>Children and Young People – Calderdale engagement</td>
<td>Core funding</td>
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<tr>
<td>Communities in Greater Huddersfield - including staff</td>
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<td>Engagement materials (low key) – Leaflet, summary document, questionnaire, design, printing, electronic format.</td>
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<tr>
<td>Accessible formats – language, large print, Braille and easy read</td>
<td>£1,000.00</td>
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<tr>
<td>Deliberative stakeholder events</td>
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<tr>
<td>Analysis of data and composite reports</td>
<td>£10,000.00</td>
</tr>
<tr>
<td>Equality expert advice</td>
<td>£10,000.00</td>
</tr>
</tbody>
</table>

| Maximum total budget required | £49,000.000 |

14. Analysis of data and presentation of findings

We will fully utilise all existing engagement and equality intelligence and ensure that we have gathered and considered previous information to inform the process.
Once the proposed engagement activity has taken place we will ensure that all recent and existing intelligence is captured into one report. This report will provide an overview of the views of all key stakeholders including the EQIA as a supporting document.

15. How the findings will be used

We have already used the views of the staff, public, patients, carers and stakeholders to inform our plans. This information identified in section 6, ‘What have public, patients and carers already told us?’ has been used in the development of our proposals to date.

The next stage of engagement will be to help us to understand if what people have already told us is all we need to consider when developing our options for consultation and that we have engaged with a representative sample of patients and the public. We need to ensure that we provide platforms for further engagement to test out our thinking and identify if there is anything else we should consider. The process for ensuring we intelligently consider views will be in stages, the stages are listed below:

- **Stage 1** – Gather views from key stakeholders (1st June – 27th July 2015)
- **Stage 2** – Analyse the findings and produce a report (end of July 2015)
- **Stage 2** – Share these findings and other evidence further with staff, public, patients carers and key stakeholders to understand if we have considered everything at a stakeholder event. (August 2015)
- **Stage 3** – Decide on the options for consultation and check back with staff, public, patients and carers to ensure the views and considerations we have gathered are captured and have been considered. (August/September 2015)
- **Stage 4** – Proceed to formal consultation (Autumn 2015)

16. High level time line for delivery

<table>
<thead>
<tr>
<th>What</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation and planning for engagement</td>
<td>April 2015</td>
</tr>
<tr>
<td>Delivery of Pre-engagement</td>
<td>1st June- 27th July 2015</td>
</tr>
<tr>
<td>Consultation Institute Assurance</td>
<td>June 2015</td>
</tr>
<tr>
<td>Analysis and report</td>
<td>end of July 2015</td>
</tr>
<tr>
<td>Stakeholder event - deliberation</td>
<td>August 2015</td>
</tr>
<tr>
<td>Stakeholder event – test options</td>
<td>August/September 2015</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Governance and approvals</td>
<td>August/September 2015</td>
</tr>
<tr>
<td>Formal Consultation (12 Weeks)</td>
<td>Commence Autumn 2015</td>
</tr>
<tr>
<td>Post consultation feedback (4-8 Weeks)</td>
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</tr>
<tr>
<td>Potential Sec of State Review (3months)</td>
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</table>
### Appendix 1: Action Plan for Pre-Consultation Engagement

**SECTION 1: Service users and carers to be engaged as part of CC2H, including planned and unplanned care questions.**

<table>
<thead>
<tr>
<th>Services in scope</th>
<th>Engagement method and approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
<td><strong>Calderdale</strong></td>
</tr>
<tr>
<td>Cancer</td>
<td>✓</td>
</tr>
<tr>
<td>Minor day surgery</td>
<td>✓</td>
</tr>
<tr>
<td>Respiratory</td>
<td>✓</td>
</tr>
<tr>
<td>CVD</td>
<td>✓</td>
</tr>
<tr>
<td>Therapies</td>
<td>✓</td>
</tr>
<tr>
<td>Rehab</td>
<td>✓</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>✓</td>
</tr>
<tr>
<td>DVT - unplanned</td>
<td>✓</td>
</tr>
<tr>
<td>End of life care</td>
<td>✓</td>
</tr>
<tr>
<td>Colposcopy – upper valley only</td>
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</tr>
</tbody>
</table>
### SECTION 2: Calderdale and Greater Huddersfield locality and protected groups – planned and unplanned care question.

<table>
<thead>
<tr>
<th>Group/Forum</th>
<th>Status</th>
<th>Description</th>
<th>Location</th>
<th>Protected Characteristic</th>
<th>Best time to Engage</th>
<th>Estimated numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale BME Network</td>
<td>Approved Provider</td>
<td>Mainly South Asian Community</td>
<td>Central Halifax</td>
<td>Race, Religion</td>
<td>Via Engagement champions</td>
<td>50 – 100</td>
</tr>
<tr>
<td>Disability Support Calderdale</td>
<td>Approved Provider</td>
<td>Service for people with disabilities and long term conditions</td>
<td>Calderdale Wide</td>
<td>Disability</td>
<td>Via Engagement champions</td>
<td>15 – 35</td>
</tr>
<tr>
<td>Women’s Centre Calderdale &amp; Kirks</td>
<td>Approved Provider</td>
<td>Women’s issues</td>
<td>Calderdale and Kirkles</td>
<td>Sex (women)</td>
<td>Via Engagement champions</td>
<td>15 – 35</td>
</tr>
<tr>
<td>Boothtown Partnership</td>
<td>Approved Provider</td>
<td>Community Engagement</td>
<td>Boothtown</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>20 – 50</td>
</tr>
<tr>
<td>Calderdale Carers Project</td>
<td>Approved Provider</td>
<td>Support for carers</td>
<td>Calderdale</td>
<td>Age, Disability</td>
<td>Via Engagement champions</td>
<td>15 – 35</td>
</tr>
<tr>
<td>Calderdale Interfaith Council</td>
<td>Approved Provider</td>
<td>Network of faith workers and groups</td>
<td>Calderdale</td>
<td>Religion, Race</td>
<td>Via Engagement champions</td>
<td>15 - 35</td>
</tr>
<tr>
<td>Calderdale Parents &amp; Carers Council</td>
<td>Approved Provider</td>
<td>Support for carers of children with disabilities</td>
<td>Calderdale</td>
<td>Parents and Carers</td>
<td>Via Engagement champions</td>
<td>15 – 20</td>
</tr>
<tr>
<td>Centre at Three Ways</td>
<td>Approved Provider</td>
<td>Centre for activities in North Halifax</td>
<td>North Halifax</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>20 - 50</td>
</tr>
<tr>
<td>Cornholme and Portsmouth Old Library</td>
<td>Approved Provider</td>
<td>Centre for activities in Cornholme and Portsmouth</td>
<td>Todmorden</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>15 – 35</td>
</tr>
<tr>
<td>Halifax Opportunities Trust</td>
<td>Approved Provider</td>
<td>Training and support for women</td>
<td>Central Halifax</td>
<td>Race, Religion</td>
<td>Via Engagement champions</td>
<td>15 – 35</td>
</tr>
<tr>
<td>Healthy Minds</td>
<td>Approved Provider</td>
<td>Support for people with mental health problems</td>
<td>Calderdale</td>
<td>Disability (mental Health), Sexual Orientation</td>
<td>Via Engagement champions</td>
<td>20– 50</td>
</tr>
<tr>
<td>Heath Stroke Club</td>
<td>Approved Provider</td>
<td>Centre for people with disabilities</td>
<td>Calderdale</td>
<td>Disability, Age</td>
<td>Via Engagement champions</td>
<td>15 - 35</td>
</tr>
<tr>
<td>Project Colt</td>
<td>Approved Provider</td>
<td>Support for people with substance misuse issues</td>
<td>Calderdale (Eldall)</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>15 - 35</td>
</tr>
<tr>
<td>St Georges Community Trust</td>
<td>Approved Provider</td>
<td>Centre for local people</td>
<td>North Halifax (Lee Mount)</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>20 - 50</td>
</tr>
<tr>
<td>Basement Recovery Project</td>
<td>Approved Provider</td>
<td>Support for people with substance misuse issues</td>
<td>Calderdale</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>10 – 30</td>
</tr>
<tr>
<td>Age UK Calderdale</td>
<td>Approved Provider</td>
<td>Services for older people</td>
<td>Calderdale</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>10 – 30</td>
</tr>
<tr>
<td>Calderdale Forum 50+</td>
<td>Approved Provider</td>
<td>Over 50s network</td>
<td>Calderdale</td>
<td>Age</td>
<td>Via Engagement champions</td>
<td>20 - 50</td>
</tr>
<tr>
<td>Ovenden &amp; Mixenden Initiative</td>
<td>Approved Provider</td>
<td>Support and community development</td>
<td>North Halifax and Warley and Shelf</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>35-60</td>
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<tr>
<td>Disability Partnership Calderdale</td>
<td>Completed training</td>
<td>Support group for people with disabilities</td>
<td>Calderdale</td>
<td>Disability, Age</td>
<td>Via Engagement champions</td>
<td>15 - 35</td>
</tr>
<tr>
<td>Pennine Magpie</td>
<td>In training</td>
<td>Support for people with Learning difficulties</td>
<td>Calderdale (North Halifax)</td>
<td>Disability (Learning difficulties)</td>
<td>Via Engagement champions</td>
<td>15 – 35</td>
</tr>
<tr>
<td>Doddnaze Community</td>
<td>In training</td>
<td>Community Centre</td>
<td>Hebden Bridge (Dodnaze)</td>
<td>Locality</td>
<td>Via Engagement champions</td>
<td>10 – 30</td>
</tr>
<tr>
<td>Association</td>
<td>In training</td>
<td>Support group for older lesbians</td>
<td>Hebden Bridge</td>
<td>Sexual Orientation</td>
<td>Via Engagement champions</td>
<td>10 – 30</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------</td>
<td>-----------------------------------</td>
<td>---------------</td>
<td>--------------------</td>
<td>--------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>St Augustine's Centre</td>
<td>In training</td>
<td>Support for new arrivals, refugee and asylum seekers</td>
<td>Central Halifax</td>
<td>Race Religion</td>
<td>Via Engagement champions</td>
<td>20</td>
</tr>
</tbody>
</table>

### 2b. Greater Huddersfield Networks

<table>
<thead>
<tr>
<th>Group / Forum</th>
<th>Contact Existing / New</th>
<th>Description</th>
<th>Location</th>
<th>Protected Characteristics</th>
<th>Best Time To Engage</th>
<th>Estimated numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sister Shout</td>
<td>Existing</td>
<td>Lesbian Support Group</td>
<td>Town Centre</td>
<td>Yes</td>
<td>Tuesday Eve</td>
<td>10</td>
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<tr>
<td>HUGG</td>
<td>Existing</td>
<td>Huddersfield Gay Group</td>
<td>Town Centre</td>
<td>Yes</td>
<td>Wednesday Eve</td>
<td>22</td>
</tr>
<tr>
<td>Chinese Community Centre</td>
<td>Existing</td>
<td>Social Hub for Chinese Community in South Kirklees</td>
<td>Town Centre</td>
<td>Yes</td>
<td>Awaiting response</td>
<td>10</td>
</tr>
<tr>
<td>APNA Health</td>
<td>Existing</td>
<td>South Asian community Health Support Group</td>
<td>Springwood Temple</td>
<td>Yes</td>
<td>Awaiting date</td>
<td>50</td>
</tr>
<tr>
<td>Huddersfield Deaf Community</td>
<td>Existing</td>
<td>Huddersfield Centre for the Deaf</td>
<td>Huddersfield Town Centre</td>
<td>Yes</td>
<td>1st May at 6pm</td>
<td>20</td>
</tr>
<tr>
<td>Huddersfield African Caribbean Cultural Trust</td>
<td>Existing</td>
<td>Huddersfield Caribbean Carnival/promotion of Caribbean culture in schools and amongst young people and the community.</td>
<td>Huddersfield Town Centre</td>
<td>Yes</td>
<td>Evening</td>
<td>7</td>
</tr>
<tr>
<td>Ahmadiyya Muslim Association</td>
<td>Existing</td>
<td>Faith Group and Health Focus</td>
<td>Birkby</td>
<td>Both male and female groups</td>
<td>Friday Daytime</td>
<td>70</td>
</tr>
<tr>
<td>REACH project</td>
<td>Existing</td>
<td>Support for Asylum Seekers and Refugees</td>
<td>New North Baptist Church New North Parade Huddersfield</td>
<td>Yes</td>
<td>15 April 2014 11.30am</td>
<td>15-20</td>
</tr>
<tr>
<td>Moldgreen United Reformed Church Friendship Centre</td>
<td>Existing</td>
<td>Friendship and Support group for individuals and family with mental health issues</td>
<td>Moldgreen United Reformed Church</td>
<td>Yes</td>
<td>Tuesday morning end April/Early May 2014</td>
<td>10</td>
</tr>
<tr>
<td>Kirklees Visually impaired network</td>
<td>Existing</td>
<td>KVIN is run by and for visually impaired people. To improve the health and well being of blind and partially sighted people</td>
<td>Kirklees Volunteer Centre Huddersfield town centre</td>
<td>Yes</td>
<td>Flexible</td>
<td></td>
</tr>
<tr>
<td>Womens Institute Central Huddersfield</td>
<td>Existing</td>
<td>Membership organisation for women's involvement and learning</td>
<td>Huddersfield town centre Pack Horse Centre</td>
<td>Yes</td>
<td>Once a month on a Thursday evening</td>
<td>Up to 70</td>
</tr>
<tr>
<td>Polish Elderly group</td>
<td>Existing</td>
<td>Luncheon group and support group</td>
<td>Polish Parish Huddersfield</td>
<td>Yes</td>
<td>Tues lunch time every fortnight</td>
<td>Up to 20</td>
</tr>
<tr>
<td>Huddersfield Pakistani Association</td>
<td>Existing</td>
<td>Older people luncheon group</td>
<td>Thornton Lodge</td>
<td>Yes</td>
<td>Monday Lunchtime</td>
<td>10-20</td>
</tr>
<tr>
<td>Friends of Beaumont Park</td>
<td>Existing</td>
<td>Park Support</td>
<td>Crosland Moor</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>15</td>
</tr>
<tr>
<td>Volunteers Together</td>
<td>Existing</td>
<td>Asylum support group</td>
<td>Kirklees-wide</td>
<td>Yes</td>
<td>Tbc</td>
<td>12</td>
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<tr>
<td>Agewell</td>
<td>Existing</td>
<td>Older peoples support group mixed ethnicity</td>
<td>Fartown</td>
<td>Yes</td>
<td>April</td>
<td>25</td>
</tr>
<tr>
<td>Group / Forum</td>
<td>Contact</td>
<td>Existing / New</td>
<td>Description</td>
<td>Location</td>
<td>Protected Characteristics</td>
<td>Best Time To Engage</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
<td>-------------</td>
<td>----------</td>
<td>---------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Birkby Croft</td>
<td>Existing</td>
<td>Sikh and South Asian Women support group</td>
<td>Birkby</td>
<td>Yes</td>
<td>8th May 2014</td>
<td>35</td>
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<tr>
<td>Hillhouse Gurdwara</td>
<td>Existing</td>
<td>Sikh Temple involved in T.B focus group. Interest in health work identified</td>
<td>Hillhouse</td>
<td>Yes</td>
<td>April 7th May 2014</td>
<td>25</td>
</tr>
<tr>
<td>Sikh Leisure Centre Prospect Street</td>
<td>Existing</td>
<td>South Asian community group</td>
<td>Huddersfield</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>15</td>
</tr>
<tr>
<td>Jamil Akhtar MBE JP Pakistan Association</td>
<td>Existing</td>
<td>Umbrella for organisations for South Asian Community</td>
<td>Huddersfield</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>20</td>
</tr>
<tr>
<td>HPCA / PYF</td>
<td>Existing</td>
<td>South Asian community group</td>
<td>Huddersfield</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>15</td>
</tr>
<tr>
<td>Averil Thompson, Care Services Executive,</td>
<td>Existing</td>
<td>Provide services and support for older people at a national and local level to</td>
<td>Kirklees wide</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>25</td>
</tr>
<tr>
<td>Horton Housing</td>
<td>Existing</td>
<td>Third sector organisation providing support, accommodation, training and employment services for vulnerable people across Kirklees</td>
<td>Kirklees wide</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>5</td>
</tr>
<tr>
<td>Kirklees Involvement Network (KIN)</td>
<td>Existing</td>
<td>KIN facilitate the Kirklees Involvement Network (KIN), a self advocacy group for people with learning disabilities.</td>
<td>Kirklees wide</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>10</td>
</tr>
<tr>
<td>Kirklees Older Peoples (KOP) Network</td>
<td>Existing</td>
<td>KOP’s role is to give older people a voice in Kirklees. It has already established a 50+ forum in North Kirklees,</td>
<td>Kirklees wide</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>15</td>
</tr>
<tr>
<td>Community Links</td>
<td>Existing</td>
<td>Mental health and substance misuse charity</td>
<td>Kirklees wide</td>
<td>Yes</td>
<td>To be confirmed</td>
<td>15</td>
</tr>
<tr>
<td>Third Sector Leaders (TSL)</td>
<td>Existing</td>
<td>TSL speak on behalf of not for profit and charity organisations which support individuals and communities</td>
<td>Kirklees wide</td>
<td>No</td>
<td>Meetings monthly</td>
<td>30</td>
</tr>
</tbody>
</table>
Appendix 5.2 - Questionnaire

QUESTIONNAIRE

As part of developing services closer to home we want to talk to you again about local hospital services.

In order to improve services closer to home we need to consider the services you receive in a hospital setting. We know that hospital services can’t stay the same if we are to provide the services for future generations. We also know that we need to ask you for more information so we can consider your views further. We are aware that services need to be affordable and of high quality and want to ensure we get any future model of care right.

To get this right and benefit local people we need to ask you some more questions to help us decide on how your local health services may look in the future.

In Spring and Summer 2014 we engaged with people living in Calderdale and Greater Huddersfield on plans to change the way hospital services are currently provided. As part of that engagement, many people said they could not comment on the plans until they better understood what services might be provided closer to home.

People said they wanted as many services as possible closer to home but that they wanted to keep local A&E services. However, we need more detail on how urgent and emergency care services are accessed and used so we can further consider peoples’ views.

We know we need to think carefully about travel and transport and improved access to local services so we have also included these questions in this survey.

Since we engaged with people last year there has been lots of work to develop models of care in the community that will treat people closer to home and reduce the need to travel to hospital, now we need to think about what services our hospital could provide.

By September of this year, the Trust must develop a plan which shows how it can be financially sustainable going forward. It is working with the regulator, Monitor, to do this. So, while it’s true to say that the Hospital Trust did express a preference for a single site and for that site to be Huddersfield; the Trust’s financial position has deteriorated since that plan was published. Now, a range of proposals for change have to be looked at again.

Knowing all of this, we want you to tell us want is important to you as a resident so we can take your views into account as plans for change get underway. We need to consider the views of people who are not always heard and ensure that we have the right information on which we will base our decisions.

We are clear that services need to change and can’t stay as they are. Your help is needed to shape the future of your local NHS.
Section 1: Urgent Care – when you have a minor illness or injury

An urgent health care situation affects all of us at some point in our life. For some, we may experience more urgent situations than others. An urgent health care need is not life threatening and can be a minor illness or injury such as a suspected broken bone, a cut, suspected sprain, upset stomach or perhaps a child who has been tired for a few days and now has a persistently high temperature.

In an urgent health care situation we need to make sure services are available when you need it. This means you are seen by the right person, as quickly as possible, to receive the treatment you need.

Of the people who currently go to our Accident and Emergency departments we know that 45 – 50% attend with a minor injury or illness. Most of these people could be seen and managed closer to home in an alternative setting such as a walk in centre, or by a pharmacist for example. An urgent care situation would require some professional advice and/or help.

1a. In a minor illness or injury situation who would you prefer to contact?

(Using 1 to 12 please rank in order of preference who you would contact – 1 being your first choice, 12 your last.)

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Chemist</th>
<th>Ring 111</th>
<th>A&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dial 999</td>
<td>Walk in centre</td>
<td>Family/friend</td>
<td>Police</td>
</tr>
<tr>
<td>I don't know</td>
<td>Dentist</td>
<td>Optician</td>
<td>Other, please state</td>
</tr>
</tbody>
</table>

1b. Please tell us more about your choices if you would like to do so.
2. When you need urgent care for a minor injury or illness, what is the most important aspect of that care to you?

(Using 1 to 10 please rank in order of importance to you – 1 being the most important and 10 being the least important)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Aspect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To be seen straight away</td>
</tr>
<tr>
<td>2</td>
<td>To talk to someone straight away</td>
</tr>
<tr>
<td>3</td>
<td>To access a service straight away</td>
</tr>
<tr>
<td>4</td>
<td>To see/speak the person I want to see</td>
</tr>
<tr>
<td>5</td>
<td>To know I will get the treatment I need</td>
</tr>
<tr>
<td>6</td>
<td>To know I don’t need to wait too long to be seen</td>
</tr>
<tr>
<td>7</td>
<td>To be treated by caring and helpful staff</td>
</tr>
<tr>
<td>8</td>
<td>To be seen closer to home</td>
</tr>
<tr>
<td>9</td>
<td>To be treated by caring and helpful staff</td>
</tr>
<tr>
<td>10</td>
<td>Other, please state</td>
</tr>
</tbody>
</table>

**Travel and Transport**

Thinking about how and the distance you would travel to receive treatment for a minor illness or injury please could you answer the following questions:

1a. How far would you be prepared to travel to receive the service that you require?

<table>
<thead>
<tr>
<th>Distance</th>
<th>15 – 30 minutes</th>
<th>30 – 60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 – 90 minutes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1b. How do you usually travel?

<table>
<thead>
<tr>
<th>Mode</th>
<th>Car</th>
<th>Hospital shuttle bus</th>
<th>Access bus</th>
<th>Patient transport</th>
<th>Other – please state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1c. Thinking about how often you may have a minor illness or injury, what else should we consider?
**SECTION 2 - Emergency Care – when your condition is serious or life threatening**

The care you receive in an emergency.

Of the people who currently attend go to our Accident and Emergency departments we know that about 50% require emergency care. An emergency would be an occasion when you might be taken to hospital by an emergency ambulance and would be life threatening or serious such as a heart attack or stroke or serious injury.

1a. If you were to need emergency care, what would be the most important aspect of that care to you

(Using 1 to 9 please rank – 1 being the most important and 9 being the least important)

| Knowing I can be seen straight away by a healthcare professional | Knowing that I don’t need to wait too long to be seen |
| Knowing I will get the treatment I need | Knowing I will see the right health care professional who understands my condition |
| Being closer to home, even if I need to be transferred for further treatment | Being further away from home but in the right place for treatment |
| Feeling safe | Being treated by a specialist who regularly deals with life threatening conditions |

Other, please state

1b. Please tell us more about your choices if you wish

2. Do you have an ongoing health condition?

| Yes | No |

2a. If you answered yes, would you be happy to tell us your condition.
Section 3: Planned hospital admissions

For the majority of patients, the hospital provides services and treatment that are planned. This means a pre-arranged time to have a procedure which could mean a short stay in hospital or for day surgery. For these patients we want to know what we should consider when looking at how planned services are delivered.

We want to know what is important to you when you receive a service that is planned so your stay in hospital is comfortable.

1. What aspect is most important to you for a stay in hospital?

(Using 1 to 9 please rank in order of importance to you – 1 being the most important and 9 being the least important)

<table>
<thead>
<tr>
<th>For my appointment to not be cancelled or changed at short notice</th>
<th>To know that it is easy for people to visit me.</th>
<th>To access a service straight away</th>
<th>To be treated by staff who understand my condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>To I know I will get the treatment I need</td>
<td>To know I can plan my life around my appointment – that it’s at the time specified.</td>
<td>To be treated by caring and helpful staff</td>
<td>To be seen closer to home</td>
</tr>
</tbody>
</table>

Other, please state

Thinking about how and the distance you would travel to be an in-patient, to receive planned care; please could you answer the following questions:

2a. How far would you be prepared to travel to receive the service that you require?

<table>
<thead>
<tr>
<th>Under 15 minutes</th>
<th>15 – 30 minutes</th>
<th>30 – 60 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 – 90 minutes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2b. How do you usually travel?

<table>
<thead>
<tr>
<th>Public transport</th>
<th>Car</th>
<th>Hospital shuttle bus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer transport</td>
<td>Access bus</td>
<td>Patient transport</td>
</tr>
<tr>
<td>Taxi</td>
<td>Other – please state</td>
<td></td>
</tr>
</tbody>
</table>
Although technology is moving on at pace, we have not, to date, embraced the opportunities fully in our health care services. Remote consultations, alarms and sensors to assist in supporting people at home, electronic records and appointment booking and many other developments all bring possibilities and need to be explored particularly in rural settings. We are interested in innovative approaches to the use of technology to improve home based and local care.

Thinking about the advancements in the use of technology in the delivery of healthcare services e.g. Telehealth, Telemedicine and E-consultations

Please could you answer the following the questions:

<table>
<thead>
<tr>
<th>3. Would you be willing to use technology to support your care? (tick all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes on my phone/mobile phone</td>
</tr>
<tr>
<td>No I don't use any technology</td>
</tr>
<tr>
<td>Other – please state</td>
</tr>
</tbody>
</table>

4. Is there anything stopping you from using technology to support you and to help manage your care? For example, no Wi-Fi where you live

5. Thinking about how often you may have planned treatment, what else should we consider?
Sometimes, following a period of illness or injury, patients may receive rehabilitation and therapy services in order to help them recover – learning how to walk, talk, move limbs again for example. Therapies can also be delivered as part of a child’s development. Much of this currently happens within a hospital setting but we know that much of it could be provided in other ways.

6. If we were to change the way we deliver rehabilitation and therapy services what would we need to take into account?

<table>
<thead>
<tr>
<th>Ability to get to place where I have rehabilitation care</th>
<th>Sharing the location with others – for example if it was provided in a gym or a swimming pool</th>
<th>When the care was delivered – for example could I go during the evening or at weekends?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those providing the care were properly qualified and had been approved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Where do you think these services should be provided; (Tick all that apply)

- A GP practice
- A Health Centre
- Home
- Other Community facilities e.g. Leisure Centre
- Other please state:

Thank you for taking time to complete this questionnaire
Appendix 5.3 – Data Capture Form

Engagement Data Capture Form

Listening to your views

To make sure that the information gathered is captured in an effective and consistent way, could you please complete this form for each event/group you attend even if you have one to one discussions.

Please return the completed form within two working days to;

The form is divided into four main categories. Please add in detailed responses in the appropriate section under the relevant headings. The categories are:

- Urgent Care – when you have a minor illness or injury
- Emergency Care – when your condition is serious or life threatening
- Planned hospital admissions
- Travel and transport

<table>
<thead>
<tr>
<th>Name of approved provider/asset</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name and location of the event/group you are attending:</th>
<th>Number of people involved:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Method of discussion (i.e. one to one interviews / focus group)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Person completing form:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Work Tel no:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email:</th>
</tr>
</thead>
</table>
Please indicate in the right hand column the number of people you talk to who agree with comments made. If any comments raised do not fall under the four categories then please put these into the other comments section at the end of this form.

<table>
<thead>
<tr>
<th>Categories</th>
<th>No. of people who agreed with this comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care – when you have a minor illness or injury</strong> (i.e. who do people contact and why?)</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Care – when your condition is serious or life threatening</strong> (i.e. what’s important to people in an emergency situation?)</td>
<td></td>
</tr>
<tr>
<td><strong>Planned hospital admissions</strong> (i.e. what’s important to people when staying in hospital, where should services be provided, how do people feel about using technology &amp; what do people want from rehabilitation / therapy services?)</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Travel and transport</strong> (i.e. how far will people travel for care?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any other comments</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
**Appendix 5.4 – Equality Monitoring Form**

In order to ensure that we provide the best services for all of our communities, and to ensure that we do not knowingly discriminate against any section of our community, it is important for us to gather the following information. No personal information will be released when reporting statistical data and all information will be protected and stored securely in line with data protection rules.

**Please tell us the first part of your postcode** (e.g. HD3 / HX3)
- Please enter here
- Prefer not to say

**What sex are you?**
- Female
- Male
- Prefer not to say

**Transgender**
Is your gender identity different to the sex you were assumed to be at birth?
- Yes
- No
- Prefer not to say

**What is your age?**

<table>
<thead>
<tr>
<th>Under 16</th>
<th>16 - 25</th>
<th>26 - 35</th>
<th>36 - 45</th>
<th>46 – 55</th>
<th>56 - 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 25</td>
<td>26 - 35</td>
<td>36 - 45</td>
<td>46 – 55</td>
<td>56 - 65</td>
<td></td>
</tr>
<tr>
<td>66 - 75</td>
<td>76 - 85</td>
<td>86+</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Prefer not to say

**What is your sexual orientation?**

<table>
<thead>
<tr>
<th>Bisexual (both sexes)</th>
<th>Lesbian (same sex)</th>
<th>Gay man (same sex)</th>
<th>Heterosexual/ Straight (opposite sex)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Prefer not to say

**What is your ethnic background?**

<table>
<thead>
<tr>
<th>Asian, or Asian British</th>
<th>Black, or Black British</th>
<th>Mixed / multiple ethnic group</th>
<th>White</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese</td>
<td>African</td>
<td>Asian &amp; White</td>
<td>British</td>
<td>Arab</td>
</tr>
<tr>
<td>Indian</td>
<td>Caribb ean</td>
<td>Black African &amp; White</td>
<td>Gypsy/Traveller</td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td></td>
<td>Black Caribbean &amp; White</td>
<td>Irish</td>
<td></td>
</tr>
<tr>
<td>Other Asian background</td>
<td>Other Black backgr ound</td>
<td>Other Mixed / multiple ethnic background</td>
<td>Other White background</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>Other:</td>
<td>Please specify any other ethnic group here</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Are you pregnant?**

| Yes | No | Prefer not to say |

**Have you given birth within the last six months?**

| Yes | No | Prefer not to say |

**Do you consider yourself to belong to any religion?**

<table>
<thead>
<tr>
<th>Buddhism</th>
<th>Christianity</th>
<th>Hinduism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islam</td>
<td>Judaism</td>
<td>Sikhism</td>
</tr>
<tr>
<td>No religion</td>
<td>Prefer not to say</td>
<td>Other: Please specify</td>
</tr>
</tbody>
</table>

**Do you consider yourself to be disabled?**

The Equality Act 2010 states that a person has a disability if: ‘a person has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on that their ability to carry out normal day-to-day activities’

| Yes | No | Prefer not to say |

**If yes above, what type of disability do you have?** (Tick all that apply)

<table>
<thead>
<tr>
<th>Learning disability/difficulty</th>
<th>Long-standing illness or health condition</th>
<th>Mental Health condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical or mobility</td>
<td>Hearing</td>
<td>Visual</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>Other: Please specify</td>
<td></td>
</tr>
</tbody>
</table>

**Do you provide care for someone?**

Such as family, friends, neighbours or others who are ill, disabled or who need support because they are older.

| Yes | No | Prefer not to say |
Appendix 5.5 – Questionnaire Raw Data

In a minor illness or injury situation who would you prefer to contact? (using 1 to 12) please rank in order of who you would contact - 1 being your first and 10 your last.

- Optician
- I don't know
- Family/friend
- Dial 999
- Ring 111
- GP Practice

When you need urgent care for a minor injury or illness, what is the most important aspect of that care to you? (Using 1 to 10 please rank in order of importance to you - 1 being the most important and 10 being the least important).

- To have an x-ray
- To be seen closer to home
- To be treated by caring and helpful staff
- To know I don't need to wait too long to be seen
- To know I will get the treatment I need
- To see/speak to the person I want to see
- To access a service straight away
- To talk to someone straight away
- To be seen straight away

If you were to need emergency care, what would be the most important aspect of that care to you? (using 1 to 8 please rank - 1 being the most important and 8 being the least important).

- Feeling safe
- Being closer to home, even if I need to be transferred for further...
- Knowing I will get the treatment I need
- Knowing I can be seen straight away by a healthcare...
Equality Raw Data

What sex are you?

- Male
- Female
- Prefer not to say

Transgender Is your gender identity different to the sex you were assumed to be at birth?

- Yes
- No
- Prefer not to say
What is your age?

- Under 16
- 16 - 25
- 26 - 35
- 36 - 45
- 46 - 55
- 56 - 65
- 66 - 75
- 76 - 85
- 86 +
- Prefer not to say

What is your sexual orientation?

- Bisexual (both sexes)
- Lesbian (same sex)
- Gay man (same sex)
- Heterosexual/Straight (opposite sex)
- Prefer not to say
Do you consider yourself to be disabled?

Yes
No

What type of disability do you have? (Tick all that apply)

Learning disability
Long-standing illness or health condition
Mental Health condition
Physical or mobility
Hearing
Visual
Prefer not to say
Appendix 5.6 – Patient Opinion postings

Variety of care and treatments for stepfather: posted 07/04/2013
Great team: posted 09/04/2013
Day surgery: posted 23/04/2013
Holme valley memorial hospital posted: 26/04/2013
Day surgery: posted 13/05/2013
Suspected stroke victim left to root: posted 19/05/2013
A&E department plus assessment ward: posted 22/05/2013
It was a great comfort Sue was there when my wife died: posted 24/05/13
My father’s recent illness: posted 17/06/2013
Calderdale A&E stroke protocol: posted 09/07/2013
Nurse is very knowledgeable, caring and willing to listen: posted 11/07/2013
My experience in rheumatology outpatients: posted 13/07/2013
DESMOND Diabetes group in Kirklees: posted 01/08/2013
this hospital is a joke: posted 06/08/2013
Don't find the diabetes diary very helpful: posted 09/08/2013
Outpatient day surgery: posted 23/04/2013
Diabetes nurse helped me with my nerves: posted 25/09/2013
Worried about staffing levels: posted 28/10/2013
Kerry-Ann is a fantastic nurse: posted 29/11/2013
My skin is so much better thanks to support and treatment: posted 02/12/2013
In three weeks my hands have vastly improved: posted 02/12/2013
Moorfields dermatology for eczema: posted 02/12/2013
My condition dramatically improved: posted 03/12/2013
The hands I could never use before, I can now use: posted 04/12/2013
Moorfields Dermatology eczema patient: posted 05/12/2013 and 6/12/2013
Dermatology clinic removal of a wart: posted 31/12/2013 and 31/12/2013
My experience was not great and I shall not be returning: posted 17/12/2013
Oncology: posted 05/01/2014
The eczema has now cleared up and is no longer any itching: posted 06/01/2014
So grateful and very pleased: both posted 13/01/2014
My time in Calderdale Royal: posted 15/01/2014
I could not have asked for a better nurse to look after me: posted 27/01/2014
Course for type2 Diabetes: posted 29/01/14
Dermatology eczema: posted 30/01/2014
Great care in dermatology: posted 05/02/2014
I am very happy with the service I received: posted 07/02/2014
The dermatologist was a miracle worker: posted 07/02/2014
It was excellent from start to finish: posted 08/03/2014
Very pleased with my outcome: posted 17/02/2014
Dermatology fungal scalp: posted 14/02/2014
Seeing my dermatologist has boosted my confidence: posted 24/02/2014
Thankful matrons exist: posted 26/02/2014
Contact dermatology: posted 26/03/2014
Great treatment for eczema: posted 15/04/2014
Thanks Moorfields my symptoms have cleared up: posted 23/04/2014
She gave me the treatments that finally helped the problem: posted 23/04/2014
Psoriasis care: posted 16/05/2014
Gaining confidence from the Local heart failure team: posted 06/06/2014
Brilliant hospital: posted 17/05/2014
Referral to Moorfields for scalp diagnosis: posted 09/06/2014
Skin complaint: posted 11/06/2014
Overall good service and friendly staff: posted 13/06/2014
Eczema treatment: posted 18/06/2014
Information and explanation: posted 26/06/2014
I am so happy with the treatment: posted 30/06/2014
Gallbladder surgery: posted 30/06/2013
Excellent care for day surgery: posted 11/08/2014
Removal of a Morton's Neuroma in my left foot: posted 18/08/2014
I can sleep well with no pain: posted 30/06/2014
Hip replacement – excellent surgery, good nursing: posted 13/07/2014
Big improvements for my eczema: posted 25/07/2014
Psoriasis: posted 28/07/2014
Great eczema care: posted 29/07/2014
I would recommend this service to anyone: posted 12/08/2014
Good care for hand eczema: posted 12/08/2014
Nurse went above and beyond and showed amazing care: posted 03/09/2014
Everything was absolutely fantastic: posted 03/09/2014
Failure in care and poor clinical care: posted 04/09/2014
Excellent day surgery unit: posted 10/09/2014
Now my readings are the best I ever had: posted 20/09/2014
Trauma resulting in fractured neck or femur: posted 26/09/2014
Prostatectomy - preparing for the after effects: posted 02/10/2014
Reassuring day surgery: posted 09/10/2014
Long wait for 2 minute injection: posted 8/11/2014
Bunion operation: posted 05/11/2014
Admission to A&E and CDU unit at Halifax Calder royal: posted 03/12/2014
Holme valley hospital - day surgery unit: posted 18/12/2014
Triage waste of time, overall useless: posted 14/04/2015
Hip arthroscopy at Harrogate Hospital: posted 05/05/2015
Not good: posted 11/12/2015
I have always received excellent care: posted 13/01/2015
Brilliant: posted 22/01/15
Faultless: posted 06/02/2015
A gold standard of care: posted 24/03/2015
Amazing: posted 23/04/2015
Colposcopy and biopsy: posted 03/05/2015
Day surgery unit: posted 29/04/2015
Efficient biopsy: posted 09/06/2015
Lack of support: posted 30/06/2015
Relaxed during colposcopy appointment: posted 03/07/2015
A massive difference to my confidence: posted 22/07/15
Went into A&E today suffering palpitations: posted 25/08/2015
### Appendix 5.7: Pals and complaints comments

<table>
<thead>
<tr>
<th>Patient concerns about lack of interpreter for hospital visits, despite requesting one they are not always provided.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maternity - She is concerned about the problems she experienced at the birth of her third child 28/2/2012, because she had encountered problems with her previous delivery causing the baby &quot;to get stuck&quot; she was offered a spinal for a C section. There was a problem after this was administered causing numbness in her upper body and breathing problems. She was immediately taken to theatre and the section was carried out under general anaesthetic. The issues she wants to discuss are around why this happened and if she was to be pregnant again what would the procedure be. She is not looking to apportion blame but is now having counselling for panic attacks and medication to help her with this and feels that a chat would help her recover.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Client had blood taken in an outpatients clinic in Todmorden and has some issues as the blood was taken half way down her arm which left her with severe bruising.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Advised by family member that female patient needs a cortisone injection in hip. Has been told direct by RBS Huddersfield Hosp that are fully booked for procedure and nothing else is in place. Caller would not identify any further information regarding patient details when requested but was unhappy with information given by RBS.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient was referred for a vasectomy in May last year and he hadn't heard anything and tried to chase it up. He was told that they had rung and left a message as there was no response he was discharged back to his GP.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Haematology - had blood tests and biopsy (possible coeliac disease) 12/11 and told would get a follow up to discuss results and treatment in 6 weeks. When chased was told end Feb 2014, but wants this sooner as he is worried about what diet he should be following. believes this has already been raised and passed on to CHT by Bradford PALS.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient had Camera down his throat at the hospital, which took various attempts at different appointments. They did a biopsy and said the patient may have coeliac disease and they also did a blood test. Client was waiting for an appointment with his consultant and saw his GP in meantime who told him the blood test was negative. client has tried to chase up the appointment with the secretary but has been given an appointment in Feb which he states is too far away.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I got a question regarding patient confidentiality. I had an MRI scan in a mobile unit. When I got to the trailer where it took place I sat direct in the room where they see the scans and I could see the patient who was having the scans pictures. When he was done I could see direct in to the room where the MRI was and the patient on the table. When it was my turn I had to take some clothes off but could still wear most of them, though they did almost want me in just the gown. After my scan the next patient was in the room outside the MRI and he could, just like I did with the previous patient, see my scans and me on the table. If I were to have worn a gown this person would have been able to see my underwears as I was still laid on the bed. I am not comfortable with someone seeing my scans like that, weather it's a stranger or someone I know, I feel like no one but the relavant staff should see my scans. Was this right of them? For me as a patient I feel it was as a miscunduct towards the patient confidentiality.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Continence - patient is end of life and has been prescribed products but they are not suitable. She is prescribed 3 green molyform pads per day and 1 blue molyform per night. She needs 4 blue per 24 hours.</th>
</tr>
</thead>
</table>
Patient concerned that has not yet received an appointment for Speech and Language Therapy (SLT) having been referred December 2013 (originally referred to Rotherham SLT but referral transferred to Calderdale and Huddersfield FT 06/12/2013. Patient would also like copies of letters but GP does not have them.

Patient rang regarding a complaint he has made about the maternity service at Calderdale and the Jubilee Centre. Client is concerned as he hasn't heard anything.

Patient's son called out of hours to mum who was at end of life at the weekend. GP arrived and called a member of the nursing team from the house. Son overheard a conversation where nurse said "be careful there's a safeguarding issue with the son". He wants to know who the nurse was and who he complains to about this. He has never heard this before and has had no documentation about it.

Maternity - patient not happy with care she received by service whilst in labour and postnatal. What can she do?

Client had a baby by caesarean section in July and suffered cardiac arrest, resulting in a hysterectomy. Waiting consultant appointment to discuss what happened and has not heard anything.

Client has an issue with the phlebotomist that she saw at her GP Practice. Phlebotomist not GP Practice staff.

Patient started to get blurred vision and confused last night and called 111 they were advised to go the A and E ASAP, they attended Huddersfield and were seen straight away and had some tests as they suspected it was a stroke.

There was a shift change with the nursing staff and they are not sure if was brought to the nurse's attention that the patient was suspected of having a stroke, they had to wait 3 hours to see the Dr. When they saw the Dr he was concerned about the time they had waited and sent them to the stroke unit at Calderdale in a blue light ambulance. The nursing staff at the stroke unit were also concerned about the time the patient had waited to see a Dr.

The patient does not want to make a complaint but wished to highlight the length of time they waited.

Maternity, patient has made a complaint about her daughter's birth in 2012 at Calderdale hospital. She made the complaint via an online complaints form 5 days ago and has not had an acknowledgement. She has checked with the website again and it advises her to call PALS if no reply.

Patient complaining about excessive waiting times at the breast clinic. They do not schedule enough time for appointments which means that there are always going to be such delays.

Oncology - Sister of unidentified patient advised that she has been diagnosed 4 weeks ago with Stage 4 lung cancer but was concerned as not started any treatment yet, however had earlier had biopsies at Huddersfield Royal Infirmary. Was unable to give any further clinical detail.

Ophthalmology
Query about waiting time from referral to treatment and cancellation of appts.

Physiotherapy - Patient advised that has been referred by GP to physio recently but not heard anything.

cardiology - call from daughter of patient who has been admitted to A & E many times in recent history for “funny turns ” it was highlighted several months ago that she needs a pacemaker fitting. This week she has been twice again and is now on the MAU however they are suggesting that she go home and wait again. Caller very worried about the risk associated with this as patient is 90 year old. She has currently refused to
<table>
<thead>
<tr>
<th>Client Name</th>
<th>Issue Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take her home but has been advised by the doctor that they will record in patients notes that she has refused to care for her mother. What can she do?</td>
<td></td>
</tr>
<tr>
<td>Client had an op in Feb on his spine and he was in pain in his back and his spine since. He has seen the consultant and has thought he was being referred for nerve conduction test but a referral has not been made. His GP has done a private referral to the Spire but client wants to know whether the NHS will pay for this.</td>
<td></td>
</tr>
<tr>
<td>Respiratory: patient had a follow up CT scan 30/1 after nodules had been found on his lung. He is still waiting for an outpatient appt to discuss findings with Dr. How long will it wait be?</td>
<td></td>
</tr>
<tr>
<td>MSK: Caller received a text this morning to cancel an appt he has been booked for today and advised to call a number to rebook. When he called he got an answer machine.</td>
<td></td>
</tr>
<tr>
<td>Dermatology: Concern regarding wording of letter sent by Dermatology at Calderdale Hosp. Patient copied same letter, after an appointment with locum dermatologist. Letter dated 1 Oct advised “that patient just turned up in clinic today asking to be seen”. Patient sent 2 separate letters dated 8 Oct direct to Dermatology dept and Chief Executive, both hand delivered but not received a response yet.</td>
<td></td>
</tr>
<tr>
<td>Physio: Son hurt his foot/ankle in Jan. This was xrayed and nothing significant found. In Feb he twisted the same ankle and has limped since. He was seen by a podiatrist who has supplied an insole and referred to Physio but mum has heard nothing.</td>
<td></td>
</tr>
<tr>
<td>Daughter of patient made a complaint about her father's care and treatment for prostate cancer on ward 12 prior to his recent death. How long will it take to hear from the complaints team?</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology: Patient arrived at hospital for a pre-booked Choose and Book appt with Ophthalmology yesterday. He was turned away from clinic who advised that his appt had been cancelled and he should return to his GP Practice for a new referral.</td>
<td></td>
</tr>
<tr>
<td>Oncology: Call via PM who asked PALS if we could support a patient to get resolution in relation to a possible misdiagnosis which has resulted in surgery for bladder cancer. The patient has lots of long term conditions including Parkinson's, Fibromyalga, Kidney Stones, and depression. She is concerned about the combination of drugs she is on and the side effects.</td>
<td></td>
</tr>
<tr>
<td>Concern by parent regarding non-availability of GP services at 2 surgeries for child patient. Also attended local walk in centre who advised could not see the child. Parent is requesting answers to why no daily GP service and why Walk in Centre could not help.</td>
<td></td>
</tr>
<tr>
<td>Caller is very unhappy with clinical advice given by GP following a stroke in 2012, he has been taken off warfarin because he FTA appt for blood test. He telephoned the Stroke ward for advise and was given conflicting advice, he has previously complained via PCT pals.</td>
<td></td>
</tr>
<tr>
<td>I inquired this morning with Patient services regarding de-registering as a patient with x group Practice and I was asked to write this request. I request that my name be removed for x group Practice even though this will leave me with no doctor in the future and I would appreciate confirmation that this has been done. I want it put on record that I was admitted to the Halifax acute stroke ward in the xxth Aug 2012 and in the following month of Feb I visited my GP at Dr. xxx due to being unable to keep an appointment to attend the Warfin clinic. Instead of trying to help she asked me to leave and to return when I had more time to sort the problem out. Each time I tried to explain why I did not attend (Due to working in Morecombe) I found her to be talking over me and not willing to listen and she refused to continue.</td>
<td></td>
</tr>
</tbody>
</table>
with my medication. I left and never returned and 8 months passed before I was told by the pre ops clinic in the hospital at Lindley that my blood pressure was very high and I risked another Stroke.

I contacted the Stroke ward and asked if there were an urgency in me being on the meds and the Ward sister informed me a relayed message from the stroke specialist was Yes it is urgent and important I continue with meds as I will be taking warfin for life without it I increase the risk of a further stroke by 100%

I would like to know why this doctor refused as she did so and put me at such a risk.

Care and treatment by GP/District Nursing and other associated clinicians for patient who is terminally ill. Concern by family member after home visit yesterday with GP, District Nursing team, care officers etc. Says care not appropriate, as increasing morphine into syringe driver linking in with end of life care plan. Unhappy with results of meeting yesterday. Has not previously put any details in correspondence to NHS.

Patient feels his GP is not supporting him, he requested a wheelchair assessment and the GP has not referred however he has already has an assessment and been offered a wheelchair which he has refused as it is not the one he wants.

We have been contacted this morning by a gentleman who is concerned regarding the treatment his wife has received at her GP surgery. His wife is currently housebound after suffering a stroke and has been treated within Secondary care, however on the xx.05.14 his wife presented to her GP surgery with signs he believed was a stroke such as weakness in her arm. The practice nurse carried out tests that day and said it was not a stroke. His wife returned to the surgery a couple of times since seeing practice nurses but not a Doctor. Until the xx/05/14 when the patient was suffering with very limited mobility and requested she see a Doctor or she will attend A & E, the surgery provided her with an appointment to see a GP who upon seeing his wife informed her she had had a stroke and needed to attend A & E. Caller feels that his wife's treatment has been handled badly at the GP surgery and that she should have seen a GP sooner rather than a nurse, and the failure to do so has resulted in his wife being in a worse condition health wise.

Patient is an insulin dependant diabetic. He works all over the country and needs to be able to access his medication when away from home. Because of his transient work he has been removed from 2 GP Practices locally in recent years. How does he resolve this?

Patient has long term skin condition which is severe and recently was prescribed antibiotics and cream from GP for infection. She was advised at that appt that if this didn't clear up this time she would be referred to dermatology. Yesterday she had appt with practice nurse who knew nothing about this what should she do?

Compliment regarding care from GP and Diabetes consultant in relation to her care.

Complaint about patient end of life care and lack of pain relief

Caller has made a complaint to the GP Practice about the lack of care and medication which led to her trying to commit suicide, she is not happy with the response what should she do now?

Patient had a vasectomy in 2012 and has had complications and pain since. He has had 2 ultrasounds and been seen by a consultant. He is provided with antibiotics and analgesia when appropriate. He really would like this sorted now - what can he do?

Cardiology - Advised by wife that patient previously referred to Calderdale for angio tests etc and now newly re referred to Leeds. GP concerned re timescale.

Complaint - caller wants to complain about the unacceptable wait for a GP to attend to see her father. Call to NHS 111 was made 11am but GP did not attend until 20.20, even though caller was told it would be within a couple of hours. Father is cancer
patient who was suffering with high temp, diarrhoea and couldn't get out of bed.

Patient is under several paediatric consultants in Leeds, but there are on-going problems with incorrect bookings & referrals going missing (at Leeds TH)

Fertility & Aspergers:
Patient is desperate to have a baby but feels she is waiting for a diagnosis for Aspergers. She feel she is being prevented from having the treatment.

Patient is enquiring if he can have physio in Manchester as that is where he works and it would be more convenient

patient registered with local practice doesn't want the new proposed Vanguard Building in his village and is setting up a campaign group to challenge this and wanted to know if there were alternative GP practices that he and others could approach for registration

A long conversation with a patient regarding 2 issues affecting her, patient is now legally female after going through through gender reassignment surgery. Patient is wanting to have hair loss surgery on the NHS via the IFR process as she currently wears wigs and finds they impact on her life and the sports that she does. Patient also has an issue with the blood tests she has done in regard to her hormone levels as the sheet she gets back has all her details on and they state that they are for transgender hormones which the patient believes they shouldn't be labelled in case they go missing and also she no longer sees herself as transgender but female.

Long conversation with the patient in regard to what is happening with him and services he uses, patient is struggling to move froward as his care coordinator is off and no one seems to be covering her work in the interim.

Patient rang to update on his situation. Patient is pleased that his GP are making steps to help with reasonable adjustments when he uses the services. He is still struggling with other services such as the Mental Health Services he uses with communication. whether it is not clearly communicating between other services, him as a service user or ensuring the communication they out to him in writing.

Also discussed patient and wife are starting divorce proceedings. Patient not happy as confusion around diagnosis for Aspergers and ADHD, why are GP unaware?

Patient referred to Sheffield but not happy as redoing some of the questionnaires and there will be delay as his mother is away.

Patient has had an ongoing health issue for the past 3 years she has been referred via her GP to Dermatology, Gastroenterology and Colorectal. Patient is under the care of an allergy clinic in Manchester. Patient has a severe rash and hives but no one has been able to diagnose of help the patient.

Patient has done some research and believes it could be mastocytosis which is an unusual condition but there is 2 specialist in the country under the NHS that deal with this condition.

Patient has spoken to the secretary in London and has confirmed the patient will need to fax through a referral.

Patient has tried to speak her GP but he refusing to refer under the NHS only private, he is wanting to refer to haematology but after the patient spoke to haematology they do not know if they can help the patient.

Patients wife is enquiring how to get an optician who will visit home as they are both
<table>
<thead>
<tr>
<th><strong>Mental Health services</strong> - caller wants to make a complaint regarding the counselling service she has been receiving at Oakdale.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Call from Supporter of patient, she is wanting to make a complaint about an interpreter who gave her inappropriate advise at a TOP Clinic, who was the interpreter and where was the service</strong></td>
</tr>
<tr>
<td><strong>Call came from CHFT PALS re Inter serve - patient has being having care since leaving hospital in July 2014. He has a motor neuron disease, tracheotomy, ventilated and peg fed. The care company have said that they cannot provide care next week and there is no other service in place</strong></td>
</tr>
</tbody>
</table>
| **Wheelchair Services**  
Patient has limb-girdle muscular dystrophy had a referral for a motorised wheel chair and had an assessment in Nov 14 but not heard anything since, he has had letters of support sent by his GP and Neuro consultant |
| **Mental Health Services**  
Patient has some issues with the treatment he has receiving for his schizophrenia and would like to talk to someone about this |
| **Patient lives in Calderdale and see's a psychiatrist in Hebden Bridge and would like to make a complaint** |
| **Mother has been trying to get her son assessed for Autism for 8 yrs, he has now been accepted but has been told that the wait for assessment by CAMHS is 3 years, he is now 15 and will not only transfer to adults services in this time but will have completed his school exams which will be affected what can she do** |
| **Memory Service - Daughter of patient advised that mother had been linking Memory Service over last few months and now told by Occ Therapist that Cognitive Stimulation Therapy is not available. Patient having side effect from 3 different medications. PALS given OT contact to speak to about situation.** |
| **Patients mother wanted to discuss her sons care whilst on a section 3 in Calderdale she wants him releasing as she believes he is suffering from Chemical Sensitivity and not psychotic - all he needs is fresh air and water** |
| **Mental Health complaint - patient says her MH services are being reduced and her status has been reduced from enhanced to standard. She has borderline personality disorder and suicidal tendencies and says this has not changed. She feels her CPA coordinator has washed her hands of her and doesn't care about her mental health anymore.** |
| **Sister of patient needing help with care. Patient has mental health issues and is not getting the integrated care he needs.** |
| **Patient recently diagnosed with Aspergers Syndrome and needs support. Requires needs assessment by problems Newly wedded and problems with confidence lost job - marriage issues - anxiety disorder. Requiring "needs assessment" undertaking but problems being encountered** |
| **Patient is an adult who has been diagnosed with ADHD and aspergers. He is currently under the care of the SWYPFT team but he is concerned that there is a lack of coordination in his care as well as a lack of services which are suitable in his area for his condition.** |
| **Patient is under the care of Dr x she has asked for a second opinion re Aspergers Syndrome as she believes the delay in this diagnosis is stopping/preventing her from having IVF because she has been removed from the list due to anger issues, she has been told several times she would have appt but nothing has happened** |
| **Enquiry re fathers appt for retinal screening, he has mobility problems can he have** |
I have some questions which I would like some answers to with your advice and support:

• Why was it not explained to my partner or I why the episiotomy was needed or what the alternatives were?
• Was the episiotomy necessary?
• Why has the episiotomy not healed? On an average it is supposed to take 6-7 weeks to heal.
• Has my episiotomy not healed due to the poor re-stitching of the doctor on the 15th of October who carried out the procedure but engaged in conversation about her personal life with the midwife a result of a bad job which I have to suffer for?
• Is it appropriate conduct for these members of staff to be talking amongst themselves so casually about their personal lives whilst a patient is fully conscious?
• Has the episiotomy cut caused me to have bowel problems (the sense of urgency I now have and the fact that I cannot relive myself fully as my cut hurts every time I do ?)
• Why have I had to wait so long for my appointments to come through?
• Why do clinicians seem to have such poor communication between them? if you are seen by a junior doctor when the consultant is not available why are you as the patient not reassured that the junior doctors notes and examination of you is reliable?
• Why was care by the midwife in particular who ‘looked after’ me on the 16 October 2012 so poor? (I am unable to recall her name but work related records should determine who this was and I am also able to provide a description if required)
• What are the clear guidelines re breastfeeding and if your body is not producing milk is it right to starve your baby?
• Does the ward think it is acceptable to give some patients formula milk for their babies whilst refusing other patients?

I am a working professional when I carry out my job I ensure that I deal with tasks to the best of my ability and in the most professional way. I am astounded at the nature in the difference of care that I received by the nurses on the ward and the inconsistencies in the treatment given to patients in the ward that I observed. I believe the least I deserve is a full explanation to all my questions so that I may start the process of coming to terms with my situation and move on. I would like you to carry out a full investigation into my concerns and supply me with a full response in accordance with the NHS complaints procedure.
## Appendix 5.8 - Focus Groups

<table>
<thead>
<tr>
<th>Provider / Forum</th>
<th>Date</th>
<th>Number of returns</th>
<th>Protected Characteristic / group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halifax Opportunities Trust:</td>
<td>23-Jul</td>
<td>11</td>
<td>Cross-community, BME, women</td>
</tr>
<tr>
<td></td>
<td>27-Jul</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Calderdale Carers Project</td>
<td>06-Aug</td>
<td>1</td>
<td>Carers – Adults</td>
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<tr>
<td></td>
<td>20-Jul</td>
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<td></td>
</tr>
<tr>
<td>Calderdale BME Network</td>
<td>24-Jul</td>
<td>10</td>
<td>Race</td>
</tr>
<tr>
<td>Cornholme &amp; Portsmouth Old Library, Cornholme, Todmorden</td>
<td>01-Aug</td>
<td>15</td>
<td>Cross-community, rural</td>
</tr>
<tr>
<td>Calderdale Interfaith Council,</td>
<td>24-Jul</td>
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<td>Religion or belief</td>
</tr>
<tr>
<td></td>
<td>15-Jul</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16-Jul</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>26-Jul</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Disability Support Calderdale</td>
<td>28-Jul</td>
<td>10</td>
<td>Disability – Physical impairments</td>
</tr>
<tr>
<td></td>
<td>15-Jul</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Healthy Minds</td>
<td>13-Jul</td>
<td>3</td>
<td>Disability – Mental health</td>
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<tr>
<td>Health Connections Consultation</td>
<td>21-Jul</td>
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<td></td>
</tr>
<tr>
<td>Calderdale Parents &amp; Carers</td>
<td>16/07/15</td>
<td>5</td>
<td>Parents of disabled children</td>
</tr>
<tr>
<td></td>
<td>07/07/15</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>27/07/15</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Survey feedback – 16 responses received</td>
</tr>
<tr>
<td>Disability Partnership, Calderdale,</td>
<td>28/07/15</td>
<td>12</td>
<td>Disability - physical and sensory impairments</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
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<tr>
<td>Age UK</td>
<td>Various dates</td>
<td>37</td>
<td>Age</td>
</tr>
<tr>
<td>The LABRYs Trust</td>
<td></td>
<td>8</td>
<td>Sexual orientation – Older Lesbians</td>
</tr>
<tr>
<td>Women’s Centre</td>
<td>21-Jul</td>
<td>5</td>
<td>Gender – women</td>
</tr>
<tr>
<td>Total</td>
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</table>
Appendix 5.9 - Equality monitoring focus group

**Sex**

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<th></th>
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</thead>
<tbody>
<tr>
<td>Women</td>
<td>51</td>
<td>65%</td>
</tr>
<tr>
<td>Men</td>
<td>22</td>
<td>28%</td>
</tr>
<tr>
<td>Prefer not to say</td>
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**Age**

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<td>16-25</td>
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<td>1%</td>
</tr>
<tr>
<td>26-35</td>
<td>7</td>
<td>9%</td>
</tr>
<tr>
<td>36-45</td>
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</tr>
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<td>15%</td>
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**Sexual orientation**

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<tr>
<td>Heterosexual</td>
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<td>68%</td>
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<td>Bisexual</td>
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<td>Gay man</td>
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<tr>
<td>Prefer not to say</td>
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<td>20%</td>
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**Ethnic background**

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<tbody>
<tr>
<td>White British</td>
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<td>White Other</td>
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</tr>
<tr>
<td>White Irish</td>
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</tr>
<tr>
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<td>10%</td>
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**Religion**

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<td>Sikh</td>
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<td>1%</td>
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<tr>
<td>No religion</td>
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<td>11%</td>
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<tr>
<td>Prefer not to say</td>
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<td>34%</td>
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**Carer**

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<th></th>
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</thead>
<tbody>
<tr>
<td>Carers (Yes)</td>
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**Disability**

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67%
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<td>Visual</td>
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Appendix 5.10 - Equality Monitoring Surveys

There were 292 equality monitoring forms returned with surveys. These are detailed below:

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<table>
<thead>
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<th>Sex</th>
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<tr>
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<tr>
<td>Male</td>
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<table>
<thead>
<tr>
<th>Transgender</th>
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<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Age</th>
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</tr>
</thead>
<tbody>
<tr>
<td>16-25</td>
<td>19</td>
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<tr>
<td>26-35</td>
<td>24</td>
</tr>
<tr>
<td>36-45</td>
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<td>86+</td>
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<table>
<thead>
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<tbody>
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</tr>
<tr>
<td>Bisexual (both sexes)</td>
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</tr>
<tr>
<td>Lesbian (same sex)</td>
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</tr>
<tr>
<td>Gay man (same sex)</td>
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</tr>
<tr>
<td>Prefer not to say</td>
<td>54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Arab</td>
<td>8</td>
</tr>
<tr>
<td>Asian &amp; White</td>
<td>2</td>
</tr>
<tr>
<td>Black African</td>
<td>10</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>11</td>
</tr>
<tr>
<td>Black Caribbean &amp; White</td>
<td>2</td>
</tr>
<tr>
<td>Chinese</td>
<td>9</td>
</tr>
<tr>
<td>Indian</td>
<td>16</td>
</tr>
<tr>
<td>Other Asian background</td>
<td>4</td>
</tr>
<tr>
<td>Other White background</td>
<td>7</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Count</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Pakistani</td>
<td>25</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>23</td>
</tr>
<tr>
<td>White British</td>
<td>170</td>
</tr>
<tr>
<td>White Irish</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>118</td>
<td>40%</td>
</tr>
<tr>
<td>Muslim</td>
<td>47</td>
<td>16%</td>
</tr>
<tr>
<td>Hindu</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Agnostic</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Sikh</td>
<td>13</td>
<td>4%</td>
</tr>
<tr>
<td>Buddhism</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>No religion</td>
<td>53</td>
<td>18%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>48</td>
<td>16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers (Yes)</td>
<td>54</td>
<td>18%</td>
</tr>
<tr>
<td>Disabled (Yes)</td>
<td>84</td>
<td>29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability</td>
<td>8</td>
</tr>
<tr>
<td>Long standing health condition</td>
<td>48</td>
</tr>
<tr>
<td>Mental Health</td>
<td>10</td>
</tr>
<tr>
<td>Physical or mobility</td>
<td>40</td>
</tr>
<tr>
<td>Hearing</td>
<td>3</td>
</tr>
<tr>
<td>Visual</td>
<td>3</td>
</tr>
</tbody>
</table>
### Appendix 5.11 - Calderdale respondents compared with local population data from Census 2011

<table>
<thead>
<tr>
<th>Sex</th>
<th>Calderdale population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>67%</td>
</tr>
<tr>
<td>Male</td>
<td>33%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transgender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

There is currently no reliable information on the size of the transgender community.

<table>
<thead>
<tr>
<th>Age</th>
<th>Calderdale population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 25</td>
<td>3%</td>
</tr>
<tr>
<td>26 - 35</td>
<td>11%</td>
</tr>
<tr>
<td>36 - 45</td>
<td>11%</td>
</tr>
<tr>
<td>46 – 55</td>
<td>30%</td>
</tr>
<tr>
<td>56 - 65</td>
<td>20%</td>
</tr>
<tr>
<td>66 - 75</td>
<td>16%</td>
</tr>
<tr>
<td>76 - 85</td>
<td>7%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Calderdale population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual (both sexes)</td>
<td>2%</td>
</tr>
<tr>
<td>Gay man (same sex)</td>
<td>1%</td>
</tr>
<tr>
<td>Heterosexual/Straight (opposite sex)</td>
<td>97%</td>
</tr>
<tr>
<td>Lesbian (same sex)</td>
<td>9%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>15%</td>
</tr>
</tbody>
</table>

There is currently no reliable information on the size of the lesbian, gay or bisexual (LGB) population. Estimates range from 0.3% to 10% using different measures and sources.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Calderdale population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian &amp; White</td>
<td>2%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1%</td>
</tr>
<tr>
<td>Indian</td>
<td>1%</td>
</tr>
<tr>
<td>Other Asian background</td>
<td>1%</td>
</tr>
<tr>
<td>Other White background</td>
<td>3%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>11%</td>
</tr>
<tr>
<td>White British</td>
<td>77%</td>
</tr>
<tr>
<td>White Irish</td>
<td>2%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>4%</td>
</tr>
</tbody>
</table>
### Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Calderdale population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhism</td>
<td>7 5% 0.3</td>
</tr>
<tr>
<td>Christianity</td>
<td>48 36% 56.3</td>
</tr>
<tr>
<td>Islam</td>
<td>16 12% 7.3</td>
</tr>
<tr>
<td>No religion</td>
<td>36 27% 7.3</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>24 18%</td>
</tr>
<tr>
<td>Sikhism</td>
<td>1 1% 0.1</td>
</tr>
</tbody>
</table>

### Carers

<table>
<thead>
<tr>
<th>Carers</th>
<th>Calderdale population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33 25% 10.5</td>
</tr>
</tbody>
</table>

### Disabled

<table>
<thead>
<tr>
<th>Disabled</th>
<th>Calderdale population %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day to day activities limited a lot</td>
</tr>
<tr>
<td>Yes</td>
<td>42 32% 8.2</td>
</tr>
<tr>
<td>Learning disability/difficulty</td>
<td>3</td>
</tr>
<tr>
<td>Long-standing illness or health condition</td>
<td>24</td>
</tr>
<tr>
<td>Mental Health condition</td>
<td>6</td>
</tr>
<tr>
<td>Physical or mobility</td>
<td>13</td>
</tr>
<tr>
<td>Hearing</td>
<td>1</td>
</tr>
<tr>
<td>Visual</td>
<td>1</td>
</tr>
</tbody>
</table>
## Appendix 5.12 - Greater Huddersfield respondents compared with Kirklees and Greater Huddersfield data

### Sex

<table>
<thead>
<tr>
<th></th>
<th>Kirklees population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>44% 49.9</td>
</tr>
<tr>
<td>Male</td>
<td>56% 50.6</td>
</tr>
</tbody>
</table>

| Transgender | 2 | 2% | Unknown |

### Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Kirklees population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 25</td>
<td>14 11% 13.3%</td>
</tr>
<tr>
<td>26 - 35</td>
<td>8  6% 12.8%</td>
</tr>
<tr>
<td>36 - 45</td>
<td>12 9% 14.5%</td>
</tr>
<tr>
<td>46 – 55</td>
<td>15 11% 13.2%</td>
</tr>
<tr>
<td>56 - 65</td>
<td>28 21% 11.6%</td>
</tr>
<tr>
<td>66 - 75</td>
<td>31 23% 8.0%</td>
</tr>
<tr>
<td>76 - 85</td>
<td>22 17% 4.6%</td>
</tr>
<tr>
<td>86+</td>
<td>2  2% 1.6%</td>
</tr>
</tbody>
</table>

### Sexual Orientation

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Greater Huddersfield population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual (both sexes)</td>
<td>3 2%</td>
</tr>
<tr>
<td>Gay man (same sex)</td>
<td>9  7%</td>
</tr>
<tr>
<td>Heterosexual/Straight (opposite sex)</td>
<td>106 80%</td>
</tr>
<tr>
<td>Lesbian (same sex)</td>
<td>2  2%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>12  9%</td>
</tr>
</tbody>
</table>

### Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Greater Huddersfield population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arab</td>
<td>8  6% 0.4</td>
</tr>
<tr>
<td>Black African</td>
<td>10 8% 0.8</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>9  7% 1.8</td>
</tr>
<tr>
<td>Black Caribbean &amp; White</td>
<td>2  2% 1.8</td>
</tr>
<tr>
<td>Chinese</td>
<td>8  6% 0.5</td>
</tr>
<tr>
<td>Indian</td>
<td>15 11% 1.6</td>
</tr>
<tr>
<td>Other Asian background</td>
<td>2  2% 0.8</td>
</tr>
<tr>
<td>Other White background</td>
<td>3  2% 2.1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>9  7% 7.4</td>
</tr>
<tr>
<td>White British</td>
<td>59 45% 79.6</td>
</tr>
<tr>
<td>White Irish</td>
<td>2  2% 0.9</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>5  4%</td>
</tr>
</tbody>
</table>

### Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Kirklees population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhism</td>
<td>4  3% 0.2</td>
</tr>
<tr>
<td>Christianity</td>
<td>59 45% 53.4</td>
</tr>
<tr>
<td>Religion</td>
<td>Count</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Hinduism</td>
<td>2</td>
</tr>
<tr>
<td>Islam</td>
<td>30</td>
</tr>
<tr>
<td>No religion</td>
<td>15</td>
</tr>
<tr>
<td>Sikhism</td>
<td>12</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Carers</th>
<th>Kirklees population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disabled</th>
<th>Kirklees population %</th>
<th>Day to day activities limited a lot</th>
<th>Day to day activities limited a little</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>27%</td>
<td>8.4</td>
<td>9.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability/difficulty</td>
<td>5</td>
</tr>
<tr>
<td>Long-standing illness or health condition</td>
<td>20</td>
</tr>
<tr>
<td>Mental Health condition</td>
<td>2</td>
</tr>
<tr>
<td>Physical or mobility</td>
<td>24</td>
</tr>
<tr>
<td>Hearing</td>
<td>2</td>
</tr>
<tr>
<td>Visual</td>
<td>1</td>
</tr>
</tbody>
</table>