A Citizen Engagement Study on the Proposed STP Reconfiguration of Urgent and Emergency Care in Mid and South Essex

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This report, commissioned by the Mid and South Essex Success Regime, presents an independent research study conducted by HWE Insights Ltd.

The study was undertaken to allow the citizens of Essex, who live in geographical areas affected by proposed ‘Sustainability and Transformation Partnership’ (STP) and Success Regime plans, an opportunity to have their voices heard on issues relating to the proposed reform of urgent and emergency care. The findings of this study will inform draft plans prior to the forthcoming public consultation process to be undertaken by the Mid and South Essex Success Regime. HWE Insights Ltd has retained full editorial control of the contents of the report.

HWE Insights Ltd is an arms-length subsidiary of Healthwatch Essex, wholly owned by Healthwatch Essex. It was set up to allow Healthwatch Essex to undertake high quality engagement, research and training activities on a commissioned basis, and to participate in joint venture arrangements. Healthwatch Essex is an independent organisation with responsibilities under the Health and Social Care Act (2012) to provide a voice to the people of Essex with regard to health and social care services. Alongside HWE Insights Ltd, it conducts high quality research on the “lived experience” of patients, social care users and citizens to inform improvements in local health and social care commissioning and provision.

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Acknowledgements

We are indebted to the patients and citizens of Essex who participated in this study by taking time to share their experiences and opinions of urgent and emergency care. These narratives offer rare and invaluable insights into how improvements might be made and we hope that future service users will benefit from this work.

It is easy to overlook the hard work that goes on behind the scenes of a study in terms of preparation, administration and presentation. Our thanks to Clare Ebberson from Essex County Council’s public health team, for her advice and support in running the deliberative workshop sessions. We would also like to thank the hospitals for facilitating us to carry out the project, and we would like to express our appreciation to all involved in the Research Ethics and R&D submission approval processes. Special thanks go to Abbi Davies for her careful reading of the text, and to Trait Design for their fantastic design work.

Abbreviations

A&E  Accident and Emergency  
CCG  Clinical Commissioning Group  
CQC  Care Quality Commission  
GP  General Practitioner  
HWE  Healthwatch Essex  
NHS  National Health Service  
STP  Sustainability and Transformation Partnerships
Background

HWE Insights Ltd was commissioned by Mid and South Essex Success Regime leaders in 2016 to undertake this research study, to seek people’s views about the proposal to designate one of the hospitals as a specialist emergency hospital. The findings of the project will be used to inform the STP plans relevant to the reforms for A&E services.

Methods

We utilised both qualitative and quantitative methods, using a two-phased approach: a survey focussed on the reasons people chose to attend A&E, and deliberative workshop sessions around the proposed changes to urgent and emergency services. A total of 306 people participated in the survey across Basildon, Broomfield and Southend hospitals. Thirty-six participants took part across three deliberative workshop sessions held in Basildon, Chelmsford and Southend. They were involved in deliberation and discussion about the possible consequences of the proposals for patients and their families.

Findings

Most people surveyed had considered where to go for treatment of their condition, with just 1 in 5 going straight to A&E without consulting a medical professional first. Most people felt that A&E was the best service for their treatment, and few people were aware of alternative places they could have gone.

The findings from the workshops reveal that many participants felt that patient voice and experience had not been considered by commissioners. Participants’ concerns about the proposals reflect issues along the patient journey, as well as implications for staff and community services. They reflected on how the changes would affect not only the patient, but also their loved ones. Participants felt that diminishing community resources are unprepared to support the proposals. Underpinning discussions was considerable scepticism and distrust regarding STPs, the openness of the process and the evidence for centralisation. Participants wanted more transparency, information and clarity about the changes, and to be assured that their concerns would be reflected in future plans.
1  Executive summary

Recommendations

1. Ensure that present and future public engagement activities follow a ‘co-production’ model of engagement that facilitates the public’s input to plans and reforms in a genuine and meaningful way.
   a. Doing so will help to build patient and public trust in the plans and will encourage patients to adopt an active role in their own and family’s health and wellbeing.

2. Set up a communication strategy that clearly explains the overall aim of the STP and why now is the right time to do it.

3. Provide proof/evidence of clinical effectiveness and patient safety to justify plans to centralise A&E facilities.
   a. This should include risk analyses of journeys to centralised services and the consideration of more complex case scenarios such as for patients near end-of-life.
   b. Such information should be easy to comprehend and accessible and at the same time the more complex original scientific papers should be made available for those citizens wishing to see the evidence in more detail.

4. Communicate plans for addressing workforce shortages including paramedics, ambulance staff, GPs and nurses.

5. Explain explicitly how the social issues raised in this report concerning patients and their families will be considered and incorporated into the plans.
   a. This should include reference to the key role played by family caregivers as advocates and carers of patients, particularly in cases where children and vulnerable adults are involved.

6. Specify how steps will be taken to ensure that existing social health inequalities in the region will not be exacerbated by the reconfiguration of services.
   a. We suggest that STP leaders collaborate with representatives of local disability and minority groups, and local authorities (including Health and Wellbeing Boards and Joint Strategic Needs Assessment teams) on such issues if this is not already being done.

7. Provide information and time frames about how community services will be reconfigured.
   a. For example, explain how primary care will be reconfigured and what community services will be bolstered.

8. Provide information about the level of support available to public services that offer an alternative to A&E in the region.
   a. Information should make it clear to the public where it is best for them to attend in order to receive the most appropriate care for their condition.

9. Provide assurances that independent evaluations following patient journeys will be conducted and made publicly available once reforms to services are implemented.
   a. We are happy to offer advice on the design and implementation of realist evaluation studies to capture the impact of reconfiguration of services on patient experience.
Sustainability and Transformation Partnerships (STPs)\(^1\) have been introduced across England with the aim of improving care for individuals and populations through joined up services and a system-wide approach.

The main aims of an STP are set out in the NHS Five Year Forward View and GP Forward View to improve health through self-care and prevention, early and more targeted intervention and to prepare the system to meet the growing future demands of the population, within the resources available. In Mid and South Essex\(^2\) the STP has focussed on transforming and expanding the capacity of primary care, pathways of care for those with frailty and complex needs and the configuration of hospital services by working together as a group.

In addition, Mid and South Essex is one of three areas in the country designated by NHS England as a ‘Success Regime’ area. The Success Regime is an intervention led by NHS Improvement and NHS England, which aims to support system-wide change in some of the most challenged health and care economies.

In this report, we focus on the STP proposals regarding the reconfiguration of urgent and emergency care. The current urgent and emergency care model in Essex means that all three of the hospitals offer A&E services, and in most cases ambulances take patients to their closest hospital for treatment. In some cases, ambulances take patients direct to specialist centres, such as the plastics and burns centre at Broomfield Hospital in Chelmsford, the Essex Cardiothoracic Centre in Basildon and other specialist centres in hospitals outside the county.

STP leaders have proposed that one of the three hospitals in mid and south Essex act as a specialist emergency hospital, receiving the most serious and life-threatening emergencies, with the other hospitals offering more selective emergency care. Although the plans are still in discussion, it is likely that Basildon Hospital would be designated the specialist emergency hospital, while Southend Hospital and Broomfield Hospital specialise in other services such as planned surgery, cancer care and burns. As a result, emergency blue light cases would be taken by ambulance directly to Basildon Hospital instead of their local hospital.

HWE Insights Ltd was commissioned by Mid and South Essex Success Regime leaders in 2016 to undertake a range of research and engagement work with local citizens. Given the remit of HWE to gather citizens’ voices and lived experience of health and social care, we feel that it is crucial for patient and citizens’ voices to inform and shape proposed plans. For this specific research study, we were commissioned to conduct a research project aiming to explore the views and experiences of people about the proposed reconfiguration of A&E services in Mid and South Essex. The findings of the project will be used to inform the STP plans relevant to the reforms for A&E services. To that end, we conducted a survey in the A&E waiting rooms to explore the reasons people visit A&E services, and held a series of deliberative workshops to elicit their views on the proposed A&E reconfiguration. We hope that the insights generated from this piece of research will assist with shaping and informing the STP plans.

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1 STPs were originally referred to as Sustainability and Transformation Plans, but this was later changed to Sustainability and Transformation Partnerships.

2 Within Essex, one STP covers the mid and south of the county (including Southend and Thurrock), another STP covers the west of the county and Hertfordshire, whilst a third STP covers the north east of Essex and much of Suffolk (excluding Waveney).
3 Background

3.1 National STPs and The Success Regime

Sustainability and Transformation Partnerships (STPs) were introduced by the NHS in 2015 with the aim of supporting the improvement of care quality and improving the efficiency of services. While the Health and Social Care Act (2012) sought to promote competition between providers, NHS organisations are now being told to collaborate in order to respond to the challenges facing their local services. STPs were introduced to encourage various organisations and providers to work collaboratively, and improve the integration of services while attending to the needs of the local population.

Forty-four geographical areas, (referred to as STP footprints) were established across England. Known as ‘place-based planning’, STPs have been working collaboratively on service reconfiguration plans since their establishment. The King’s Fund recently highlighted the many challenges faced by STP leaders across England. In particular, local STP leaders are often having to manage this work on top of clinical and local government duties, and at a time when public health and social care budgets are facing ‘an unprecedented slowdown in funding and dramatic cuts...’ (The King’s Fund, 2016). NHS guidance for those responsible for developing STPs emphasises the importance of involving people, communities and stakeholders meaningfully throughout by collectively identifying problems and designing solutions (NHS England, 2016).

However, it has been recognised that patient and public involvement in this process has largely been absent so far (The King’s Fund, 2016). We therefore recognise the Mid and South Essex STPs attempts to engage with patients and the public, and for committing to work with Healthwatch Essex towards this.

In addition to the STPs, NHS England and NHS improvement have established a Success Regime programme with Mid and South Essex being one of three such initiatives in the country. The Success Regime was introduced to bring national support to areas with deep-rooted and persistent pressures, financial deficits and service shortfalls. The Mid and South Essex Success Regime was put in place because of long-standing issues relating to both the quality and sustainability of services.

3.2 Urgent and emergency care

3.2.1 The national picture

Demand for emergency and acute care is increasing; overall, there has been an increase in emergency admissions. In 2016 the number of emergency admissions to hospital via A&E was up 4.5% compared to 2015, with an average of 500 extra admissions each day (Baker, 2017). Of all attendances at A&E in England during 2015-16, ambulance/helicopter arrivals accounted for 4.6 million (22.5%) (NHS Digital, 2017). Of those arriving by ambulance or helicopter, 51.7% were admitted, whereas just 11% of those who arrived by any other method were admitted to hospital (NHS Digital, 2017).

The increased demand, coupled with rising financial and operational pressures, is placing enormous strain on A&E departments and hospital services. At present, such pressures are presenting a major challenge for the delivery of high quality care and patient experience. The key performance indicators (KPIs) for A&E focus on waiting times: average time to treatment, average time spent in A&E, and percentage of patients spending less than four hours in A&E (Baker, 2017). These form part of the NHS Constitution, which contains a list of expected rights and pledges for patients that NHS England should consider when planning and overseeing services.

The measure of 95% of all patients to be treated and then admitted, transferred or discharged within four hours of their arrival has not been met in the monthly data since July 2013 (QualityWatch, 2016). When an A&E is under pressure the department can become crowded. Crowding in A&E is known to cause...
many negative effects; it reduces the quality of care that patients receive, the length of stay for non-elective admissions rises, and the number of serious incidents rise (Morris et al., 2012).

Crowded A&E’s lead to adverse clinical outcomes, and patient dissatisfaction is increased as waiting times are prolonged and resources are stretched (Jayaprakash et al., 2009). Reducing emergency admissions to hospital is a major concern for the NHS, not only because of the costs associated, but also because of the disruption it can cause to planned elective care.

3.2.2. Mid and South Essex

Broomfield Hospital is an acute hospital part of the Mid Essex Hospital Services NHS Trust. Based in Chelmsford it provides services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree. Basildon University Hospital is part of the Basildon and Thurrock University Hospitals NHS Foundation Trust, which provides services for 405,000 people living in the south-west of Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. Southend University Hospital is part of Southend University Hospital NHS Foundation Trust. It serves a population of around 338,800 from the Southend-On-Sea, Castle Point and Rochford areas.

In 2015-16 these Trusts saw a total of around 319,500 attendances at A&E departments, an increase of 5.7% compared to 2014-15 (NHS Digital, 2017). The Trusts performed below the national average (91.9%) for the number of patients spending less than four hours in A&E with a combined average of 87.3%. The Trusts also see a higher than average number of patients admitted following an emergency, with 26.6% admitted compared to the national average of 20.4%.

3.3. Plans for transformation in Essex

The Mid and South Essex STP covers a wide geographical area (see map below, figure 2). Within the STP area for Mid and South Essex, the three hospital Trusts, Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, and Southend University Hospital NHS Foundation Trust, have agreed to work together to meet rising demands. The footprint also encompasses five different Clinical Commissioning Groups (CCGs), as well as provider organisations, such as community and mental health services, and the three local authority councils, responsible for the provision of social care in Mid and South Essex. These are Essex County Council, Southend-on-Sea Borough Council, and Thurrock Council. Other major service providers in the region include the East of England Ambulances Service NHS Trust, who are also part of the STP footprint.

Figure 2. The area covered by the Mid and South Essex Success Regime and STP. Reprinted from: http://www.successregimeessex.co.uk

Figure 1. CQC ratings for each of the hospitals A&E departments

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basildon Hospital</td>
<td>Good</td>
</tr>
<tr>
<td>Broomfield Hospital</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Southend Hospital</td>
<td>Good</td>
</tr>
</tbody>
</table>

Clinical Commissioning Groups are groups of GPs and clinicians who plan and buy health services on behalf of the public. They receive money from the government each year to meet the health needs of their local population. They agree contracts for services from provider organisations, such as hospitals, community and mental health services.
The Mid and South Essex Success Regime published a proposed plan in March 2016 to tackle the top priorities for system change that they hoped would: ‘ensure the highest quality health and care to meet the growing demands of the population of Mid and South Essex, tackle the gaps in clinical staffing across all health and social care and enable the system to achieve sustainable financial balance.’

They further proposed to the development of the plan with a focus on two main areas:

- Local health and care – to build up services in the community
- In hospital – to reconfigure and redesign hospital services across three sites

See [http://www.successregimeessex.co.uk](http://www.successregimeessex.co.uk) for further details.

One major priority of the STP is to accelerate plans for changes in urgent and emergency care, in line with the recommendations from The Urgent and Emergency Care Review (NHS England, 2013). Key elements of the review are the provision of better support for self-care, improved accessibility of the right information for those with urgent care needs, increased provision of highly responsive urgent care community services, and to ensure that those with serious life-threatening emergency care needs receive the best treatment to maximise recovery.

The current urgent and emergency care model in Essex means that all three of the hospitals offer A&E services, and for most conditions ambulances take patients to their closest hospital for treatment. STP leaders have proposed that one of the three hospitals act as a specialist emergency hospital, receiving the most serious and life-threatening emergencies, whilst the other hospitals offer more selective emergency care. Although the plans are still in discussion, it is likely that Basildon Hospital will be designated a specialist emergency centre, while Southend Hospital and Broomfield Hospital specialise in other services such as planned surgery, cancer care and burns. As a result, emergency blue light cases would be taken by ambulance directly to Basildon Hospital instead of their local hospital.

3.4. Issue to be addressed

NHS guidance for those responsible for developing STPs emphasises the importance of involving people, communities and stakeholders meaningfully throughout by collectively identifying problems and designing solutions (NHS England, 2016). Proposals to reorganise how care is delivered often faces public opposition, with concerns over future access (Farringdon-Douglas & Brooks, 2007). Therefore, involving people, communities and stakeholders is imperative in gaining support for STPs (NHS England, 2016). Eliciting the views, values, knowledge and experiences of the public can offer new perspectives on issues and be the source of important new information and ideas – resulting in policies and services that are better designed, more efficiently and effectively implemented, and have more public support (Andersson et al., 2013). HWE Insights Ltd was commissioned to carry out this research to engage with local citizens, to ascertain their views about changes to the provision of emergency care services, and to gather their experiences and use of A&E services.

Proposals to reorganise how care is delivered often faces public opposition, with concerns over future access.
Methodology

We utilised both qualitative and quantitative methods, using a two-phased approach to carry out a survey, and then a series of deliberative workshops.

4.1. Ethics

All health-related research is looked at by an independent group called the Research Ethics Committee who protect the safety, rights, wellbeing and dignity of research participants. This study was reviewed and given a favourable opinion by the NHS Research Ethics Committee (REC Coventry and Warwick 16/WM/0429) and the Health Research Authority. It also received approval from the local Research and Development offices for the three hospital Trusts. All participants provided their informed consent, and they were briefed about issues of confidentiality.

4.2. Phase 1: Survey

We conducted a survey to collect both quantitative and qualitative data, to help understand the reasons people visit an A&E department, actions taken before visiting A&E and whether they felt it is the best service for their treatment (Appendix A).

4.2.1. Recruitment

Potential participants were approached while in the waiting rooms of the three hospitals. If they expressed an interest in participating they were provided with an invitation letter. We did not recruit people who had been transferred by ambulance, although we did approach some of their relatives in the waiting room. Researchers took care not to approach anyone who seemed too unwell, distressed, or unable to participate, and no undue pressure was placed on anyone to take part.

To get a snapshot, the hospitals were visited by a researcher at periods covering every day of the week and at timeframes between 8am and 10pm. Capacity issues meant we did not visit the hospitals during the night. Consideration was given to the needs of patients and medical staff within the waiting room, by ensuring that surveys did not interfere with or delay a patient’s treatment. Surveys were not carried out with anyone under the age of eighteen, although accompanying adults were interviewed where this was possible.

4.3. Phase 2: Deliberative workshop sessions

Deliberation is a participatory approach that involves collective problem-solving discussion which facilitates and allows individuals from different backgrounds, persuasions, and values to listen, discuss, understand, potentially persuade, and finally come to informed and public-spirited decisions (Habermas, 1984; Fearon, 1998; Abelson et al., 2003). The decisions and the process through which these decisions are made are underpinned by a commitment to civil engagement, which promotes people’s involvement in the decision-making process for topics of interest. Group discussions are designed to give sufficient time and space to enable participants to gain new information and to discuss in depth the implications of their new knowledge in terms of their existing attitudes, values and experience. These discussions result in a considered view, which may (or may not) be different from participants’ original view, and which has been arrived at through careful exploration of the issues at hand (Involve and National Consumer Council, 2008).

We employed a deliberative approach to gain an in-depth understanding of people’s opinions on the proposals for reconfiguration, and how people feel they might affect patients, families and carers. This approach was deemed appropriate as it can inform, interact, and then assess public opinion (Rothwell et al., 2015). This process is assumed to generate more thoughtful data because public opinion is derived after education, interaction, and discussion of the topic (Cooke, 2000).

Workshop sessions were held in each of the Hospital Trust areas; Basildon, Chelmsford and Southend during April 2017.
4.3.1. Recruitment

Initially, we hoped to recruit the participants for the workshops from people who had taken part in the A&E survey. Because of low recruitment rates we later added a variety of other methods to recruit participants. Below we present the range of methods used to recruit a diverse range of people to take part:

- We invited survey participants to take part in the discussions
- We advertised the study in a variety of local papers
- We issued a press release to local media to help promote the study
- We used Healthwatch Essex’s social media channels (e.g. Facebook/Twitter) and newsletter, to inform people about the study and invite them to participate

We aimed to recruit 25 people for each workshop, with the belief that around 10 to 20 would attend. Participants were offered a £40 voucher in consideration of their time and to cover any expenses they may have incurred. Three group discussions were held in different locations in Essex during April 2017 with a total of 36 participants taking part; Basildon (5 participants), Chelmsford (18 participants) and Southend (13 participants).

4.3.2. Procedure

The research team introduced participants to the project, and informed them of our independent role to listen to their views and feed them back to commissioners. Participants were informed that the findings of the study will be considered as evidence to help inform the development of proposals for consultation regarding the urgent and emergency care reconfiguration. To provide background information, participants were then given an explanation of STPs and shown an animated video produced by the Mid and South Essex Success Regime. The video briefly explained the proposals for the reconfiguration of urgent and emergency services. This was followed by a presentation of the initial survey findings.

Participants were then split into groups and were presented with scenarios, which had been developed by clinicians involved in the STP process (see pages 09-12). These scenarios were designed to elicit responses and deliberation on the consequences of the proposals for patients and their families, and participants were asked to discuss important issues and considerations. Researchers used probing questions, to further complicate the scenarios and to get participants to consider a range of issues. At the end of the session, each group discussed the issues raised, and fed back their thoughts to the rest of the participants in a closing discussion.

An updated version can be found at: Developing health and care plans for the future https://www.youtube.com/watch?v=xSNn_nZ2Opl
Scenario 1

Harry, an 82 year old man, has a stroke

At home one morning, Harry appears to lose consciousness. He has problems with speaking and seems unable to move one side of his body. His wife dials 999 for an ambulance. The call team give advice on the phone while a rapid response vehicle (a car) and an ambulance are dispatched.

A rapid response car arrives after ten minutes (two minutes over the target response time) and the ambulance arrives two minutes later. Seeing signs of a stroke, the paramedic team explain to Harry’s wife that they are taking Harry to a specialist stroke centre, which is further away than the local hospital. Harry’s wife is very concerned. She cannot drive and has limited mobility. She is not able to follow the ambulance. She wonders why he can’t go to the local hospital. The team explain that the specialist stroke centre is the best place for Harry to get the care he needs.

The ambulance leaves the house and transports Harry to the stroke centre within 45 minutes. Staff in the rapid response car stay with Harry’s wife and try to help her decide what to do next.

Harry meanwhile is taken straight to the specialist stroke centre, bypassing A&E, and straight to diagnostic scans, quickly followed by the removal of a blood clot that was the cause of the stroke. Clinical evidence shows that Harry’s chances of survival and a good recovery are higher as a result of having access to a specialist stroke centre than they would be in the current model of having a stroke unit at a local general hospital. Soon after treatment, therapy begins to help Harry make the speediest recovery.

After three days, Harry leaves the specialist centre and goes by patient transport to a local care home that provides stroke rehabilitation.

Questions for discussion:

1. What do you think are the important issues here for Harry?
2. Consider implications for his wife.

Questions for workshop leaders to probe further if needed:

1. When Harry returns home, what support do you think he will need to stay well at home? Who could provide this support?
2. Harry and his wife have one son and he lives in Cornwall. They do not have any other friends and family close by.
3. What if his wife has dementia and Harry is her carer?
4. What if Harry has dementia and his wife is his carer?

When Harry returns home, what support do you think he will need to stay well at home? Who could provide this support?
Scenario 2
Michael, a 7 year old boy, has appendicitis

Michael complains of a stomach ache and his mother (a single parent) decides to keep him off school. The pain becomes severe and he is also vomiting. He is too ill to leave the house and his mother calls the local GP. The GP visits Michael at home that afternoon and decides to call an ambulance.

The GP explains to Michael's mother that Michael may need an urgent operation, as he could have appendicitis. The best place for Michael is the specialist paediatric surgical unit (Basildon) which is further away than the local hospital. The journey is around 40 minutes by ambulance, up to an hour by car and much longer and problematic by public transport. Michael's mother goes with her son in the ambulance.

Michael goes straight to the specialist children's surgical centre where he is diagnosed quickly and taken into theatre. His mother is supported by the specialist paediatric team and she stays at the centre until Michael comes back from surgery. She is offered a mattress for the night so she stays with her son until the next day. Finding that the team in the centre are able to give Michael good care and with plans in place for Michael to return home on the second day after his operation, she goes home with a friend to get clothes and prepare for his return.

Clinical issues relevant to this scenario:
Wherever possible, the aim is to avoid children having to go into hospital, as they can be better cared for and supported at home. However, in this scenario, where surgery is needed, the child has access to the best possible care and chances of a quick recovery if treated in a specialist children's surgical centre. The centre has a team of surgeons, anaesthetists and others who are specially trained in caring for children as well as being experts in their healthcare field.

Questions for discussion:
1. What possible issues does this case raise for Michael and his mother?
2. Can you think of anything else they might need to support them?
3. What do you think could be done about the issues raised?

Questions for workshop leaders to probe further if needed:
1. Michael and his mother are very close and he does not like her not being around as he had bad experiences when his father left them. Michael doesn’t want her to leave him the next day. Given that we know that children can find being in hospital a frightening experience, how might this concern of Michael’s be addressed?
Scenario 3
Charlotte, aged 18 months, has breathing problems

Charlotte has a cold, but it gets much worse in the night and she cannot get her breath. Feeling extremely alarmed, Charlotte’s parents drive their daughter to their local A&E which is only ten minutes away from where they live. They arrive at the front door at around 1am.

The A&E team stabilise Charlotte’s condition. She then moves to the children’s assessment unit so that a clinical team trained in caring for children can monitor her condition overnight. Charlotte’s mother stays with her daughter until she is settled and then waits in the hospital until morning. Her father goes home, planning to return in the morning.

Charlotte is much better the next morning and one of the children's consultants is able to send her home with an appointment to see a specialist nurse at the local GP surgery. There is a possibility that the incident is not just due to a viral infection, but could be associated with asthma and further investigation is needed.

Clinical issues relevant to this scenario:
Wherever possible, the aim is to avoid children having to go into hospital, as they can be better cared for and supported at home. The clinical model is to develop more paediatric and specialist expertise working closely with GPs and other community services.

Questions for discussion:
1. What type of support and assistance do you think that the child and the family members require in this scenario?
2. What improvements do you think might need to be made to the present GP and community services available?
3. An asthma attack can often be a frightening experience for infants and their parents; what reassurances might parents need?

Questions for workshop leaders to probe further if needed:
1. Other than the GP, what other community services are you aware of that Charlotte and her family could go to for support with asthma? What support do you think could help someone with asthma to stay well?
2. Possible questions around the group’s own experiences of asthma services - given that it is a common condition.
**Scenario 4**

**Sarah, aged 87, slips and falls at home**

Sarah’s son drops in to see his mother and finds her on the floor. She looks very poorly and is very confused. Worried that she may have broken something, Sarah’s son calls 999.

The paramedic team arrive and spend time checking and stabilising Sarah’s condition. After assessing the situation, the ambulance takes Sarah to her local hospital, where she is admitted to a frailty assessment unit.

Sarah’s son has a busy job to go to so he tells his mother he will see her later.

At the frailty assessment unit, there is a team of professionals, including a social worker, who are trained in caring for older people. They are able to establish that she has an ankle sprain, but nothing broken. However, Sarah is severely dehydrated and needs to stay in the unit overnight. At the same time, the team build up an understanding of Sarah’s situation. Living alone, she has a number of problems. The team works on a plan to support Sarah at home when she returns the following day.

**Clinical issues relevant to this scenario:**

Wherever possible, the aim is to avoid older people having to go into hospital, as they can gain independence if supported at home. In this case, Sarah has an urgent need for assessment and stabilisation and the frailty unit is able to do that and get Sarah back home as quickly as possible. An important part of this clinical pathway is the connection between the urgent care team, Sarah’s GP, and other services in the community, including social care, voluntary sector and other public services, such as benefits and housing.

**Questions for discussion:**

1. What type of support and assistance do you think that the patient would require in this scenario?
2. What support would the family members require?

**Questions for workshop leaders to probe further if needed:**

1. What support do you think older people need to stay well at home? Who could help with this support? (e.g. services, voluntary sector, family etc)
2. Although Sarah has been told she can go home, she is very anxious, feels unwell and is unsure about how she will manage once home.
3. Sarah has no food in the house and her son has an important business meeting in Europe and will not be able to visit for a few days - discuss this issue.
6.1. Phase 1: Survey

Summary of survey findings
To summarise, the key findings from this section include:

- The majority of people had attended A&E because of an injury they had sustained
- 21% had decided to go straight to A&E, without consulting a medical professional
- On average, 84% thought that A&E was the best service for their treatment
- Only a quarter of participants were aware of other places where they could have received advice or treatment for their health condition
- Of those that were aware of alternatives, most thought that A&E was easier to access, whilst many people commented that they needed diagnosis equipment and tests only available at A&E

A total of 306 people took part in the survey across Basildon (n=101), Broomfield (n=103) and Southend Hospitals (n=102). Since the survey was conducted in the waiting room and researchers did not want to delay access to treatment, not all participants had the opportunity to complete the full survey. Below we present a summary of the survey findings, further detailed analysis can be found in Appendix B.

About the patient
Over half (57%) of the people we spoke to were the patient themselves, others were accompanying a child, a family member or another adult. They had mostly attended A&E because they had sustained an injury. This reflects national findings of the most common category of first diagnosis for A&E patients being dislocation, joint injury, fracture, or amputation (Baker, 2017).

Actions before attending hospital
The majority of patients had visited their GP, or sought medical advice from at least one medical professional such as NHS 111, before attending A&E. However, analysis of all the surveys showed that 21% had decided to go straight to A&E, meaning they had not consulted another medical professional, or alternative service.

Best service
A high proportion of those surveyed (84%) thought that A&E was the best service for their treatment. Of those who gave further comments about their answers, those who did not feel that A&E was the best place to receive treatment would have preferred to have been able to see their GP, attend a minor injuries unit or walk-in-centre, or see an out-of-hours GP.

Respondents who felt confident that A&E was the best place to receive treatment did so because they felt they needed a scan or x-ray, had been referred by their GP or NHS 111, or saw it as a gateway to other healthcare services. Other explanations included being unable to see a GP, needing to see a specialist, and there being no alternative place to be treated.

Awareness of alternatives
Only a quarter (26%) of participants were aware of other places they could have received advice or treatment for their health condition. Those that were aware of an alternative service, were then asked why they had not accessed that service. The majority thought that A&E was easier to access, whilst many people commented that they needed diagnosis equipment and tests only available at A&E. Most people did not provide free text comments, however, those who did felt that they would have been referred to A&E anyway, had been advised to attend by a GP/NHS 111, were unable to see their GP, been told to attend A&E if their condition got worse, or had exhausted other options.
Overall, the survey findings suggest that most people had tried to, or had accessed, alternative sources of advice and treatment – with just one in five going straight to A&E. Participants provided reasons for choosing A&E, as they considered other services would not be suitable or they would not be able to access an alternative service. As a result, the majority felt that A&E was the best service for their needs. Whilst a quarter were aware of a suitable alternative, A&E was their preferred choice as it is easy to access, and has a better range of diagnostic equipment (e.g. tests and scans).

6.2. Phase 2: Deliberative workshop sessions

The themes to emerge from our analysis were issues which reflect the patient journey, as well as diminishing community care, both of these were underpinned by scepticism and distrust. We explore these themes below:

6.2.1. The patient journey

Throughout the workshops participants raised concerns that reflected the entire patient journey: from deciding to seek medical treatment, being transferred by ambulance, and the need for follow-up after discharge. Participants felt that many issues raised had not been fully considered by commissioners. They considered fast access to treatment essential in an emergency. Participants feared that they would be responsible for having to decide whether they would be best to drive to the local hospital or call for an ambulance and risk being taken further away for treatment. Participants felt there were consequences for the ambulance service, and that there was unpreparedness for the changes at the hospitals. Issues surrounding the effects on the family were also considered, with participants recognising that it is not only the patients who will be affected by the proposed changes.

Seeking the fastest medical treatment

Participants commented that they felt there was a trade-off between fast treatment and specialist treatment, whereby on occasions they would be the ones expected to make the decision about the most appropriate choice:

“I’ve got a daughter on the way in June, and there’s a list of conditions that I’m effectively going to have to have written down whereby it’s going to be better for me to get in the car and actually go and drive to Broomfield. To make sure they go to A&E quicker than calling an ambulance. I’ve got to make that decision. That is not a decision I’m qualified or should have to make. It’s an awful decision, and if I choose the wrong one, what do I do? It’s a really hard dilemma.” (Chelmsford participant).

Similarly, another participant commented that members of the public might not know the best way to seek treatment:

“I mean if we have something which you think is a stroke, or someone we know we think has a stroke, you would just drive them to the most local hospital wouldn’t you? And it might be a life-threatening condition. We’re not doctors.” (Chelmsford participant).

In the case study for Michael, a young boy with appendicitis, participants recognised that parents often panic when a child is ill and getting access to fast clinical care becomes their main priority:

“I think if it was my child that had appendicitis I wouldn’t be worried about going to a specialist children’s centre in Basildon. I’d be more worried about getting to hospital as soon as possible and just get it fixed. You know, it’s an emergency, you’re not worried about people - really good at looking after children, not worried about any of that. Just want to get him to hospital and get him fixed.” (Southend participant).

On the other hand, one participant argued that people might avoid seeking treatment, if they know they won’t be treated locally:

“People’ll know that you can’t go to Southend, what’s the point, sit indoors, die, deaths go up and so you’ve got a situation.” (Southend participant).
When considering factors to seeking treatment, participants regarded the need for fast treatment as one of the most important factors in deciding where to seek medical treatment. They regarded fast access to treatment, rather than specialist care, as the most important factor in an emergency.

The ambulance service

During the case study discussions, many of the participants raised concerns relating to the ambulance service, and the effect of the proposals. Participants feared that the longer journey times could mean that the ambulance service is placed under increased pressure. They raised concerns about whether ambulance crews would have to decide whether it was best to take a patient to the specialist hospital, or to their local A&E. And questioned whether the ambulance crew would have the resources and training to be able to diagnose and make this decision. Some felt that lifesaving treatment in the back of the ambulance could be compromised by increased journey times. They were worried that family members may not have the opportunity to be with a loved one, if they were to pass away on route to the hospital, or shortly after arriving.

Participants raised concerns about the impact the proposals on ambulances travelling further to get to patients, potentially causing delays to treatment:

“The priority calls have got an eight-minute response time. How’s an ambulance going to get from Basildon to respond to Leigh-on-Sea or Foulness in eight minutes?” (Southend participant).

There were also concerns about the roads, and the potential for further delays getting the patient to the hospital, because of road closures and traffic jams, which are frequently reported on major routes:

“The other day... it was gridlocked, literally. And I don’t care how good the ambulance driver is, he couldn’t have got through, because it was solid traffic.” (Southend participant).

However, participants were also concerned about the impact longer journey times would have on the ambulance service, causing additional pressure to a service already facing resourcing and staffing issues:

“I think, in terms of the East of England Ambulance Service we know how up against it they are as it is... [they] are struggling as it is to get adequate staffing levels. They’re going to have longer journey times and it’s going to put pressure on them. I can’t see how... You put two and two together and it doesn’t look like it’s going to be able to cope.” (Chelmsford participant).

As a result, participants sought reassurance that ambulances would still be located across Mid and South Essex as a way of reducing the effect of this:

“What is the plan, where the ambulances are going to be located? Are they all going to sit in Basildon and wait to get a call and then travel off or are there going to be ambulance stations around the county? How do you judge how many you need... in different areas?” (Southend participant).

A common concern was whether the ambulance crew would need to decide between the specialist emergency hospital and the local A&E for the best treatment, and the knowledge, resources and experience needed to make this decision. One participant reflected on how the proposals would have affected his uncle who sadly suffered a fatal asthma attack:

“I think the decisions that are going to be made, are what level of any provision is there going to be at Southend and Chelmsford and to give the example of Uncle with his asthma attack, if he lived in Chelmsford would he have been better being taken by the ambulance or paramedic crew to an A&E department? You see, that’s the thing that I think troubles a lot of people...” (Basildon participant).
Whereas some felt this decision may be taken away from the ambulance crew:

“What decisions are they allowed to make? Because if they say, ‘Well, you’ve got to take everybody to Basildon.’ They’ve got no decision to make, they just have to do it.” (Basildon participant).

In the case study of Sarah, participants raised additional concerns about the ambulance crew having to decide between taking her to the frailty unit at the local hospital and A&E at the specialist emergency hospital. They argued that the ambulance crew may not know the cause of the fall or have the full patient history to be able to make this decision:

“So, if there’s a frailty unit in every hospital, that’s really heavily dependent on the paramedics deciding that she doesn’t need A&E... elderly people, they can present with one thing, but actually you find a whole host of other things.” (Southend participant).

Furthermore, they doubted the training and experience of the ambulance crew to make these decisions:

“And that’s a lot of burden to put on a paramedic and I don’t see how when so many of the crews aren’t paramedic based, they’re tech based, you know, you get two techs, how can they be responsible for making those decisions for direct admission to the frailty unit. I think it’s a great idea as a unit to have for admission after A&E. But the point of A&E is to rule out life-threatening injury and that can’t be done.” (Southend participant).

In the case study of Harry, an elderly man who had had a stroke, many participants recognised the need for quick treatment of his condition. There were concerns whether the ambulance crew would be trained and have the resources to deliver this treatment:

“And the thing is with a stroke, it’s very important the patient is dealt with very, very quickly. It’s absolutely vital. And it depends what’s causing it... if you’ve got a bleed that needs clotting, you need a vitamin K injection and that can be done at general hospital and it wasn’t in the case that I was aware of. And, you know, it’s not black and white, it depends what causes a stroke. If the paramedics can’t work that out then…” (Chelmsford participant).

Similarly, participants were concerned that if a patient deteriorated on route to the specialist emergency centre, lifesaving treatment in the back of the ambulance would be compromised:

“You’ve got someone with a heart condition and they’re on the way to Basildon from wherever and they have another heart attack or something, trying to do CPR... while you’re travelling at 60, 70 miles an hour while on an ambulance... We’ve got a duty of care to the people in the ambulance as well.” (Basildon participant).

The wellbeing of paramedics was also mentioned in relation to them having to make moral decisions about not going to a local hospital, and having to travel further whilst treating a critically ill patient:

“They will end up losing their patients because of time travelled and that, in itself, is going to have a massive burden on the front-line staff’s mental health... that’s a massive burden to be putting on to those people having to make those decisions that they’re driving past a perfectly equipped hospital in a life-threatening situation...” (Chelmsford participant).

Further worries were around the family, and the emotional impact if the patient died whilst on their way to the hospital, or soon after arrival:

“So many people that have come to hospital and unfortunately pass away within a couple of minutes of being there, but luckily they’re local people. They’ve got local families. They can get there and they can be with them. Heaven forbid, your partner, your - you know, they end up in that hospital, you can’t get there, because you weren’t with them at the time and they pass away in an ambulance...” (Southend participant).

Participants felt that the proposed changes put significant pressure on the ambulance service and their staff. They raised concerns that the impact on staff and ambulance vehicles travelling further have not been thoroughly considered.
Family members
There were numerous issues raised relating to the impact on the whole family involved. As participants considered not only the needs of the patient, but also their loved ones. Hospital admission was recognised as a traumatic experience for vulnerable patients, and family were seen as key to reducing this. Yet workshop participants considered the impact the proposals would have on family members visiting a loved one; having to travel further, negotiate public transport, and the additional costs involved.

Participants commented that admission to hospital can be very traumatic, particularly for children and the elderly, and participants felt that it is important that the patients’ family are there to provide reassurance and support:

“I had a similar situation with my dad, where he was taken by ambulance after a heart attack from a care home, but he had Alzheimer’s and every hospital visit sent him on a nose dive, because he was so traumatised by it and we had to be with him.” (Chelmsford participant).

In the case studies for both Michael and Charlotte, participants emphasised the need for ill children to have their parents with them. There were particular concerns that if a child was taken ill at school, the parents would have to make their own way to the specialist emergency hospital:

“Say if he had gone into school, started vomiting, was really poorly, they would have called for an ambulance and it would have gone to Basildon. So you’ve then got to get Mum over there without the use of an ambulance. So she’s either going to have to pay for a taxi, which as a single parent, probably is going to be a real strain on finances. You know, if he’s that poorly, they’re going to need to take him to theatre without consent of Mum, which is a massive issue. How old is he? Seven?” (Southend participant).

On admission to hospital, participants saw the needs of the patient and their families as mutual, whereby the family can support the patient’s recovery. In the case study for Harry, participants commented that it is important for is wife to be there for him:

“He’s lived with his wife for 75 years and he’s suddenly not got his wife with him, he’s going to be disorientated, nervous, upset and anxious.” (Southend participant).

Similarly, participants recognised the role of families in supporting patient care needs whilst in hospital:

“If she can’t visit he’s going to have no one to bring him any like basic provisions like pyjamas and toiletries and things and a drink.” (Southend participant).

However, participants mentioned the detrimental impact proposals could have, especially if the patient was worrying about their family members and how they would get to the hospital to visit them:

“He’s going to have the impact on him of worrying about his wife and thinking, ‘How is my wife going to get to me? How’s my wife going to come to see me?’” (Chelmsford participant).

Participants also considered the additional burden for visiting which patients’ families would face. They discussed the difficulties getting to and from the hospital, trouble of travelling by public transport, and the additional cost of having to travel further.
The groups also considered the effect of other family circumstances, particularly in the case of Michael, where the scenario stated that his mum is a single parent. Participants felt that it is not only the patient who is effected by the proposed changes, but the whole family:

“We’re looking specifically at is a specialist hospital the best place? Well, yes, of course it is. Absolutely. Only a fool would argue that point. But it’s not just about that, it’s about everything else that’s involved. And everybody is an individual. Every family is an individual. They all have individual circumstances.” (Basildon participant).

Participants felt there was a lack of clarity and uncertainty around the proposals, and were worried about what that means for the patients’ family members. They considered that the patient is getting the care they need, but the proposals put additional pressure and burden onto family members.

**Level of preparedness**

Participants reported a lack of preparedness at the hospitals, with uncertainty around what provision would be available at the other hospitals, implications for staff, and a lack of an integrated IT system.

At all three of the workshops, participants had serious concerns about what emergency provision would be available at the other two local hospitals. Participants felt it was important that all three of the hospitals could still provide emergency care, so they could stabilise a patient’s condition if the ambulance crew thought it was critical, or if the patient attended their local hospital:

“Life-saving stuff must be there, because time is always going to be more critical than quality, well, quality comes into it, but the time element is absolutely vital…” (Southend participant).

Participants weren’t convinced that treatment after arriving at the specialist emergency hospital would be quicker than at a local hospital, in relation to Harry’s scenario, one participant said:

“What we’ve not heard is the scenario in terms of time once he gets in there. If it’s a busy night... I know you said the specialist’s there, but that diagnostic treatment, how much quicker is it?” (Chelmsford participant).

Participants in Southend had specific concerns about risk factors in the area, and what would happen in the event of a major incident occurring:

“There’s also a lot of risk areas in Southend. We’ve got the sea front, we’ve got the airport, major incidents could happen and people have got to be transferred a longer way. The other thing, with a major incident, if a hospital’s on lock-down in the A&E because there is a major incident, and the blue lights and emergency teams are not at the other two hospitals, what’s going to happen to the regular patients?” (Southend participant).

They offered a solution, suggesting that once seriously ill patients had received treatment and been stabilised locally, it would then be more acceptable for them to be transferred for specialist care:

“Take them into an A&E, stabilise them, sort out what’s wrong, ring Basildon and say, ‘I’m sending you this guy over; he’s got this, this, this and this. Be with you in an hour.’” (Southend participant).

However, they argued that without being regularly exposed to emergency cases, staff would de-skill, and therefore not be prepared to deal with emergency situations:

“My concern is say the ambulance attended and he was really sick, or like peri-arrest... if they decided that they couldn’t safely make the journey to Basildon and that they were going to say Southend, at that point was pretty much just a walk-in centre. The staff there, having not been exposed to sick children, as frequently as they were before, have they deskillled? And have they now got the right skills and the expertise in looking after those children and those patients?” (Southend participant).

Similarly, it was commented:

“And if, you know, you’ve got all of your surgeons, all of your eggs, as you say, in one basket, at the specialist centre, he needs an operation right now at Southend, where’s your surgeon? Where’s your team? Are they all over at Basildon? Or is there going to be a provision, say if he was absolutely on death’s door, that you could save his life there and then?” (Southend participant).
Participants further considered the effects of having the specialists cover A&E, and whether this would have a knock-on effect on the other two hospitals and outpatient services:

“So how can you have 24 hour, 365 day cover of specialists in A&E, your orthopaedic surgeons, your paediatric surgeons, your general surgeons, gynae, obstetrics how can you have all of those specialists there and expect to provide specialist care in the out-patient’s - in the other local hospitals for out-patient services?” (Southend participant).

Similarly, participants had concerns about how the proposals for an elective centre of excellence would affect patient choice around where they go for treatment:

“How are they going to factor that in then, if they’re planning on having specific elective sites, but still give patient choice, those two don’t work together.” (Chelmsford participant).

At all the workshops participants raised issues with the current IT systems NHS services use, complaining that these are not linked between the hospitals, or with community services. One participant told of a recent experience whereby blood test results were not available as they had been done at a different hospital:

“My husband had a blood test at Southend [Hospital] and the GP’s got access to it, but because we’ve had it done at Basildon [Hospital] they haven’t got access to it.” (Basildon participant).

Participants were worried that patient records are not shared between services, and felt that this could lead to treatment delays:

“If you go to Chelmsford and you need a blood transfusion, you’re going to have to do all your bloods repeated, because they don’t have the access. So you might have had them done two hours before at Southend and then they’ve transferred you over, ‘Oh, yes, it doesn’t matter, because they’re going to have to do it all again anyway.’” (Southend participant).

Similarly, regarding the case study for Sarah, participants argued that it was unlikely she would receive a timely social care assessment, resulting in a delayed discharge:

“In reality, she wouldn’t go home the next day, because social care wouldn’t be in place to take her and assess her at home. There would be a home assessment if she’d fallen and they’d deemed she was frail, and that’s where half the problems evolve, because then they bed-block.” (Chelmsford participant).

Participants felt there were other implications for the patients discharge from hospital, for example, in the case of Harry participants were unclear as to who would be responsible for organising and funding his discharge arrangements:

“Yes... Harry’s been put in Basildon and he’s not from Basildon, he’s never been to Basildon, suddenly people who have worked for Basildon to be a better place are now having their facilities being utilised by someone. But there’s no money, the council don’t have the money or any of the input from Harry to pay for it.” (Chelmsford participant).

The participants felt that the hospitals were not prepared for the changes, and had fears about losing the current level of emergency care at their local hospital. They raised concerns about staffing and not having enough specialists to cover outpatients, and how patient choice would be affected. Participants raised serious issues about IT systems not being linked, meaning the hospital may not have access to patient records. There were also consequences for hospital discharge, as it is unclear about who will organise this.

Overall, participants felt that the consequences of the proposals were present along the entire patient journey. They considered that in some cases faster treatment is more important than specialist treatment. Some feared that longer journey time would lead to delays in treatment. It was felt important to recognise individual family circumstances, as families are crucial in supporting a patient’s recovery. Some argued that there would be implications for patient discharge, as it would be unclear who would be responsible for funding and organising this. There were also strong feelings that all three hospitals need to remain able to provide a good level of emergency care.
6.2.2. Diminishing community care

Through discussion around the case studies the participants were asked to consider what kind of community services are needed to prevent hospital admissions and facilitate a patient’s recovery. It was clear that participants were aware of a range of services, but felt that there was a gap in community services to support the proposals for a specialist emergency hospital. Participants felt that the rest of the health and social care system is unprepared for the proposed A&E reforms. This was compounded by poor out-of-hours access, cuts to community services and pressure on the social care system. Some agreed that whilst it is best to avoid A&E, there is a lack of alternative services, particularly at evenings and weekends.

Participants felt it was important that if we have specialist hospitals, community services could support these by providing alternative sources of care:

“If they’re going to do the specialist hospitals they have to have something in place in the community to support the specialists.” (Chelmsford participant).

However, participants raised concerns that community services had been cut, and under the proposals there will be a reliance on an under-resourced social care system:

“Yes. And it’s all well and good them saying, “Put the care back into the community.” And, yes, a lot of that does rely heavily on the GPs and the district nurses and stuff, but so much more of it is on the social side and the social care provision and there’s just not the budget there.” (Southend participant).

Participants argued that current out-of-hours service provision is poor, particularly at weekends, meaning that A&E is sometimes their only option:

“There’s this massive gap, especially in the evenings but as well from a Friday at 6:00pm until Monday morning at 8:30, or whatever it is, where there’s this huge gaping hole where you’ve got a child, or anybody in your family who falls ill, and you think, ‘Is it 999? No, it’s not. Is it A&E? No, I don’t think it is. Can a pharmacist deal with it?’ because we’ve all seen the signs up at A&E and in the doctor’s surgeries telling us what we’re meant to do, ‘No, a pharmacist is not going to cut it.’” (Chelmsford participant).

Participants in Chelmsford argued that the walk-in centre had previously filled the gap in service provision, before it was closed by commissioners:

“I would have thought that a town the size of Chelmsford, for an example, it would be even better to have a walk-in centre, like the one that used to be at the Sainsbury’s...” (Chelmsford participant).

Additionally, participants raised concerns about not knowing which service was the best one to use, and felt if they were aware of services and expectations then pressures on A&E would be reduced:

“Just taking this back, what everyone’s saying is if there was a set strategy or a set resource, if the communities knew exactly who was responsible for what, A&E would not really be as pushed as hard as it is and we would be able to use the facilities better because we’d be more aware of the expected process.” (Chelmsford participant).
Some participants mentioned that it is best to avoid hospital admission, and they preferred to be treated within the community:

“I wouldn’t choose to sit at A&E for nine hours, I’d much rather have been in my doctors if my doctors was open, or somewhere local to where I lived. That’s what my choice would’ve been. On both occasions I’d gone to A&E I’d much rather have had access to something in the community because they could’ve managed it... it could’ve been managed better, sooner and quicker (Laughter) in the community.” (Chelmsford participant).

Whilst some participants argued that more funding should go into social care:

“I think quite honestly, I’d like to see social care bolstered first and see what response that has on A&E.” (Chelmsford participant).

Participants felt that GPs had a role in supporting patients after discharge from hospital. This was particularly mentioned in the case of Charlotte, a young girl with asthma. They felt it was important after being diagnosed with a long-term condition, such as asthma, that people are given information about their condition, supported with self-care techniques, and are made aware of condition specific services (e.g. asthma clinics) as this will reduce their need for urgent and emergency services. In the case of Charlotte, one participant commented that her parents would need educating about her condition and how to manage it well:

“[Her parents] could go home with some [information] and then be put in touch with perhaps someone else.” (Basildon participant).

Similarly, other participants felt they should be given more advice for how to look after themselves following discharge from hospital:

“No, there’s not enough focused self-help is there. So when you leave hospital you need to do this, this and this and if this doesn’t work come and see me...” (Basildon participant).

In the case study for Sarah, an elderly lady who had suffered a fall, participants identified the need to maintain her independence whilst living at home. It was mentioned that she would need an assessment to prevent further falls, and mobility aids and adaptations that can support her. One participants suggested that elderly people should receive regular home visits from their doctor, to check on their health and wellbeing:

“I think, getting back to the initial thing, all these things in place prevents people, and especially the elderly, going into A&E, if they are checked on, and just looked over. Luckily mum’s got a lot of family round her who visit and all the rest of it, but people don’t. You know, and a lot of them are, I’m afraid, are outliving their family. So for doctors to have these things in place, to go and check on them, I think it’s very good.” (Chelmsford participant).

Furthermore, in all three of the workshops participants discussed the need for a personal alarm, allowing an elderly person to call for help if they have a fall. Participants recognised that sometimes an elderly person may not want to wear one, or may be afraid to use it at certain times:

“My mum, she had one, she had a fall and it was in the middle of the night and we said, ‘Why didn’t you use it?’ She said, ‘I didn’t like to wake anybody up.’” (Basildon participant).

Participants regarded the proposals as something being taken away from them, and were unconvinced that there would be alternative sources of care available within the community. This was complicated by feelings of mistrust and beliefs that the changes are designed to cut costs. These opinions are discussed further in the next section.
6.2.3. Scepticism and distrust

The findings from our deliberative workshops revealed there is considerable scepticism and distrust among citizens about the plans under construction for the transformation of services. They were unconvinced by the clinical arguments being put forward for central specialisation and wanted to see the evidence for themselves. Concern was raised by all groups about the validity of the case being made for the centralisation of some urgent and emergency services at specialist centres. Some questioned whether this was always the best option for patients and wanted to see a broad range of evidence before being convinced. Others said they would like to see more detailed risk assessments carried out, particularly for ambulance journey times during road closures and when traffic jams occur as these are commonly reported on major routes. There were also suggestions that once plans have been implemented, evaluations based on case studies of the patient journey from ambulance call through to admission and discharge should be conducted. A few people were even more distrustful and felt that academic research and other evidence was often contradictory and would be used in a convenient way to suit the proposed plans.

Across the workshops participants expressed a lack of trust in the commissioners, the proposals, and the evidence underlying them. Many of the workshop participants were sceptical about the proposals, with some suggesting that commissioners have not yet fully developed them:

“You’d really want to feel confident that there was depth and detail to the STPs that just doesn’t seem to be there at the moment.” (Chelmsford participant).

There was some confusion around the implications of the proposals, and uncertainty about which services would remain available at the local hospitals. This was complicated by misinformation being shared within the communities, causing concern about what the changes might be and the future of the local hospitals:

“Broomfield’s not closing? That’s what everyone’s saying here.” (Chelmsford participant).

One reason participants were sceptical was that they did not believe that the commissioners had considered issues of relevance to them when developing the proposals:

“The only reason I say that is that we keep being told about this Centre of Excellence and the thoracic unit at Basildon and we do need to sort of say, ‘Well, there are other issues.’” (Basildon participant).

Similarly, another participant commented:

“Well I think it seems to be a ‘them and us’ situation. They’re sitting over there saying, ‘We’ve got these plans, we’ll talk down to you because you don’t know what you’re doing.’” (Southend participant).

During all three of the workshops participants expressed concerns about the evidence that commissioners have used to inform the proposals. Many participants simply did not believe the claims put forward by commissioners:

“At the presentation I was at... They’d got some figures showing that nobody was more than 45 minutes from any one of the hospitals. They’d got their information from Google Maps on an average. I mean it needs somebody to get into a [ambulance] and off to Basildon [Hospital] and see how long it actually takes, especially in the evening.” (Southend participant).
Similarly, another participant argued against the benefits compared to the additional journey times:

“They said that having centres of excellence would bring patient benefits and that I wouldn’t be compromised by small increases in journey time, but I don’t think that’s what you’re looking at here, if you’re looking at going from Braintree to Basildon, frankly, in the rush hour, I think you’re looking at probably doubling or tripling the journey time.” (Chelmsford participant).

Workshop participants strongly believed that the evidence base should be made public, as they felt otherwise they were being expected to take the statements made by the commissioners at face value, without being given the opportunity to scrutinise the evidence themselves:

“In order to have a valid argument you need to be able to have your information available, because they’re just saying one thing and we’re expected to believe that one thing based on what they said.” (Southend participant).

Another participant noted that research findings can be contradicted:

“You know what it’s like with research. One piece of research will come out and then within two years you will have six pieces taking it apart, and saying it’s wrong. That’s the way it works with academic research.” (Chelmsford participant).

Through seeing the evidence base participants felt they would be able to make their own judgement about the argument for centralisation. Participants would be less sceptical if they knew the proposals were based on reliable, accurate and robust evidence:

“We can’t take that as a given unless we can see something – because I think that does change the whole complex - complexity of the whole thing. If that is true, then these other things are secondary aren’t they to some extent?” (Chelmsford participant).

A few participants discussed the importance of the evidence being recognised and endorsed by experts in the field, giving the public added confidence that they can trust its rigour. There were concerns that experts within the field had failed to come to a consensus about the best options for transforming A&E services, and participants felt this meant the was no clear preferred option:

“As far as I can tell, there is no clear consensus on this. There are people with different opinions.” (Basildon participant).

This was compounded by the view held by many that the STPs aim principally at cutting costs, rather than improving patient care. In fact, some disputed that patient care would be improved at all:

“This is purely a money saving exercise and patient care is a by-product, it’s not important.” (Southend participant).

By suggesting that the commissioners are driven by hidden motives, participants further insinuated that the system is untrustworthy. There were strong political views that the STPs are the start of NHS privatisation. Participants were worried that the proposals are a conspiracy to create additional problems in the health service, generating the need for private investment:

“They want to screw it up so they can push it over to the private sector. This is what it’s all about.” (Chelmsford participant).

With many of the participants questioning the motivations of the commissioners for the proposals, they felt that they did not have any choice in the changes. One participant commented on his belief that the plans were a foregone conclusion and he seemed more convinced of this after having watched the film produced by the Success Regime during the workshop discussion:

“…they’ll make these few central things and they’ll gradually downgrade, downgrade, and then you’ll be lucky if it’s a GP unit. I think this is a very slippery slope, especially as it’s already been decided that they are going to work together, that was on that film. So that’s a foregone conclusion, that we are going amalgamated whether we like it or not, and I think that takes away the choice... You won’t be able to make the decisions.” (Chelmsford participant).
There were additional concerns that none of the proposed options included keeping the current configuration of services, and participants feared losing access to good services:

“Not one of these five plans they’re going to propose is to keep things as they are. Sometimes it’s [the biggest] thing to swallow, but actually saying, ‘Do you know what? There are some really good services there right now.’ There is some really good stuff. If you tinker with things and you change consistently… They’re talking about making £110m of admin savings and hiding a lot of things within the detail… I’m afraid I’m just not convinced.”

(Chelmsford participant).

In this regard, some participants mentioned the need for an evaluation of the changes once they are in place to make sure they are beneficial to patient care:

“There’s going to be modifications going forward, at what point are they going to have a schedule of whether they’re going to know how effective those changes are? When we make a change or access something we have to go back and we have to say whether your assumptions or your hypothesis was correct.”

(Chelmsford participant).

However, one participant raised concerns about whether we can truly know whether the changes negatively affect patient outcomes, as the proposals will affect the most critically ill patients:

“How can you prove it was the journey and not the person who was going to die anyway? Because you can’t prove anything, they get away with it.”

(Southend participant).

In addition, some participants commented that they would like to see better accountability within the NHS, and felt that because it is split up into lots of services, no one took responsibility. One participant recognised the positive opportunity that STPs and the Success Regime provide, towards developing a holistic approach to meeting the health and care needs of the whole population, rather than users of individual services or organisations:

“The Health and Social Care Act of 2012 also emphasised competition, which meant that foundation trusts look after what they choose to look after and there is no one responsible for healthcare as a whole. So if the Success Regime restores the responsibility for looking after the whole population, that will be a bonus.”

(Basildon participant).

A lack of trust and scepticism unpinned discussions throughout the deliberative workshop sessions. This was driven by a lack of information and clarity, beliefs that proposals are driven by saving costs, and suspicion of increased privatisation. Subsequently, participants were unconvinced that patient outcomes and patient experience are at the centre of the proposals, and do not want the changes to be implemented.
In this study participants articulated their concerns about many of the issues also highlighted by experts who have studied the STPs planning processes across England (The King’s Fund, 2016; Boyle, Lister, & Steer, 2017). While many participants recognised that the health care system needs to be reformed, they also articulated a deep resentment for downgrading local A&E services.

Our findings show that people are concerned about the preparedness of our local health system to implement such reforms while ensuring that high quality care is delivered across the county. Noticeably, almost all participants were unclear about the content of the proposed reforms, with many reporting that the changes would result in being unable to access their local A&E facilities. Considering that the discussions around the STP plans started over a year ago, participants’ misconceptions about the proposed reforms indicate that the STP leaders have failed to engage meaningfully with the citizens of Essex. Communication, on behalf of the STP team, about the aim, scope and reason of the STP, and particularly about centralising A&E services, has resulted in confusion, distrust and discontent, not only surrounding the proposed reforms, but also directed at the people in charge of planning and implementing them. Below we summarize and discuss the main reasons for participants’ dissatisfaction.

Community care

There was a consensus that the reforms should have started with the improvement of community care services, rather than A&E services. The diminishing provision of health and social care services in the community had led many people to seek professional help and support from A&E services. Our survey findings show that whilst a large number had sought medical advice from at least one medical professional, 21% had decided to go straight to A&E. Nevertheless, 84% agreed that A&E was the best service for their treatment. Those that did not agree would have preferred to have been able to see their GP, attend a minor injuries unit, a walk-in centre or out-of-hours GP. In addition, many workshop participants were critical of the continuous devaluation of community care, such as difficulties registering with a GP, in accessing GP appointments, and closure of emergency walk-in centres. Such services were seen as important in supporting self-care, the maintenance of good health, and in receiving care for injuries and medical conditions that did not necessarily require visiting hospital A&E services. By empowering people with the confidence and information to look after themselves when they can, and visit the GP when they need to, people gain greater control of their own health and encourages healthy behaviours that help prevent ill health in the long-term (Self Care Forum, 2017).

We suggest that STP leaders prioritise community care services so they can work more effectively and efficiently, and more crucially in doing so re-examine the systemic factors that have affected the quality and level of care that these deliver.

Consequences for the patient journey

Despite their dissatisfaction with the way that the STP leaders had decided to proceed with the overall focus of the STPs, participants engaged in debate, deliberated on the case scenarios, and other material provided, and raised a number of important issues regarding the proposed reforms. Participants discussed the consequences for changes to services throughout the patient journey from first alerting, or not, emergency services, through to patient discharge and what might occur if a patient died in the specialist hospital located much further than the local hospital. These consequences were centred on the difficulties with travelling to the specialist hospital, the capacity and expertise of paramedics to reach patients within the timelines set out in national guidelines, the administrative organisation of discharge planning and care following discharge, as well as community support. Noticeably many participants commented that the proposed A&E reform will result in patients and families having to give more consideration about whether they would call an ambulance or drive to the local hospital given that the ambulance may not necessarily take the patient to the nearest hospital. A few participants reported that they would be inclined to drive to the local hospital rather than wait for an ambulance to transfer them to the specialist centre. It goes without saying that such actions could increase the risk of harm for many patients.
Social consequences of reform outcomes

Our participants highlighted a number of social consequences of the proposed plans that would impact on them and their families. Overall, they were distressed at what they saw as the loss of health services, particularly community services and were further distressed at the prospect of additional losses. They were concerned that patients would feel isolated and alone because friends and relatives may find it difficult to visit their relatives in a non-local hospital. For example, in cases where a single mother may be prevented from being with her young child because she does not own a car, there are no public transport links and she does not have the money to pay for a taxi. They considered further consequences for family carers and the patient if a frail elderly person is taken to a hospital at the other end of the county. Carers and family members play vital roles in a patient’s health, wellbeing and recovery (Corrigan et al., 2016) and many spoke of their experience as important advocates and care givers for relatives in hospital. These discussions, and the notion that being present with a family member would become much more difficult, appeared to cause distress to participants.

Children and the elderly are particularly vulnerable groups of patients, and the extent to which the proposals may impact on them and other vulnerable groups needs to be considered. Such concerns have also been raised in relation to STP plans across the country, specifically the failure to take account of the impact of the expanded geographical area covered by proposed plans. Also that health inequalities will be exasperated if the difficult issues of access to services and transport problems related to service relocation are ignored (Boyle et al., 2017). There are parts of mid and south Essex where health inequalities are particularly marked (Joint Strategic Needs Assessment, 2017), and we suggest that STP leaders work closely with local authorities (Essex County Council, Southend-on-Sea Borough Council and Thurrock Council) to identify and address the impact of proposed reforms on local populations.

Our findings suggest that STP leaders need to consider very carefully how the proposed reforms are going to affect patients, families, healthcare staff and organisations delivering care in mid and south Essex. Although the reforms aim to improve the health and care outcomes of the local population and ensure the financial sustainability of the local health care economy, our study shows that the reforms will have far reaching implications frequently not measured by health, care and financial indicators. In addition to the practical factors (e.g. transport, capacity of the road network to enable ambulances to reach patients living in distant locations from the specialist hospitals), our local STP leaders need to take account of the important social aspects of healthcare and reform and in listening to people’s concerns, find ways to resolve these issues and provide reassurance to the citizens of Essex.

Effects on ambulance and other key staff

It should also be underlined that many participants were not only concerned about patients and families but also about the wellbeing of healthcare professionals such as doctors, nurses, and paramedics. For example, participants were of the opinion that the ambulance service was being asked to stretch even further while it is already stretched to full capacity to provide ambulatory care. Participants were not convinced that the current capacity levels of the ambulance service can manage and sustain the demand of providing ambulatory care across mid and south Essex. National sources show that owing to increased workload and diminishing resources, ambulance crews experience high levels of stress and burn out, which often have negative effects on service delivery and on the wellbeing of the professional (Green, 2017). They were concerned too about the capacity of GPs and did not know how the current shortage of GPs across Essex would be addressed.
While we recognise that STP leaders are well aware of the problems they face due to national workforce shortages, and have stated that they will need to develop new ways of working which will involve local health and care and community health staff taking on new roles (Mid and South Essex Success Regime, 2016), we expect local STP leaders to provide further clarification on their plans about how the ambulance and other services will cope with the increasing demand that will result from the proposed reforms.

**Scepticism and mistrust of evidence base for reforms**

Many participants were not convinced that the reforms proposed would improve the health of the local population and the care they receive. These participants wanted to see the hard evidence that the proposed plans had worked in other locations and whether these locations had similar characteristics to the county of Essex. For example, they were not convinced by the argument that the centralisation of stroke services would be better for all patients and wanted to see the evidence for themselves. Indeed, in the absence of such data some participants had carried out their own research of medical and scientific data online. Their concern about the evidence base for reform became very clear when participants watched the video produced by the Mid and South Essex STP/Success Regime commissioners. They did not believe the narrative of the short video and considered it to be a public relations exercise. Given that the video problematized the rising number of people who attend A&E services in the area and presented a picture whereby people would need to be accessing ‘new’ community services rather than attend A&E facilities, participants were particularly sceptical. Again, participants complained that any evidence for the specialist centralisation of urgent and emergency care services had not been made available for public scrutiny, and that there had been no consideration given to traffic and timing at various times of the day, and so on. They wanted to see various risk analysis tests carried out as soon as possible and for the results to be made publicly available. Such concerns also echo research findings of the STP processes in England which reveal that the majority of the STPs ‘offer no proper needs analysis above a few selected statistics, and fail to show that their proposals take account of the size, state of health and locations of the population’ (Boyle et al., 2017).

Participants were highly sceptical too about the case scenarios that were presented for discussion during the workshops. These concerns were mainly centred on the positive patient outcomes portrayed (i.e. patient X, while possible slightly inconvenienced by having to travel further to receive specialist treatment, he/she received better treatment as a result and was subsequently making a good recovery). Participants thought that the way the scenarios had been structured neglected the myriad of factors that currently affect timely access to A&E services. They added complex factors and unintended outcomes to flesh out what they considered to be overly simplistic cases presented, and in doing so, they brought to the surface safety issues and challenged the claim that what was being proposed was the best outcome for patients. They highlighted social factors, in particular the importance of family members to be present as advocates and carer givers and they argued that in some these factors should take priority over clinical outcomes.

**STP leaders should publish and make available any relevant evidence to support their proposals and commission further risks analysis test to reassure the public that proposed plans are evidence based. More transparency, openness and clarity of information about the current process and plans for reconfiguration are required. Such information should reflect the complexity of issues and factors involved.**
Public trust and citizen engagement

The scepticism and lack of trust participants revealed has consequences for the acceptability of the reforms and worryingly, this can undermine public trust in healthcare services. While personal trust between patient and clinician is understood to play a crucial role in patient outcomes (Birkhäuser et al., 2017), studies show that trust relations are also influenced by wider factors, and in particular by changes in the organisation and delivery of healthcare (Rowe and Cailan, 2006). One of the consequences for the lack of patient trust in the plans that we have identified is that it could lead to a lack of trust in healthcare services overall and could lead to people delaying seeking treatment or bypassing systems to access care they need. Trust has been shown to be a critical factor influencing a variety of therapeutic processes including patient acceptance of therapeutic recommendations, adherence to recommendations, satisfaction with recommendations, satisfaction with medical care, and symptom improvement (Brennan et al., 2013). It is important therefore that trust is not eroded as a result of the STP and Success Regime reconfiguration of services.

Evidence shows that shared decision-making between patients and those providing their care is one way in which trust can be engendered. This involves listening to patients, their families and the wider public. It is widely understood that gaining public trust in issues such as reform to healthcare is best achieved by engaging citizens in a meaningful way (Oxman et al., 2009). This study shows the importance of engaging the local population in the process of deliberation about urgent and emergency care reconfiguration. However, the challenges involved in incorporating patient experience data into service improvement should not be underestimated as there is considerable evidence showing that patient experience data are often considered less important than clinical data and are rarely used to improve services (Sheard et al., 2017). The challenge will therefore be for the social and other non-clinical issues to be given the priority they deserve. It has been suggested that some healthcare professionals consider obtaining good patient experience to be ‘nice but not necessary’ (Sheard et al., 2017; NHS Confederation, 2010). Furthermore, lay citizens are often assumed to suffer from a lack of scientific and technical expertise, and consequently a deficit model of citizen involvement tends to dominate (Wynne, 2006) whereby citizens are imagined as lacking the ‘correct’ knowledge or information to inform policy. However, this deficit model that often underpins many communication strategies between experts/policy makers and lay people has been challenged and superseded by a model whereby citizens’ experiential or ‘lay’ knowledge and expertise based on personal experiences is foregrounded (Wynne, 2005). New models of citizen communication recognise that citizens are often experts in the management of their own health conditions and possess important local knowledge about their families and communities that clinical experts do not. New forms of user and community engagement define this as ‘co-production’ whereby the provision of services are co-designed through regular, long-term relationships between professionalized service providers and service users or other members of the community, where all parties make substantial resource contributions (Bovaird, 2007).

Deliberation is not only important because it is the right thing to do from a democratic perspective, but by drawing on citizens’ own experiences and knowledge of local services and their community, the consequences of service reconfiguration can be more clearly envisaged. It is important therefore for commissioners to listen to and respond to the concerns raised in this report. Given that the STP plans are ‘clinical led’, it is important to recognise that patient experience, safety and clinical effectiveness are inextricably linked (Doyle, Lennox, and Bell, 2013). It is important for STP leaders to understand too that if the practice of better self-care is to take hold in the way it is hoped for and imagined in the overall plans for STPs, it is imperative to recognise citizens as active agents of care for themselves and their families and not as passive recipients of care. It is more than 15 years since Sir Liam Donaldson, the then Chief Medical Officer for the Department of Health, argued:

...the era of the patient as the passive recipient of care is changing and being replaced by a new emphasis on the relationship between the NHS and the people whom it serves – one in which health professionals and patients are genuine partners seeking together the best solutions to each patient’s problem, one in which patients are empowered ... and work in partnership with their health and social care providers, ... given greater control over their lives (our emphasis, Department of Health, 2001).
Transforming the NHS should not be a panacea; technological innovations have radicalised treatment modalities which have increased life expectancy and improved the quality of life for many patients. Similarly, health care delivery innovations need and should be incorporated within our local service delivery to ensure that all patients have equal chances of receiving high quality care. The STPs are indeed an opportunity to transform the way we talk about health and practice care. They offer a ground to open up discussions about what care should look like amidst the rapidly changing demographics of our locality, the decreasing availability of health care workforce, and the advancement of technological innovations.

However, we need to recognise and understand that our STP leaders have been asked to make radical changes in their local health economies within very restricted timelines. Improving the efficiency and effectiveness of A&E services (and a range of other services) requires time and a lot of effort by clinicians and managers to explore their options, understand and evaluate the outcomes of the reforms. Meaningful engagement with patients and the public should be at the centre of every effort for reform, and not a tick box exercise. Our local STP plans involve five Clinical Commissioning Groups and three hospitals, all having different priorities for the populations they serve. Identifying common goals and developing shared visions of care as well as working closely with local authorities is important but requires time, which these organisations do not have. They have been asked to make radical changes swiftly, with the aim to reduce costs and save money; therefore, the emphasis is placed upon sustainability rather than transformation. As The King’s Fund notes, the ‘NHS now faces huge financial and operational pressures and while the changes outlined in STPs could help address these pressures... but there is a risk that work to sustain services will crowd out efforts to transform care (The King’s Fund, 2016). Furthermore, STP plans generally are further hampered by poor communication and public engagement and in a more recent report by the Institute for Public Policy Research (Quilter-Pinner, 2017) they conclude that the public is either unaware of the reform plans or is misinformed about them, leading to opposition.

Our recommendations centre on issues pertaining to communication plans and public engagement activities. We know that many of the underlying issues raised by study participants are being addressed, however, the public need to be aware of these. Where we have raised concerns that have not been identified or are not being addressed as part of the plans, we recommend that STP leaders do so.

The recommendations presented below should not be considered definitive or comprehensive, but they are a start. Therefore, Healthwatch Essex welcomes comments, constructive feedback and suggestions relating to them.
9 Recommendations

Recommendations on Public Engagement and Communication Activities:

1. Ensure that present and future public engagement activities follow a ‘co-production’ model of engagement that facilitates the public’s input to plans and reforms in a genuine and meaningful way.
   a. Doing so will help to build patient and public trust in the plans and will encourage patients to adopt an active role in their own and family’s health and wellbeing.

2. Set up a communication strategy that clearly explains the overall aim of the STP and why now is the right time to do it.

3. Provide proof/evidence of clinical effectiveness and patient safety to justify plans to centralise A&E facilities.
   a. This should include risk analyses of journeys to centralised services and the consideration of more complex case scenarios such as for patients near end-of-life.
   b. Such information should be easy to comprehend and accessible and at the same time the more complex original scientific papers should be made available for those citizens wishing to see the evidence in more detail.

4. Communicate plans for addressing workforce shortages including paramedics, ambulance staff, GPs and nurses.

5. Explain explicitly how the social issues raised in this report concerning patients and their families will be considered and incorporated into the plans.
   a. This should include reference to the key role played by family care givers as advocates and carers of patients, particularly in cases where children and vulnerable adults are involved.

6. Specify how steps will be taken to ensure that existing social health inequalities in the region will not be exacerbated by the reconfiguration of services.
   a. We suggest that STP leaders collaborate with representatives of local disability and minority groups, and local authorities (including Health and Wellbeing Boards and Joint Strategic Needs Assessment teams) on such issues if this is not already being done.

7. Provide information and time frames about how community services will be reconfigured.
   a. For example, explain how primary care will be reconfigured and what community services will be bolstered.

8. Provide information about the level of support available to public services that offer an alternative to A&E in the region.
   a. Information should make it clear to the public where it is best for them to attend in order to receive the most appropriate care for their condition.

9. Provide assurances that independent evaluations following patient journeys will be conducted and made publicly available once reforms to services are implemented.
   a. We are happy to offer advice on the design and implementation of realist evaluation studies to capture the impact of reconfiguration of services on patient experience.
References


Appendices

Appendix A – The Survey

Location:
Date and time:

**Urgent and emergency care in mid and south Essex: survey**

The aim of the study is to understand why people visit the Accident and Emergency (A&E) department. The survey is anonymous and will take about 5 minutes to complete. It is entirely voluntary to take part. The personal information you will share will not be passed onto any third party.

1. Who is the patient today?
   - [ ] Myself
   - [ ] Adult related to me
   - [ ] Another adult
   - [ ] Child

2. Which age group does the patient belong to?
   - [ ] 0-9
   - [ ] 10-19
   - [ ] 20-29
   - [ ] 30-39
   - [ ] 40-49
   - [ ] 50-64
   - [ ] 65 and over

3. What is the reason for you attending A&E today?
   - [ ] Complication from elective procedure
   - [ ] Heart problems (e.g. chest pain)
   - [ ] Injury (e.g. fracture, sprain, head injury)
   - [ ] Long term condition (e.g. diabetes, chronic obstructive pulmonary disease)
   - [ ] Mental health condition
   - [ ] Respiratory problems (e.g. difficulties breathing, short of breath)
   - [ ] Stomach problems (e.g. diarrhoea)
   - [ ] Virus or infection (e.g. flu, chest infection)
   - [ ] Other (please state) __________________________
   - [ ] Prefer not to say

4. What did you/the patient do before attending the A&E department? (tick all that apply)
   - [ ] Asked someone else for advice
   - [ ] Phoned NHS 111
   - [ ] Phoned GP for appointment/advice
   - [ ] Saw an out-of-hours GP
   - [ ] Spoke to an outpatient consultant
   - [ ] Visited GP
   - [ ] Visited pharmacist
   - [ ] Visited Walk in centre/Minor Injuries Unit
   - [ ] Waited to see if it got better
   - [ ] Went on NHS choices
   - [ ] Nothing, came straight here
   - [ ] Other (please state) __________________________

5. What were your main reasons for coming to A&E today? (tick all that apply)
   - [ ] Advised to attend by NHS 111
   - [ ] Advised to attend by GP / other health professional

Survey, v1, 20 September 2016
☐ Attended before
☐ Nowhere else known to be open
☐ Nearest/most convenient place
☐ Urgent injury/condition
☐ Unable to get a GP appointment
☐ Wanted to be seen quickly
☐ Other, please state: ___________________

6. Do you think that A&E is the best service for the treatment of your medical condition?
   ☐ Yes
   ☐ No
   
   Additional comments: ________________________

7. Are you aware of any other places where you could have received advice or treatment for your health matter today?
   ☐ Yes
   ☐ No

8. If yes, could you tell us why you did not access that service?
   ☐ Do not know how to access other services
   ☐ Difficulty accessing other service (no available appointments/closed at this time)
   ☐ No alternative service in my area
   ☐ It is easier to access A&E
   
   Additional comments: ________________________

Thank you for your participation. We anticipate the results of the survey will be available on our website www.healthwatchessex.org.uk from January 2017.

We would like to invite you to share your views or experiences in more detail

We would like to talk with individuals in more detail to find out how urgent and emergency services are delivered in Essex. If you would be willing, we will be holding group discussions in community locations within Basildon, Southend and Chelmsford. Each participant will receive a £40 voucher in appreciation of your time participating.

If you wish to participate, please let the researcher know so they can give you an information sheet with more details. A member of the research team will contact you within the next few weeks. We will randomly select participants so you may or may not be contacted.

Survey, v1, 20 September 2016
Appendix B – Survey findings

1. About the patient
Of the 306 people surveyed, the majority (57%) were the patient themselves, while 22% were accompanying a child, 16% were with an adult related to them, and 5% were accompanying another adult.

Across the hospitals, the most common age groups for those surveyed was 65 and over (22%), followed by 20-29 (18%) and 50-64 (16%). Just over a quarter (26%) of patients were under 19 years old. There were fewer patients at the older end of the age spectrum, with 22% of the sample being aged 65 or over.

2. Reason for attending
Participants were asked about the condition that had caused them to visit A&E, some participants ticked multiple options with 328 answers for the question. The majority of patients attended the A&E because they had sustained an injury, whilst a high proportion chose the ‘other’ option. Several of the ‘other’ options included people with eye injuries, problems during pregnancy, and others with tooth infections, cuts and kidney issues.

3. Actions before attending A&E
There was a difference in the actions patients took before going to A&E between the three hospitals. The majority of patients in Basildon Hospital reported phoning 111 (n=27), or visiting their GP (n=24). Most patients in Broomfield Hospital reported seeing their GP (n=28), or going straight to A&E (n=23), whereas in Southend Hospital most patients phoned 111 (n=20) or either phoned or visited their GP (n=19, n=19).
Overall the majority of patients had visited their GP before attending A&E, whilst a large number had sought medical advice from at least one medical professional. However, 21% decided to go straight to A&E.

When asked for their main reason for attending A&E that day, most people reported: being advised to attend by a GP or other health professional; that they felt their condition or injury was urgent; or that they had been advised to attend NHS 111.

Some people added free text comments such as needing an x-ray or tests which are only available at an A&E department, whilst in Basildon many people felt it was easier to access A&E.

5. Awareness of other services

Just over a quarter (26%) of all participants were aware of other places where they could have received advice or treatment for their health condition. This was slightly higher in Basildon Hospital, with 35% aware of alternative services.

Those that were aware of an alternative service were then asked why they had chosen to not access that service. Thirty-two percent of the overall sample answered this question (n=99).

Many people gave other reasons such as needing an x-ray or tests which are only available at an A&E department, whilst in Basildon many people felt it was easier to access A&E.

Figure 6. Are you aware of any other places where you could have received advice or treatment for your health matter today?

Figure 7. If yes, could you tell us why you did not access that service?