

Mid and South Essex Sustainability and Transformation Partnership

A programme to sustain services and improve care

Pre-consultation Business Case

Appendix 7 – Communications & Engagement

Views from local people

Part 1 – Engagement in proposals for service change



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Annexe 1 - Links to further information

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For further information and background

To find out more about health and care plans for mid and south Essex, please visit our website www.successregimeessex.co.uk

The website provides a downloadable summary of the mid and South Essex Sustainability and Transformation Partnership (STP) plan called ***10 things you should know about your local health and care plan.***

If you would like to give your views about plans for the future of health and care, or you would like to get involved or join the Success Regime Service Users Advisory Group, please email us at england.essexsuccessregime@nhs.net or write to:

Mid and South Essex Success Regime, Swift House, Hedgerows Business Park, Colchester Road, Chelmsford, CM2 5PF

1. The purpose of this report and what's inside

This report summarises the outcomes of four phases of engagement and how local people have influenced proposals for potential hospital reconfiguration as part of the mid and South Essex Sustainability and Transformation Partnership (STP) plan.

Main aims

The report's primary purpose is to inform a pre-consultation business case with the views of service users and representatives. There are two main aims:

- To highlight themes from a service user and public perspective that contribute to framing the proposals for hospital reconfiguration
- To identify key issues and implications for service users that should be considered as part of the pre-consultation business case and risk management plans

Broader value

The feedback in this report will help to inform the ongoing development of the mid and South Essex STP plan and provide service user insights to influence service design in future implementation.

The report should be widely available to patient reference groups, watchdog bodies, scrutiny committees, Health and Wellbeing Boards, planning groups involved in service redesign, partner organisations and regulators.

Links to other engagement

This report does not include information and outcomes of clinical engagement. This work is within the scope of the five clinical commissioning groups in mid and south Essex and the group of three hospital trusts. A summary of clinical engagement is included in the pre-consultation business case.

A separate report on equality impact will explore the issues and implications of service change for protected groups and vulnerable people. A summary of this will also be included in the pre-consultation business case.

2. Short background on the Mid and South Essex Sustainability and Transformation Partnership (STP)

We started as the mid and South Essex Success Regime

In 2015, NHS England designated Essex to be one of three “success regimes” in England. The other two success regimes were in Cumbria and Devon. These areas were designated success regimes to support system-wide change where there are deep-rooted systemic problems and persistent deficits in workforce, finance and service quality.

Autumn 2015 diagnostic phase

The Success Regime started in October 2015 with an intensive review to assess the challenge and scope for action. The programme itself was set up in January 2016 to draw together health and care organisations covering mid and south Essex. This included five clinical commissioning groups (CCGs), three local authorities, three hospital trusts, four community and mental health service providers, the East of England Ambulance Service and 183 GP practices and a network of public service organisations.

March 2016 outline plan

On 1 March 2016, the Success Regime published an outline plan and commissioned several working groups to develop proposals for developing *local health and care* and services *in hospital*. Other areas of health and care, such as mental health and learning disabilities services were to continue with their established change programmes.

Ref: Press release 1 March 2016

June-November 2016 – STP planning

By June 2016, 44 sustainability and transformation partnerships (STPs) were set up across England. It was agreed that ours would be the mid and South Essex STP to develop from the Success Regime. In November 2016, we published a five-year ambition and emerging options for hospital redesign in the draft mid and South Essex STP plan. The public summary, *10 things you should know about your local health and care plan*, explained the strategic vision and potential service changes to achieve it.

Ref: Press release 23 November 2016

February and March 2017 options appraisal

Drawing together the findings of its working groups, the Success Regime (now the STP) arranged a process to appraise options for a reconfiguration of services across the three hospitals in Basildon, Chelmsford and Southend. The options appraisal ran through several stages during February and March 2017 and included a service user panel as one of four appraisal panels.

All four appraisal panels identified one of five options for potential hospital reconfiguration as the stronger option, which had the maximum separation and consolidation of emergency

care services and suggested Basildon as the better site to provide a designated specialist emergency hospital.

Even though the options appraisal process clearly identified one preferred option for the potential hospital reconfiguration, there was a strong view that this theoretical approach should be sense checked to address local concerns, practical issues and implications.

Further discussions with hospital staff, CCGs and local communities led to a change in thinking that was announced on 20 July 2017.

The outcome from a HealthWatch Essex research project is included in this report. Although this project reported its findings after the July announcements, it provides a deeper dive into the perceptions and concerns of our local public and patients.

Ref: Press release 25 January 2017

Ref: Stakeholder update 13 March 2017

Ref: Press release 20 July 2017

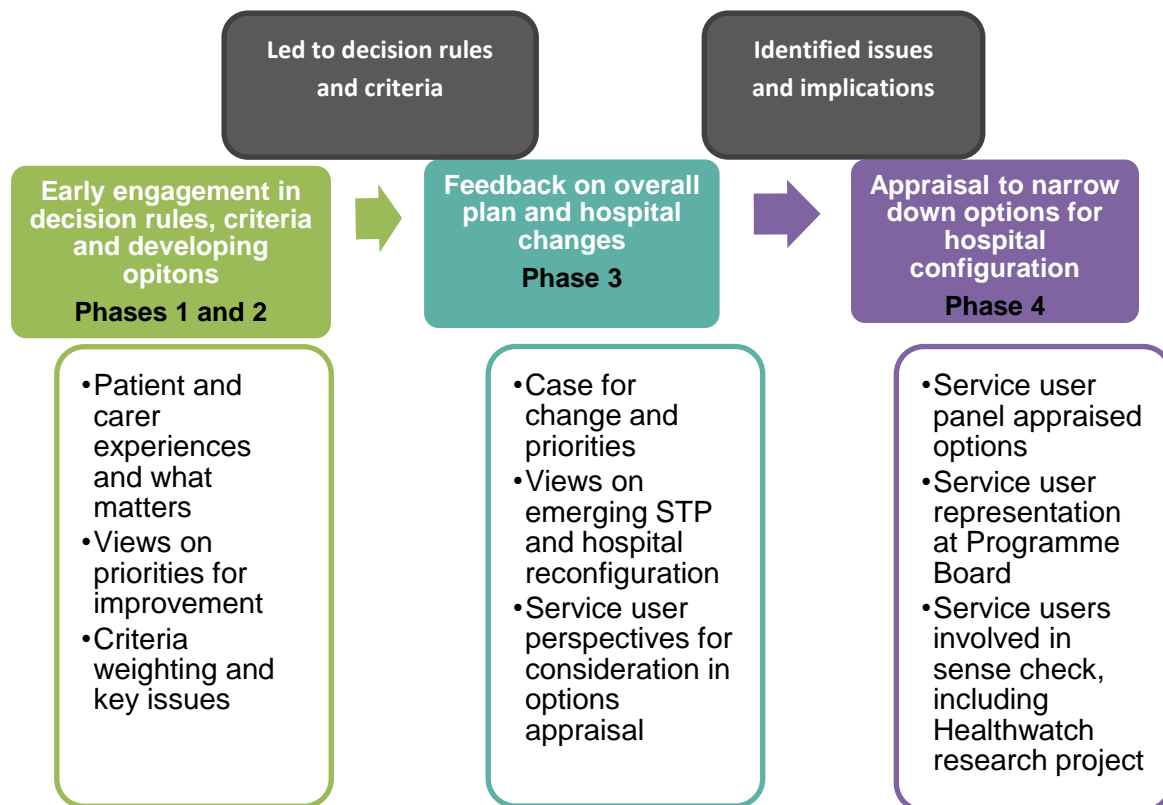
3. How people were involved in framing options for change

The Mid and South Essex STP ran the following four phases of engagement from March 2016 to July 2017:

- Phase 1 (March-May 2016) – Early engagement in decision rules and criteria
- Phase 2 (June-August 2016) – Involvement in developing options
- Phase 3 (September 2016-January 2017) – Engagement in STP and hospital service change
- Phase 4 (February-July 2017) – Engagement in options appraisal and subsequent modification of the preferred model for access to hospital services

See Annexe 1 – for links to further information and details of engagement activities, focus groups and workshops

Phases of public and patient engagement



The work to date lays the foundations for an annual cycle of engagement to support planning and delivery over the next four years and beyond.

4. Phase 1 – Early engagement in decision rules and criteria (March-May 2016)

Summary

Phase 1 covered the period between publishing an outline plan for system change on 1 March and the launch of clinical working groups. During this period, we published information about emerging plans, engaged with partner organisations and representative bodies and agreed plans for wider engagement later in the year, including coproduced local engagement plans with the three HealthWatch organisations covering Essex, Southend and Thurrock.

Within a range of public discussions, a structured engagement exercise called *In Your Shoes* brought together lead clinicians and patients and carers who had experienced hospital emergency care.

Learning from patient stories, a significant outcome was a set of decision rules for service redesign and early thinking around criteria to identify preferred options.

Action

Discussions with partner organisations

A board paper for public discussion and feedback went to all NHS partners. Given the broad nature of the initial plan, there were few specific issues raised at this time.

The five clinical commissioning groups (CCGs) in mid and south Essex continued to plan health and care in their local communities, influenced by local engagement and consultation over the previous two years.

The main mental health service providers in Essex, NEP and SEPT, made clear their aspirations for joined up services. The two trusts requested that the Success Regime endorse the Essex mental health review, which has separately involved service users. The review has since informed the Essex Mental Health Strategy which has been incorporated within the mid and South Essex STP as part of the vision to drive up standards and improve care for local people.

Health and Wellbeing Boards

The three Health and Wellbeing Boards for Essex, Southend and Thurrock, provided an effective public forum for early discussions, given their multi-agency membership and meetings in public with papers and minutes publicly available from local authority websites. Early input to the initial Success Regime plan came from councillors, social care leaders, CCGs and trusts at a joint session with all three health and wellbeing boards on 10 February 2016.

The Success Regime has continued to publish regular updates via the public meetings of the Health and Wellbeing Boards.

HealthWatch and Scrutiny

On 18 April, the three HOSCs collaborated with the three HealthWatch bodies and held a conference for patient and public representatives to discuss both the Success Regime plans and methods of engagement. The conference produced a report and recommendations which were incorporated into the Success Regime Communications and Engagement Plan and led specifically to the following actions in later phases:

- Public participants in engagement workshops were asked whether they agree there is a case for change, and what their priorities for change would be
- Service users were involved at the beginning of the service redesign work with an “In your shoes” exercise involving clinicians and service users together
- We worked with HealthWatch to extend our reach to patients and public through videos, podcasts and a range of survey approaches.
- We established a Service Users Advisory Group

Ref: “Ensuring Citizen Engagement is incorporated in the Essex Success Regime”
www.healthwatchessex.org.uk/wp-content/uploads/2016/02/HOSC-Success-Regime-Report.pdf

All three HealthWatch bodies for Essex, Southend and Thurrock routinely attended the System Leadership Group (SLG), where they were able to stay up to date with developments and could influence plans, particularly in terms of patient and public engagement. Initially, HealthWatch Essex acted as lead representative for all three HealthWatch organisations, but HealthWatch Thurrock became actively involved in supporting the engagement work from May onwards.

In addition to the SLG, HealthWatch officers maintained ongoing relationships with the Success Regime through personal contact with the communications lead, programme director, senior responsible officers and the independent clinical chair. They participated in planning through various stakeholder workshops and working group sessions. HealthWatch Essex is a member of the SR Communications and Engagement Group, representing all three HealthWatch bodies. All three HealthWatch organisations are active members of the Service Users Advisory Group. HealthWatch Essex is the lead HealthWatch representative on the SR Programme Board.

In addition to the specific engagement activities of the Success Regime, all three HealthWatch organisations have contributed insights to service change through work that they undertook in 2015 and 2016.

Structured engagement exercise – *In Your Shoes*

The acute hospital part of the Success Regime plans set up clinical working groups to develop potential options for reconfiguration. As recommended by local authority health overview and scrutiny committees and HealthWatch, clinicians leading the plans for reconfiguration and redesign of the three hospitals listened to patients before mobilising the clinical working groups. 20 lead clinicians and 18 patients and carers worked together in a structured engagement exercise to develop the criteria for redesigning services.

The exercise concentrated on emergency care and drew participants from people with direct experience of hospital emergency care. At the time, this was the main priority for service redesign. They began by learning from service users' experiences good and bad. The exercise went on to identify what matters most to patient and carers and this led to views on criteria for developing emergency services and decision-making rules for service redesign.

Outcomes

Summary of the views of the Health and Wellbeing Boards by the end May 2016

Essex Health and Wellbeing Board	Noted potentially profound changes and the need for all stakeholders to be involved. Made a commitment to ensure that all three HWBs would be fully engaged, including joint work on financial projections for both health and social care. There was a view that there should be greater emphasis on prevention and mental health. These areas were strengthened in the June and October STP drafts.
Southend-on-Sea Health and Wellbeing Board	Noted the emerging STP. There was a view that there should be greater emphasis on prevention and development in primary care. These areas were strengthened in the June and October STP drafts.
Thurrock Health and Wellbeing Board	Noted proposed service changes and next steps. Keen to know more about managing access to services. This was developed later in the preparation for options appraisal.

Summary of the views of the scrutiny committees by the end May 2016

Essex County Council Health Overview and Scrutiny Committee	The HOSC views itself as a supportive but "not an uncritical partner". Noted plans and would like to see and influence plans for consultation. The Success Regime has continued to update the HOSC and take views on board.
Southend-on-Sea People Scrutiny Committee	Noted the emerging plans. Comments from the Chair were supportive of the overall direction of travel. The Success Regime has continued to update the HOSC and take views on board.
Thurrock Health and Wellbeing Overview and Scrutiny Committee (9 June 2016)	Noted proposed service changes and next steps. Concerned about potential risks associated with big changes and agreed to consider further reports in November. The Success Regime has continued to update the HOSC and take views on board.

Outcomes of *In Your Shoes* exercise

Ref: In Your Shoes Feedback report May 2016

The "ideal" emergency and urgent care service and what patients value

Listening to patients' stories and their views on what people want from emergency care services, the following were identified as the top three themes:

- Communication (strong emphasis on "listening")

- Prevent A&E admissions (strong emphasis on access to GPs)
- Speed of access (included reference to same day investigations)

Communication

This theme covered a number of issues including, for example; clear patient information about how best to use health and care services, information at the point of service to make access easier and ensure a good patient experience, good personal communications between clinicians and patients and effective communications between staff and services to ensure a smooth patient pathway. Poor communication is frequently perceived to be the main cause of poor quality care and patient experience.

Prevention

This theme included recognition that patients and public should understand more and take responsibility for their own health and care to avoid illness and emergencies. Participants suggested the need for more information and support, but were also keen to see the development of urgent care services out of hospital e.g. rapid response teams to avoid hospital admission. There was a strong perception that one of the reasons why people turn to A&E is because they feel they cannot get immediate access to GP services.

Speed of access

Service users appreciated the speedy response of ambulance and speed of access to other services, such as the medical assessment unit and specialist services. Some people were very happy that they had had all investigations in the same place on one day.

“Long waits” was the top theme in the list of what patients and carers do not want from their emergency services.

Other common themes

Strengths to build on:

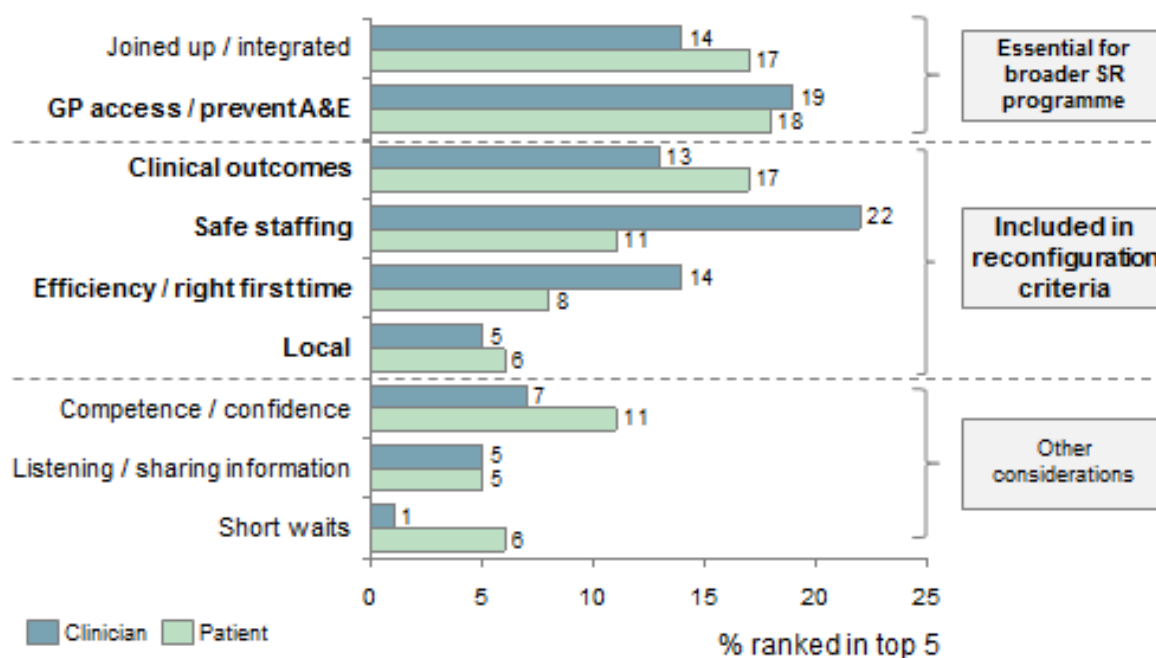
- Competent staff – *“I felt confident in the people who treated me, they knew their job”*
- Quality of care and treatment
- Joined up services – *“Pre-hospital care was good and I was smoothly transferred from one hospital to another”*
- Patient and carers involvement and choice – *“They gave me the option for self-directed medication”*
- Support for carers and families – *“My brother felt supported by the palliative team caring for me”*

Priorities for improvement:

- Not being listened to and repeated questions
- Lack of communication (between teams and organisations)
- Lack of confidence in staff – *“Staff were too busy to do a complete assessment. I was worried things were missed.”*
- Families and carers not involved
- Lack of humanity – *“Some staff had an abrupt tone. They were not polite or friendly”*

- Disjointed care and poor discharge – “*Delays in discharge due to waiting for pharmacy. Happens every time.*”

Comparison of priorities between service users and clinicians



How feedback influenced the development of options for service change

Taking in the feedback from *In your shoes* alongside clinical views, working groups agreed a set of decision rules to develop potential options for hospital reconfiguration and redesign. Those for redesign are listed below, highlighting the ones that were influenced specifically by patient and carer insights.

1. Design along pathways. Any service that can be delivered more efficiently and effectively out of hospital should move.
2. All changes should be implemented with measures that allow their impact to be assessed objectively.
3. Apply common standards at all sites. Measure to ensure the same processes and outcomes.
4. All designs and pathways should focus on creating simplicity for patients and referring doctors.
5. All staff should be working to the top of their skill set. Don't use a doctor where an allied health professional can do it.
6. Don't make staff and patients travel when there's a technological solution e.g. telemedicine, remote monitoring, community access to specialist advice.
7. Prioritise. Initially focus redesign on bigger services and those with many interdependencies.

The early feedback from patients and carers also led to a short list of agreed themes for criteria to be used in the later options appraisal process. By July 2016, the criteria themes were as follows:

Considerations / criteria	Key issues
Clinical outcomes and patient safety	<ul style="list-style-type: none"> • National guidelines for improving survival rates • Move towards national and international best practice
Sustainable clinical workforce	<ul style="list-style-type: none"> • National recommendations for clinical staffing levels • Improvements in training and development
Efficiency and productivity	<ul style="list-style-type: none"> • Cost reduction • Ability to treat more patients per year
Access to services	<ul style="list-style-type: none"> • Appropriate access to services for patients • Access for carers and families • Access for staff

5. Phase 2 – Involvement in developing options (June-August 2016)

Summary

The acute hospital working groups and CCGs continued to plan service changes with local partners with the aim of completing a draft STP and pre-consultation business case by the autumn.

During July and August, the Success Regime ran a programme of focus groups with service users and workshops with hospital and CCG staff. These exercises identified issues for consideration, gained views on decision-making and helped to determine the weighting of each criterion for options appraisal.

There was a consistent pattern of views among service users and staff that has informed the weighting of criteria used in the appraisal of options for hospital reconfiguration. Common themes and notable issues from feedback influenced the draft STP and in particular the style and content of the STP public summary.

Action

In July and August 2016, we ran six service user focus groups and eight open workshops for hospital and CCG staff.

Objectives

- To highlight important issues at an early stage (to help frame options for service change)
- To gain staff and service user insight on the wider context (to inform the STP)
- To gain staff and service user insight to inform the weighting of criteria for options appraisal
- To test messages and content (to inform the STP public summary and other communications)

The sessions

The sessions were designed to be interactive and deliberative as follows:

- Participants were asked at the start of the session to answer the question, “*What is the first thing that comes to mind when you think about your health and care in the future?*”
- Following a presentation by lead clinicians on the key points of the STP, participants were asked for feedback prompted by, “*What strikes you, sounds promising, and gives you concerns?*”
- Following discussions with the whole group, participants then worked in smaller groups to provide feedback on, “*What do you want decision-makers to consider – what matters?*”

- Participants were asked to score a set of decision-making criteria and to add to the list any other criteria that they felt should be applied in an options appraisal process

Who took part?

The service user focus groups were organised in partnership with CCGs and Councils for Voluntary Services (CVSs) who drew together service users from a range of backgrounds and age groups, including representatives of protected groups, such as older people, young people, people with disabilities and mental health service users.

Location	No.	Mix of people and overall reactions
Chelmsford	14	HealthWatch members, hospital service users, hospital patient council, CCG patient reference group members - middle to older ages Strong support towards the case for change
Canvey Island	10	CVS network of volunteers, CCG patient reps – middle to older ages Positive towards case for change, with concerns about access to services
South Woodham Ferrers	20	Practice participation group reps, community group reps – middle to older ages Overall accepting of direction, concerned about GP access
Southend	15	CVS network of volunteers, practice participation groups, Southend Youth Council – mix of ages Strong concerns about access. Ideas and positive views from younger participants
Grays	Over 20	CVS and HealthWatch network, service user groups Overall accepting of direction, concerned about primary and community services
Rayleigh	Over 15	Practice participation groups, community groups – mix of ages Mainly positive towards strategic direction with concerns about access
Location	No.	Mix of staff and overall reactions
Broomfield Hospital (2 sessions)	Over 80	Mixed nurses, consultants, technicians, administrative staff (not many bands 2, 3) Balance of positive ideas and strong concerns about emergency care
Basildon Hospital (2 sessions)	Over 70	Mixed nurses, consultants, technicians, administrative staff (not many bands 2, 3) Overall positive ideas about collaboration between services
Orsett Hospital	26	Nurses, clinical support, administrative staff Concerns about HR issues, positive ideas about collaboration between services
Southend Hospital (2 sessions)	Over 115	Mixed nurses, consultants, technicians, administrative staff (not many bands 2, 3) Mix of positive ideas and strong concerns about emergency care
Castle Point and Rochford CCG	10	Commissioners, finance, administrative staff Balance of positive ideas about joined up services and concerns access to emergency care

Outcomes

A baseline snapshot of views about future health and care

The following common themes were described by service users and staff before getting into discussions about emerging plans for service change:

Service users

- Concerns about the future of the NHS and whether it will continue to be a free service
- Hoping for support to remain well, independent and “able to control my own health and care”
- More should be available in the community – more staff and resources, better access to GPs
- Aspirations for joined up services
- Quick access to care
- Support for carers
- Concerns about mental health and dementia

Staff

- Concerns about the future of the NHS – should continue to provide free and safe care
- Where to go for care in the future – seems uncertain
- More should be available in the community – concerned about pressures on GPs and social care
- Quick access to care

Summary of views on criteria for appraising options

Considerations / criteria	Key issues
Clinical outcomes and patient safety	Consistent quality and the need for standardisation Clear information for patients Service users emphasise the importance of a good patient experience to aid recovery Staff emphasise safety and clinical assurance in a potentially complex set of patient pathways e.g. clarity around managing multiple medical problems
Sustainable clinical workforce	Strong concerns about recruitment and retention and the impact of change Incentives e.g. working environment, employment terms Equal opportunities e.g. pay, training and development – joined up and shared development Support for staff through change Pressure on work / life balance
Efficiency and productivity	Improve care for people at home and avoid emergencies Data sharing and IT Joined up services in the community Potential costs of transport Consider “did not attends” due to access difficulties Adopt and spread innovation Deal with prescribing costs and medicines waste

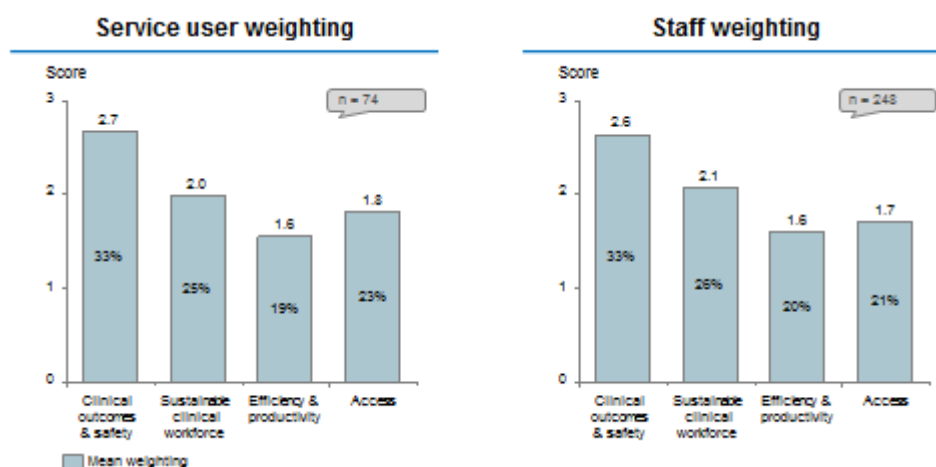
	Raise taxes
Access to services	<p>Transport to appointments in the community as well as hospital</p> <p>Road infrastructure, parking and public transport – consider shuttle between sites and times of appointments</p> <p>Ambulance and hospital transport</p> <p>Support for carers at centres of excellence e.g. overnight accommodation</p> <p>Patient information on where to go – e.g. to make better use of urgent care services</p> <p>Older and vulnerable people need more person-to-person time, face greater challenges in travelling to services</p>

Views on weighting of criteria

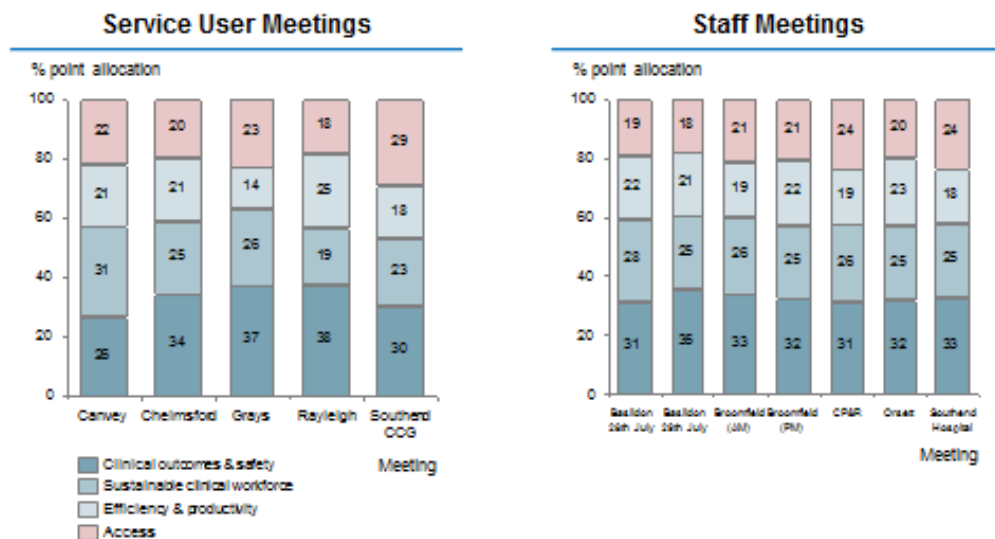
A key objective for the service user focus groups and staff workshops was to weight the criteria for the options appraisal process. This was the final task in the sessions after people had had detailed considerations of the plans for service change and potential implications.

Interestingly, the pattern of views on weighting the criteria was broadly the same for service users and staff, showing some agreement that clinical outcomes and safety was the highest priority. This varied slightly between locations. The service user group in Canvey Island weighted “sustainable workforce” the highest.

Total criteria weighting



Criteria weighting by session



This feedback influenced the weighting of criteria for the options appraisal process for hospital reconfiguration, which were set as follows:

- Clinical quality, outcomes and safety (35%)
- Sustainability of workforce (25%)
- Access (22%)
- Efficiency and productivity (18%)

6. Phase 3 – Engagement in STP and hospital service change (September 2016-January 2017)

Building on the feedback from previous phases, discussions with stakeholders continued with greater attention on the STP story and case for change, leading to publication of the draft STP on 23 November.

In terms of potential hospital reconfiguration and redesign, the clinicians had narrowed down the possibilities in line with national clinical evidence and by applying the decision rules from phase 1. It was agreed that existing centres of excellence should remain unchanged, these being the Essex Cardiothoracic Centre at Basildon, Radiotherapy and Cancer Services at Southend and the Plastics and Burns Centre in Chelmsford. The STP therefore describes two potential models of hospital configuration with three variations of one model and two variations of the second model. In all five possible configurations, there is a designated specialist emergency hospital. In two possible configurations there is a specialist centre for planned care at Southend Hospital.

At this time, a number of clinicians and local people suggested that there should be further engagement and discussion before the options appraisal. The period for engagement was therefore extended and the options appraisal process shifted from November to February 2017.

During September and October 2016, and before completing the draft STP, the Success Regime held 11 open public workshops across mid and south Essex to test the case for change and gather wider views from public and service users.

The majority of participants in the open public workshops agreed that the health and care system needs to change and identified some common views on priorities for improvement.

The open workshop technique produced substantial feedback on the STP and potential issues and implications for patients, carers and protected groups. These issues will be considered as part of the pre-consultation business case and in future implementation planning.

Action

11 open public workshops took place across mid and south Essex in September and October 2016. Participants came from local community networks and general public, openly invited through local media and a leaflet distribution using the established distribution networks of the CCGs and trusts, supported by Health and Wellbeing Boards, scrutiny committees, HealthWatch bodies and councils for voluntary services (CVS).

Objectives

- To highlight important issues at an early stage (to help frame options for service change)
- To gain staff and service user insight on the wider context (to inform the STP)
- To gain staff and service user insight to inform the weighting of criteria for options appraisal
- To test messages and content (to inform the STP public summary and other communications)

The sessions

The sessions were designed to be interactive and deliberative as follows:

- Participants were asked at the start to say what they hoped to achieve during the session
- Following a brief presentation by lead clinicians on the case for change, participants were asked for feedback prompted by:
 - *Would you agree/disagree that the health and care system in mid and south Essex needs to change?*
 - *What would be your top three priorities to improve health and care for future generations?*
- Following a presentation on the overall STP and potential hospital reconfiguration, there was general discussion prompted by:
 - *What strikes you?*
 - *What sounds promising?*
 - *What are your concerns?*
- In the final task, participants used a post-it exercise to identify issues and implications for patients, carers and local people.

Who took part?

The workshops attracted a mix of people, mainly from middle age groups, but there were some from younger age groups. In the nature of this being a self-selecting exercise, all participants had a keen interest in health and care for various reasons, such as being already involved in community representation, being a champion for a particular group or service area, political interests and being involved in providing services. Some protected groups were represented.

Engagement in Thurrock

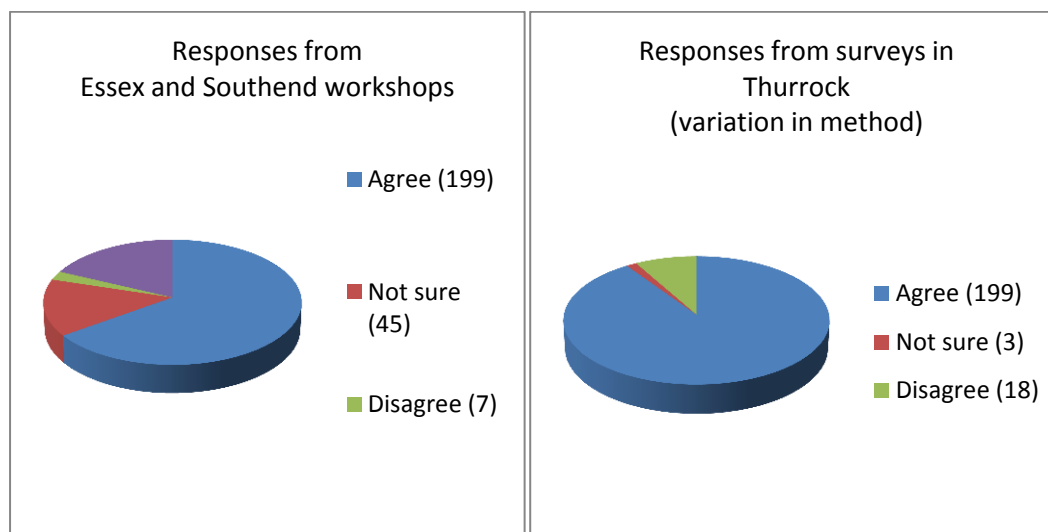
Methods in Thurrock varied from the workshop programme in Essex and Southend. In the interests of building on engagement that was already happening in Thurrock, HealthWatch Thurrock adapted its methods to gather feedback for the Success Regime. This included a written survey, discussions with local groups, discussions with individuals and two workshop events.

HealthWatch Thurrock was able to target specific service users of services for older people, stroke, COPD, people with learning difficulties and also local shoppers.

Ref: Informing Thurrock Residents about the Essex Success Regime report October 2016

Outcomes

Views on the case for change



Priorities for how the health and care system needs to change

The following lists the common themes in order of the number of times these issues were included in the feedback on top three priorities for improvement.

<u>Views from Essex and Southend workshops</u>	<u>Views from Thurrock surveys (variation in method)</u>
1. Access to GPs	1. Waiting times for primary care appointments
2. Better access to community care	2. Access to primary care and basic tests
3. Prevention	3. Available health professionals
4. Staffing	4. Local specialist services
5. Efficiency improvements	5. Joined up care
6. Increase in Government funding	6. Better social care
7. Mental health	7. Funding
8. Integrated health and social care	8. Transport
9. Increase/improvement in social care	9. Personalised care
10. Education for the public on services	10. More time for patients
11. Discharge and care planning	
12. Better hospital experience	

General reactions to outline plans (STP and hospital reconfiguration story)

Southend (45 attended)	Braintree (25 attended)
<p>Some people articulated that they could see that the strategy made sense, while others expressed the view that increased Government funding was a better solution.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Population and housing growth • Social care causing blockages • Poor road infrastructure • Timescale for developing primary and community care • Resilience to handle a major incident • Need to see evidence to support hospital centralisation <p><i>“Incidental things may make it difficult. Staff may not want to work in the new places.”</i></p> <p><i>“Clearer access in the community for patients. Proper education and signposting to services away from A&E”</i></p>	<p>Significant support– “welcomed” the idea of centres of excellence. Were reassured by positive contributions from a paramedic in the audience who explained the cardiac model.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Staff recruitment and retention – what are the incentives? Effects of Brexit, effects of staff having to travel • Ability of GPs to work together • More reablement in the community • Getting discharge right in an even more complicated system • Mental health • Need to see evidence of costs versus benefits <p><i>“Mental health hasn’t been mentioned much tonight, so it would be good to see in your business case/consultation document how mental health services will be changing or improving.”</i></p>
Maldon (55 attended)	Rayleigh (35 attended)
<p>Notable political interests. Some people were cynical about the case for change, but written feedback showed strong support for developing community based care.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • The future of St Peter’s Hospital • Social care • Community support in rural areas • Streamline CCG system • Pace of change may not support adequate consultation <p><i>“It all boils down to money. If there is more available all the problems will disappear.”</i></p> <p><i>“Personal good health is as much a matter of personal responsibility as it</i></p>	<p>Initial concerns about proposed changes in A&E were moderated with discussion. Access to GP services was a key issue.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Variation in quality of GP services • Current problems – waiting times, blood tests, ambulance, transport and parking • Increasing population and housing • Proposed A&E at Basildon could be hard to reach and create bottlenecks <p><i>“No system will work well without a motivated workforce. Centres of excellence should provide a creative environment for staff.”</i></p> <p><i>“Not enough GPs in the local area for all the new housing developments they are expected to cover.”</i></p>

<p><i>is a 'right'. We need to get that message across."</i></p> <p><i>"I want to see parity of esteem given to mental health in these plans – I need to know that these important services will be sustained in future."</i></p>	<p><i>"More joined up thinking between NHS services and social care."</i></p>
<p>Brentwood (20 attended) Some commented appreciatively on the opportunity to have a strategic co-ordinated plan. Others concerned about whether there would be sufficient support in the community to make the plan work.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Children's inpatient care should be as close to home as possible • Impact of Thames Gateway • Consultant empires <p><i>"Services in the community – should live up to claims"</i></p>	<p>Basildon (14 attended) There was a mixed audience with very different perspectives, some supportive of radical change, while others were sceptical.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Hospital transport • Sufficient ambulance services • Investment in social care • Distance and timing for life threatening cases <p><i>"We've been discussing these issues since 1990s Professional competition gets in the way"</i></p> <p><i>"There are people in hospital beds who should be at home with adequate care."</i></p>
<p>Canvey Island (25 attended) A supportive group showing considerable agreement with the strategic approach.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Population growth • Holistic approach to care • Consistent care for older people and carers – too many different departments • Shared information – shouldn't have to keep repeating same information • Upgrade for public transport • Maternity and children's services – women who need support need it in the community, not in hospital centre. • Research suggests time spent in an ambulance has a detrimental effect on patients <p><i>"Presentation was excellent and makes sense – need to improve on media coverage and get right messages out"</i></p>	<p>Chelmsford (35 attended) Challenging but thoughtful and deliberative audience. Supportive of strategy, while questioning issues of future implementation.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Minimise disruptive reorganisation • Population growth • PFI debt for MEHT • Collaboration of GPs • Transport and parking • Improve 111 • Specialist elective hospital may not attract staff • Ambulance capacity • Mental health • Impact of Brexit on recruitment <p><i>"The integration of social and health care. This is a really tough one but needs resolution."</i></p> <p><i>"Give patients more control of their own care – be more open with patients and share information re: their health, let them take control"</i></p>

<p>Billericay (18 attended) Given the relatively small size of this group, it was easier to have a detailed conversation with a strong flow of ideas about how to make the strategy work.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Agree with principles – can it become reality? • Distances on lower class roads for ambulances in stroke and cardiac situations • Care for carers • Social care • Population growth • Mental health care for young people • Compatibility of NHS and non NHS providers e.g. GPs, social services/private care homes • IT interface between primary and secondary care <p><i>“Many people will think that the loss of local services will be worse, this is not necessarily so and much work will need to be done to overcome this.”</i></p>	<p>South Woodham Ferrers (30 attended) Some people commented on the opportunity to improve local services, but most people were unsure about whether the vision could be achieved.</p> <p>Concerns to be addressed:</p> <ul style="list-style-type: none"> • Access to GP and other local services • Social care • Increase in housing locally • Workforce • Pressure on ambulance • Education about where to go for help <p><i>“We need evidence that local authorities and health are going to have shared budgets so that people can access the support that they need in the community and not block beds. We need concrete plans as this has been talked about for years and still no change.”</i></p> <p><i>“Unless local services are functioning correctly then everything else goes haywire – people who could have seen a pharmacist, nurse or GP end up in A&E.”</i></p>
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Issues and implications to be considered as part of decision-making

Workshop participants engaged in an impact assessment exercise to identify as many as possible issues and implications that should be considered in planning. This has produced substantial material, rich in detail that will inform the options appraisal and other planning decisions at later stages. The main themes are summarised under the following headings:

- What matters to patients and carers, including choices
- Issues for disadvantaged people and equality issues
- Transport and travel
- Advice on “making it work”

See annexe 2 for further details on the main issues under each of the above themes.

The main issues were as follows:

What matters to patients and carers, including choices?

- Personalised and compassionate care
- Prevention through good community services
- Joined-up services and development in the community
- Achieving good quality care from centres of excellence
- Increased funding for the NHS as a public service

Issues for disadvantaged people and equality issues

- Providing appropriate support to ensure access to good quality care
- Ensuring greater emphasis on mental health issues in all care settings
- Ensuring equality, particularly for those living furthest away from services and for those who may be disadvantaged

Transport and travel

- Addressing transport challenges for some patients – suggest an impact assessment focused on transport
- Transport issues for staff and how this could impact on care delivery
- The impact of additional travel and transfers on cost and efficiency

Advice on “making it work”

- Shared patient records
- The need for culture change among staff, patients and public
- The need for joined up services and consistency
- The need for investment and development, particularly in primary, community and social care
- Workforce recruitment, retention and development
- Ideas about making efficiency savings

7. Phase 4 – Options appraisal and further engagement (February-July 2017)

During phase 2 of engagement, the Success Regime established a Service Users Advisory Group (SUAG) to steer and challenge engagement in planning service changes. The Group is an assembly of representatives from the established network of CCG patient reference groups, trust governors, HealthWatch and Councils for Voluntary Services (CVS).

SUAG advised on service user involvement in the options appraisal resulting in the following agreed actions:

- The appraisal process included a review panel of service user representatives as one of four panels (the others being clinical experts, finance experts and system leaders).
- The outcome and recommendations of the service user review panel were considered together with the outcome of the other expert panels to review the options for hospital reconfiguration.

A report from the service users' panel was presented to the system leaders' panel and was included with the outcome of options appraisal for consideration by the STP Programme Board.

Action

15 service user representatives from the Success Regime Service Users Advisory Group (SUAG) met on 20 February 2017 to discuss and score the five possible options for hospital reconfiguration, using the scoring process agreed against three criteria.

The 15 panel members comprised three people from each of the five CCG areas. Although it was agreed that panel members should undertake the appraisal in the best interests of patients and public as a whole, it was considered important to ensure a balance of locality interests alongside care group interests.

Pre-briefing

Prior to the session, there had been a detailed briefing on 8 February to ensure that participants were familiar with the options and to introduce people to the background information and evidence. There was a detailed discussion with some 30 members of the SUAG based on a draft abridged version of the data pack for options appraisal. Subject matter experts were present to brief and answer questions. Subsequently, the full data pack was circulated to the service users' panel prior to the appraisal session.

Scoring process

There was a short recap at the start of the session to reiterate the five possible configurations and an opportunity for people to ask questions before considering the options. Subject matter experts were in attendance to answer questions.

Before inviting scores from the panel members, there was a brief summary of the available evidence for each criterion. This generated further discussion and debate among the panel members. From this debate, we have captured the main points showing where there are variations in views and where there are important matters that the panel feels should be taken into consideration.

For the first criterion, *clinical quality, safety and outcomes*, the panel divided into three mixed groups to reach a consensus score for each of the options. The final score was taken as an average from the three groups. For the other two criteria, the panel worked as a whole group to agree the final scores.

Outcomes

1. Quality, safety and outcomes

Overall acceptance that reconfiguration offers the potential to improve clinical quality

Participants commented on the clinical evidence that specialisation can improve clinical quality, but at the same time noted that there was evidence that increased travelling time by ambulance could have a negative impact on mortality rates.

On the whole, most people felt that consolidation and separation of emergency from planned care did offer the potential to provide better clinical quality, safety and outcomes.

Factors that influenced views on location of services

Two of the three sub-groups gave their lowest score to Option 1C, where they felt that Southend was too remote to provide a safe specialist emergency hospital for the majority of residents in mid and south Essex.

The third group gave a lower score for Options 2A and 2B as these options were associated with more patients travelling or transferring between services and it was considered that this increase in journeys could affect patients' clinical conditions. Some panel members were concerned about the impact on emergency care for people in Southend in model 2.

Another key factor that influenced the lower score for model 2 was that some people were not convinced that it would be possible to maintain the ideal of an elective care centre. It was felt that, while the theory held some merit, it would not be possible to protect the bed capacity from the impact of ever-increasing emergency demands.

Co-location and interdependency issues

Three members of the panel were extremely keen on the opportunity to co-locate specialist emergency services with specialist women's and children's services – which made Broomfield their preferred location for the specialist emergency hospital.

One person remained unconvinced that the cardiothoracic centre had interdependency with other emergency care services, as it operates as a stand-alone unit.

Issues and implications for further consideration:

- The models can work but need radical changes in the local health and care system, joined up care in particular
- All of the models rely on effective shared information and patient records – this needs clear plans and “watertight” communications between services.
- There is a need for more discussion with service users about whether emergency care and assessment services at the “yellow” hospital would be available 24 hours a day.
- Do the hospitals have the estates capacity to create the required additional beds?
- Public education is vital e.g. how will people know where to go?
- Some members of the panel felt strongly that there could be clinical benefits in a specialist emergency hospital at Broomfield due to the opportunity to provide specialist obstetrics and children’s services from the same site. The view was that women’s and children’s services should not be separated
- It was felt that there should be accommodation for carers, particularly for parents of sick children
- Family support for patients was considered highly important to clinical outcomes and that this should be taken into account when patients have to travel long distances from home for specialised care.
- The Eastern Academic Health Sciences Network (EAHSN) was funded by and therefore biased towards the aims of NHS England. We should not describe it as “independent”.
- The EAHSN report itself acknowledges that some of the data available is of low quality.
- The EAHSN report makes clear that, while there is national evidence and clinical guidance on component parts of the model, there is limited evidence associated with the particular model proposed by the Success Regime. Some members of the panel were concerned with the risks associated with this.

Scoring

Average scores from the three sub-groups

Option	Score
1A	4
1B	4
1C	3.67
2A	3.67
2B	3.67

Unlike sustainability of workforce and access, the quality, safety, and outcomes criterion was judged separately by three tables. On options 1C, 2A, and 2B, the consensus reached on each table was not consistent, and therefore the average was taken.

2. Sustainability of workforce

Overall view

For all options, there is a reliance on an adequate specialist workforce, which may or may not be available. This needs to be in place in readiness for change.

Following discussion and debate, there was a general agreement that there were too many unknowns and uncertainties to reach a conclusive view on the differential benefits of each option against this criterion.

Some people accepted that specialisation in certain fields could be attractive to clinicians in those fields. Others remained unconvinced that reconfiguration would attract and retain the workforce as a whole.

There was a wide range of opinions and no genuine consensus, but the panel agreed that the effect of perceived benefits versus perceived disadvantages gave all options a score of 3.

Comments on the two models

Model 1 did not seem to offer a convincing solution to the current workforce pressures as it was stated in the evidence available that this model required an increase in clinical staff.

Although it was explained that model 2 would require broadly the same staffing level as currently, it was felt that there was insufficient evidence that model 2 would improve staffing issues. An important issue was that people felt there was a lack of evidence about how the staff themselves would react to reconfiguration and what their future choices would be.

Issues and implications for further consideration:

- There need to be clear plans about training and development to “grow our own” workforce
- The workforce across the three hospital sites should have equality in terms and conditions of their employment e.g. if Basildon was to offer a London weighting and not the other two hospitals, then this could affect the choice of reconfiguration
- How do we influence where people might want to live?

Scoring

Option	Score
1A	3
1B	3
1C	3
2A	3
2B	3

3. Access

Overall view

The views arising during discussion and debate that influenced thinking were as follows:

- Southend offered the least accessible site for the specialist emergency hospital
- Basildon offered good access for the specialist emergency hospital (although not perfect, when demography is taken into account)
- A centre for elective care could offer significant improvement in access, given the potential to improve cancelled operations
- Broomfield as a specialist emergency hospital posed significant access difficulties for people in Southend. (Although, three panel members were of the view that keeping women's and children's services together improved access to high quality care).

Issues and implications for further consideration:

- There is wide diversity across the patch, pockets of deprivation and vulnerable people and carers. We need to investigate fully the impact of a potential hospital reconfiguration on all residents and vulnerable groups. It was considered that disadvantages in terms of access can impact on clinical outcomes.
- Do we have the resources to increase the number of ambulances and paramedics required to transport patients to hospital and to step down services?
- There is a need for improvements in patient transport. Anecdotal evidence suggests current arrangements cause lateness for appointments and significant inconvenience for some patients.
- There is a need for improvement in community and step down care in order to improve discharge and reduce hospital lengths of stay. The perception was that social care is a major area for improvement.

Scoring

Option	Score
1A	3
1B	3
1C	2
2A	4
2B	3

Comments on the process

Several panel members made clear at the start of the session that they felt that there had been insufficient time to digest the evidence and background information provided, given the complexity of the subject matter. It was agreed that there would be a further sessions to explore unanswered questions and test the potential options with patient scenarios.

Other issues raised after the session

- We need a clearer view of the proposed level of emergency care at the amber and yellow hospitals
- We do not yet know the impact of Brexit on staffing
- Travelling time for consultant staff to different hospital sites could be expensive and could reduce the time available for patients, particularly if they are stuck in traffic for example. *“As a patient, I would want to see the surgeon who is going to operate on me and would rather travel to this appointment than see an alternative doctor.”*
- Will junior doctors get the range of experience they need for training? Are there risks to maintaining training status?
- We would like to see greater clarification on how minor injuries services fit into plans
- How might we develop the Southend cancer centre to become a national centre of excellence?
- Have we factored in the increase in housing and industrial sites over the next few years?

Further engagement

Even though the options appraisal process clearly identified one preferred option for the potential hospital reconfiguration, there was a strong view that this theoretical approach should be sense checked to address local concerns, practical issues and implications.

Following the options appraisal, local discussions became more focused on access to emergency care and a common concern as to whether or not a “blue light” ambulance journey to Basildon Hospital could be clinically assured.

The SUAG and others sought further details on the levels of service that would be available at each local A&E and which patients would be travelling direct to Basildon for life-saving emergency care. This will be addressed as part of the forthcoming public consultation.

At the same time, the emergency care clinicians and others, including CCG clinical chairs put forward a strong view of the benefits of a “treat and transfer” model.

As part of the further engagement, we commissioned HealthWatch Essex to conduct a detailed study into the views of local citizens on potential changes in access to hospital emergency care. Although this project reported its findings after the July announcements, it provides a deeper dive into the perceptions and concerns of our local public and patients.

The following extracts from the HealthWatch report summarise up the study’s findings.

Phase 1: Survey

A total of 306 people took part in the HealthWatch survey across Basildon, Broomfield and Southend Hospitals.

To summarise, the key findings from the survey 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*

Phase 2: Deliberative workshop sessions

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.

For a full copy of the report, please visit the HealthWatch Essex website

In this fourth and final phase of engagement, following the options appraisal, we changed our thinking from a model where patients would access specialist emergency care at a single specialist emergency hospital to a model where the majority of patients would be treated initially at their local A&E and then, if needed, transferred by ambulance to a specialist service, which may be in another hospital.

The feedback which led to this development came from several groups of stakeholders, including both professional and public voices. The influence was particularly strong from engagement that was embedded within the planning process and the options appraisal e.g. with the Acute Leaders Group. feedback from wider hospital staff, CCG clinical engagement, Service Users Advisory Group (SUAG), Health and Wellbeing Boards, Scrutiny Committees, HealthWatch bodies and liaison with local MPs.

Annexe 1 – Links to further information

Annexe 2 – Further details on issues and implications to be considered in decision-making and implementation planning

Workshop participants during September and October engaged in an impact assessment exercise to identify as many as possible issues and implications that should be considered in planning. This has produced substantial material, rich in detail, which will inform the options appraisal and other planning decisions at later stages. The main themes are summarised under the following headings:

- What matters to patients and carers, including choices
- Issues for disadvantaged people and equality issues
- Transport and travel
- Advice on “making it work”

What matters to patients and carers, including choices?

Personalised and compassionate care

- Choice feeling part of decision making process
- Having time with carers and family
- Consistency – getting to know staff, having a good relationship
- Clearer explanations about options – feel listened to
- Time allocated to patients
- Support for families when patient in hospital (especially when out of environment)
- Communications after hospital
- Patients and carers not always together when choices explained. Doctors rounds are early morning when carers rarely there

Prevention through good community services

- Improvements in out of hours care in community
- Better access to GPs
- Access to GP services 6 days a week 7am-8pm
- GPs should have more time with patients
- Information and advice (for younger people)
- Choices about lifestyle changes
- Hubs could train/advise people on choices
- Information about treatment including pathway if there is one
- Each area has its own local needs

Joined-up services and development in community

- Good communications between services – to get back to local care
- A one stop shop for patients – team who look after a patient and their family – help so they know where to go and who to see for different problems
- Consider spokes in those areas furthest away from centres of excellence

- Social care services in hospital to prevent blocks
- Improve hospital discharge e.g. reduce waiting time for medication and social care package
- Stronger links and support for rehabilitation post specialist care
- Intensive rehab services in the community
- True integration of health and social care with GPs and other health professionals
- Continuity of care for long term conditions
- Day surgery and minor injuries should be local – like bringing back community hospitals
- Local prescribing in the community - nurses and other services should be able to administer some drugs
- One patient care record. Systems (IT) that talk to each other
- Access for residents outside the mid and south Essex area
- Vol sector can help with choices and decisions e.g. access alternative services
- Mental health centre that GPs can fastrack
- Improve information on benefits as part of information about care

Good quality care

- Centres of excellence
- Consistency in patient pathways
- Consistency among GPs on referral and prescribing
- No long waiting times
- Speedy, reliable diagnosis
- Safety, dignity, effectiveness
- Outcomes – best service for patient in critical condition
- Accommodation for relatives

NHS funding

- Protect our NHS as a free resource
- Charge for some things
- Raise taxes

Issues for disadvantaged people and equality issues

Support

- Patients without drivers need real support if long journeys involved
- Support for older people who can't drive
- People with learning disabilities need support to access new pathways - need a disability nurse for communication
- Transport for physically disabled people
- Need to be near friends and family – treatment close to home – reduce travel for sick people e.g. cancer patients, people with MS
- Transport for dialysis patients
- Long distances with sick children are very difficult
- Parents with other children having to travel
- Respite care needed for some
- Cost of travel and parking for low income people
- Support for people with autism spectrum disorders
- Staff need to be trained in how to manage needs of older people with, for

- example, deafness, confusion, pride
- Accessible information e.g. easy-read, video
- Sensory impairment keeps being forgotten – use vol sector specialists

Mental health

- More focus on mental health
- Mental health out of hours
- Support for people with dementia
- Dementia training needed for hospital staff
- Mental health care at A&E – problems if taken out of area
- Hospitals should link with mental health services

Equality

- Those in rural areas disadvantaged
- People who cannot get out of their home should be assured of as good a service as others who are more mobile. Could have a mobile GP
- People who rely on carers will have access difficulties
- Access for people at the edge and outside the area
- Difficulties for some in using IT
- Older people using public and community transport sometimes miss appointments
- Vulnerable people will have a lot to arrange
- Training to all staff in equality communication, diversity, culture, respect, disability
- Would it be mandatory for all GPs to be part of a hub? Otherwise it's unfair to patients
- Different terms and conditions for staff
- Rural geography difficult for community staff

Transport and travel

Transport challenges for patients

- Need an impact assessment focused on transport
- Special transport for planned care
- Partnership with public transport – link timetable with clinic times and visiting times
- Community transport needed
- Transport for relatives
- Integrated travel for patients/carers
- Road infrastructure and access to hospital sites
- Being able to park, park and ride
- Need to publicise available transport option e.g. DART (staff didn't even know)
- No parking charges
- Car parking could be part of council tax – removes stress when attending hospital
- Access to hospitals for carers and visitors
- No bus services in some areas after 7pm – lack of public transport to Basildon
- How people get home after treatment if they cannot afford a taxi
- Develop an app for community transport – like Uber model
- Better ambulances – improved design

Staff and internal transport issues

- Transport and parking for staff
- Look at costs and time involved

Impact on efficiency

- More reliable appointments improves travel arrangements
- Transport links to clinics and centres

Advice on “making it work”

IT and shared records

- Consistent IT and shared records – improved communication between services
- Single IT system, speedier access to results
- Shared care records between health and social care
- Local surgery is doing well with telephone appointments with GPs – extend to video conferencing
- All systems consistent e.g. appointments booking, health analytics
- Increase use of assistive technology

Culture change

- Keep providing clear information and encourage hearts and minds
- People need more education about how to get help
- Help people to understand the rationale for reconfiguration
- Think differently about organisations and delivery
- Stronger partnership culture in GPs and hospitals
- Do we always have to see a specialist in hospital? Think carefully about centralisations v decentralisation. E.g. many cancer treatments now best delivered at home or locally
- Information on plans publicly known – openness and honesty
- Use artistic methods to explain change e.g. drama, music
- Make people aware of social care schemes
- Involvement of patients – consideration of actual experiences

Joined up services

- Better communications between joined up services
- Have single points of access – more joined up thinking – one point of contact responsible for your care
- When seeing neurologist– need to have access to nurse specialist
- Cooperation between services crucial in rural areas
- More integrated mental health and more resources
- Use more community staff instead of GP
- GPs to divert time wasters in A&E
- Better coordination and timely communications especially on discharge
- Include thinking on links to other hospitals and services outside the footprint
- Engage with voluntary sector – use specialist understanding
- No competition, services working together
- CCGs need to work together
- Pharmacists/housing/ all critical

- Co-located multidisciplinary team works well

Improvements and development

- Major improvements in ambulance services
- Separate A&E for adults and children
- End of life plan for all
- Access to local A&E should be 24/7 even if then transferred
- Local day care operations
- Local minor injuries and treatments
- Shorter waiting times for appointments and hospital treatment
- Improve quality of 111
- Review models of proven excellence
- Reduce bed blocking e.g. with assessment centres for older people
- Fast track discharge
- PPGs are a great resource for adopting innovation and best practice
- Transition planning

Workforce development

- Reward, recognise and motivate staff
- Increased use of peer support groups by professionals
- Shared information and good practice
- Nurse led clinics are more efficient than consultant led
- Specialist emergency hospital could attract more staff
- Grow the workforce – consistent employment contracts
- Rotation for clinicians
- Nurse education needs an overhaul. Engage with schools e.g. sixth form college have nurse apprenticeship classes linked to local hospital
- Nurse education needs to be free of charge – university system has disadvantages

Costs and savings

- Rationalise CCGs
- Pool commissioning resources
- Ask for more funding – argue for Treasury to write off PFI debt
- Consider payment for some services
- Medication reviews and waste management
- Opportunity to make better use of estates
- Make sure non-eligible NHS patients pay for their treatment at private market rates
- Consider closing a hospital
- Higher taxes to fund NHS